Gold Coast Hospital and Health Service

2012–13 **Annual Report**

Great state. Great opportunity.

Queensland Government

Gold Coast Hospital and Health Service Annual Report

Welcome to the inaugural annual report of the Gold Coast Hospital and Health Service following its establishment as a statutory body on 1 July 2012. The report is designed to meet the Gold Coast Hospital and Health Service's annual reporting requirements to the Queensland state government, Minister for Health, the community and other stakeholders.

This annual report provides an overview of the financial and non-financial performance and financial position of the Gold Coast Hospital and Health Service for the 2012-13 reporting year. This includes details of the Service's outcomes against its 2012-13 strategic priorities and the Queensland Government's health priorities detailed in *Getting Queensland Back on Track: Statement of Objectives for the Community* and the *Blueprint for better healthcare in Queensland*. This report also provides information on how the Service is governed, the people who enable the Service to operate and plans for building a healthier Gold Coast community.

Public availability statement

An electronic copy of this publication and other annual online data reporting documents are available at www.health.qld.gov.au/goldcoasthealth/html/news/publications.asp

For further information, or to request a hard copy of this publication, please contact the Governance and Executive Services Unit, Gold Coast Hospital and Health Service, by phone (07) 5519 8767 or email ExecOfficeReception@health.qld.gov.au

Interpreter Service statement

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on (07) 5519 8767 and we will arrange an interpreter to effectively communicate the report to you.

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Letter of compliance

The Honourable Lawrence Springborg MP
Minister for Health
Member for Southern Downs
Level 19, 147-163 Charlotte Street
Brisbane QLD 4000

Dear Minister

I am pleased to present the 2012-13 Annual Report for the Gold Coast 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 in this report.

Yours sincerely

Mr Ian Langdon
Board Chair
Gold Coast Hospital and Health Service

Contents

Message from the Chair

Board Chair Ian Langdon

When my fellow Board Directors and I made the decision to apply as inaugural members of the newly created Hospital and Health Boards it was because we were committed to the principles of health transformation.

It has been a privilege to lead this monumental change for the health industry on the Gold Coast. The goal of devolving decision making to the local level is to improve efficiency and engage the local community in its health services. Over the past 12 months the Board has taken steps to ensure that goal is achieved.

A key priority was to find a leader with the background and drive to support the Board's vision and priorities and it is without doubt that Chief Executive Ron Calvert has been a catalyst for change within the Service.

Four of our key priorities for this period focused upon: access to services, budget integrity, operating an expanded Robina Hospital and preparing for the opening of Gold Coast University Hospital.

These priorities have been seized upon and the results have been impressive.

We have finished the year with a $5.98 million surplus. Our waiting times to access emergency departments have decreased markedly to the point where Gold Coast is cited as an example of what can be achieved with the introduction of national access targets and empowering staff to find new ways of delivering care.

Outpatient clinics are being addressed to improve patient access to health services. A conversation is underway in our community because more information is available to patients around waiting times for specialties. Greater transparency enables us to better engage and build community confidence in our health services.

Services at Robina Hospital continue to expand and the realisation of one of Australia's finest health facilities, Gold Coast University Hospital is looming large. We are exploring opportunities to build partnerships, undertake contestability and find new ways of delivering care.

The community is reaping the benefits of greater efficiencies in our system as funds are channelled toward clinical areas of need and patient safety initiatives. During 2012-13, new initiatives have enabled over 750 additional patients to receive an endoscopy appointment and seven out of ten patients are now consistently seen within four hours of presenting to our emergency departments.

None of this achievement can be made without the people who deliver the services. The efforts of our staff and the diverse skills they bring combine to produce quality care in the hospital and the community every day. It is true our successes have not come without challenges. A voluntary redundancy process was initiated to support an emergent budget adjustment and, more significantly, to design a new structure to better position the Service for the future.

A new strategic plan has been endorsed and a key goal of the Board is to develop a brand that elicits pride from our staff and our community. Staff members are being consulted as part of this program with an aim to develop a culture that will support our desire to become an employer of choice.

Message from the Chief Executive

Chief Executive Ron Calvert

The first year as a statutory authority has been eventful and productive for the Service. Upon my arrival in October 2012, I made it clear that my immediate focus would be on patient safety, quality and service delivery.

We have made good inroads on these aspects of our service delivery. Key highlights over 2012-13 include:

- improved access to emergency services
- reduction in the standardised mortality rate
- improvement in hand hygiene compliance
- reduction in infection (clostridium difficile) rates since November 2012
- reduction in waiting times for endoscopy procedures
- improved outcomes towards national targets
- end of year surplus operating result
- funding approval to commence new tertiary services
- contestability inroads on innovative service delivery models
- increased evidence of autonomy as a statutory authority
- restructure of clinical governance
- progress on planning and delivery of Gold Coast University Hospital.

It has been a strong start but there is further to go. To this end, the Board has approved a strategic plan for 2013 – 2017 and it will form the basis for our priorities in the coming year. The plan guides our future direction alongside the annual Service Agreement negotiated with the Queensland Department of Health.

It has been a time of change for our workforce due to the significant growth in infrastructure on the Gold Coast, the introduction of national health reform, and the imperative to reassess health service delivery models in the current economic climate.

In the face of such challenges, the dedication to patient care has been reflected in the improvements described above and the commitment shown in times of natural disaster such as the floods we experienced last year.

I am pleased to confirm that a surplus of $5.98 million has been achieved. This community dividend will be used to further focus on our strategic agenda, starting with making significant reductions in outpatient waiting times. Clinician feedback has been instrumental to defining our priorities. The Board has also committed to patient safety initiatives in addition to introducing ward based pharmacists and increasing investment in wound care management and patient falls prevention.

By this time next year, the magnificent Gold Coast University Hospital will be incorporated into the Service alongside our many existing facilities such as Robina Hospital, Carrara Health Centre, Robina Health Precinct and extensive range of community based services. I look forward to working with our Board, the Executive Management Team and our staff to realise the myriad of opportunities available to us in the future.

Highlights

2012-13 Operating Surplus
$5.98 Million

More than **12,000** elective surgeries performed

More than **300,000** outpatient appointments provided

More than **125,000** people attended emergency departments

3760 Births

Dedicated volunteers provided
30,000 hours of service

76% increase in compliments
15% decrease in complaints

826 inpatient beds:

445 Gold Coast Hospital
318 Robina Hospital
63 Carrara Health Centre

2755 Nurses
853 Medical officers

About Us

Gold Coast Hospital and Health Service was established as a statutory body on 1 July 2012 under the *Hospital and Health Boards Act 2011*. The Service is governed by the Gold Coast Hospital and Health Board. The inaugural Board was appointed by the Governor-in-Council and is accountable to the local community and the Minister for Health.

The Board's first meeting was held on 29 June 2012, which heralded the commencement of local control and decision making for public health services in the Gold Coast region.

Our vision

The Service will, through innovation and patient-centred care, become a world-class provider of public healthcare services.

Our purpose

To provide safe, sustainable, efficient, quality and responsive health services for the Gold Coast regional community.

Our mission

- Lead disease prevention on the Gold Coast
- Provide secondary and tertiary services of the highest quality and best value
- Design and implement contemporary models of integrated healthcare
- Provide high quality health sector education
- Contribute to knowledge development through research and evidence-based clinical practice

Our values

- Acting with integrity
- Being accountable
- Serving the community
- Empowering people
- Working together
- Striving for excellence

Our priorities and strategic objectives

The Board is responsible for ensuring that the Service addresses its strategic priorities, congruent with the key themes of the Government's health priorities detailed in *Getting Queensland Back on Track: Statement of Objectives for the Community* and the *Blueprint for better healthcare in Queensland*.

The Service's 2012–13 strategic objectives were:

1. To provide better services and access for our patients
2. To work with our partners to improve the health of our community
3. To work with our consumers and the community, to allow a greater say over their hospital and local health service
4. To improve efficiency and deliver better infrastructure
5. To empower frontline staff and value our employees

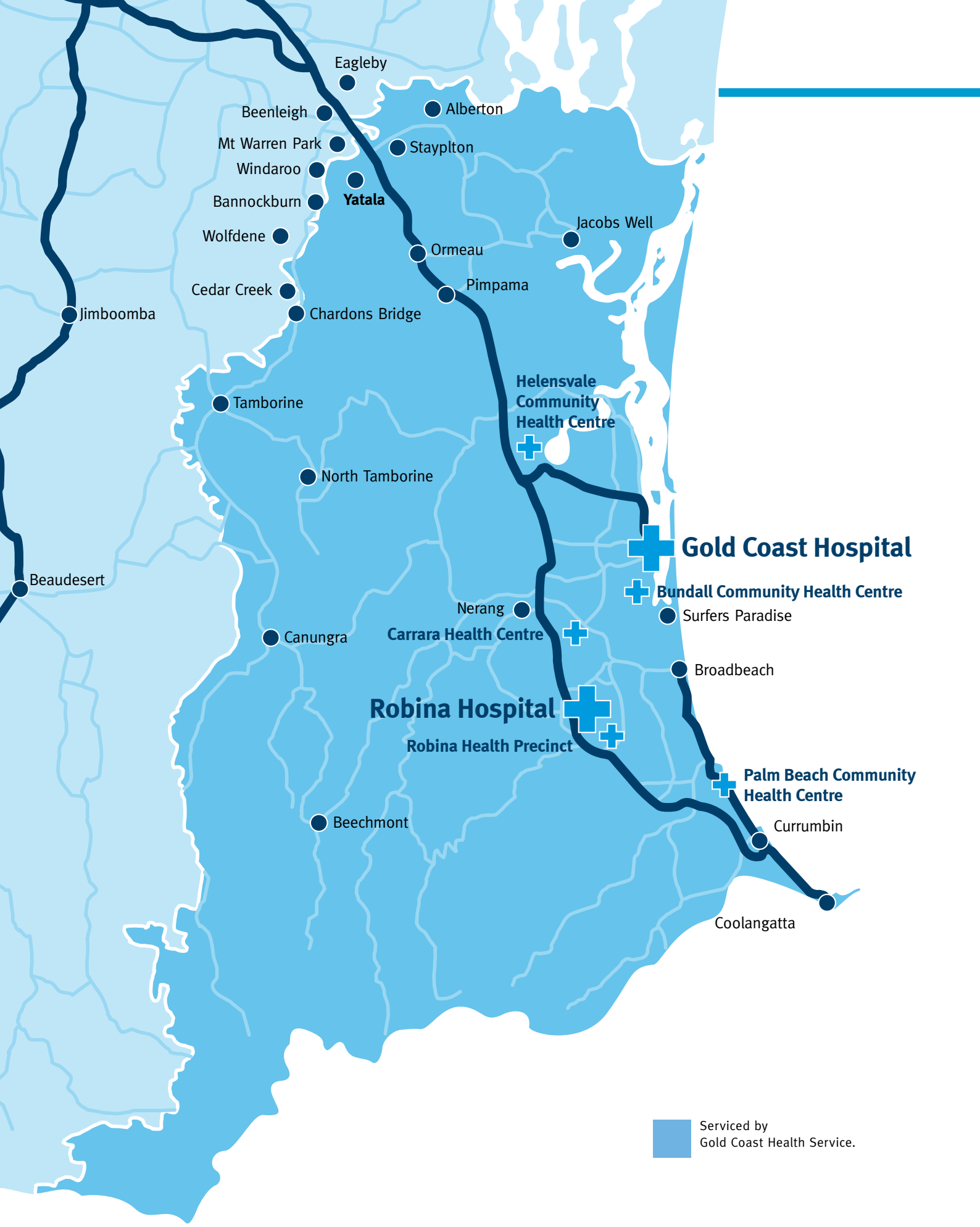


Figure 1: Geographic area serviced by Gold Coast Hospital and Health Service

Our strategic challenges

The Queensland health system is undergoing significant reform and facing increasing demands from the state's changing demographics. Operating in this environment, the Service has identified a number of key strategic challenges it will face in the next four years. These are:

- Ongoing achievement of national performance targets while continuing to provide sustainable services to meet increasing demand. This will be managed with a range of strategies to optimise utilisation of our services in partnership with the primary healthcare services, with the key theme of developing integrated care pathways.
- Meeting critical performance outcomes in a period of major change. This will be achieved with on-going clinician engagement, strengthened accountability and reporting systems.
- Recruiting and retaining a talented workforce in a highly competitive market in areas where national and international workforce shortages exist. Specific targeted recruitment and retention strategies will be employed to overcome this challenge.
- Maintaining a positive workforce culture during a time of significant change and leveraging the opportunities to enhance research, education and training through the positive engagement with university partners.

Our community

The Service delivers public hospital and health care services to a population of approximately 525,000 people across a region bounded by the Logan and Albert Rivers in the north and northwest, Mount Tamborine, Canungra and Beechmont to the west, and Coolangatta in the south. The area features high population growth, high tourist numbers, an ageing population and lower incomes compared with the rest of Queensland. Additionally, the Service delivers secondary and tertiary health services to the Northern New South Wales community and the many tourists who visit our region.

Figure 1 provides a visual representation of the geographic area serviced.

Our workforce

More than 5000 medical, nursing, clinical and clinical support staff, along with a committed team of volunteers, work together to deliver quality care to the Gold Coast regional community.

Our services

The Service delivers a broad range of secondary and tertiary health services across two public hospitals and a number of health precincts and community health centres throughout the Gold Coast. Additionally, the Service delivers key primary health services including community child health clinics and oral health services for both adults and children.

The Service is committed to strengthening the quality, safety and efficiency of its services to its community. The leading causes of illness on the Gold Coast are cancer, nervous system and sense organ disorders, cardiovascular disease and mental health issues.

Establishment of the Service as a statutory body has provided increased opportunities to tailor services to the needs of the local community. During 2012-13 the Service continued its planning to introduce new and expanded services to address identified community health needs. These include neonatal intensive care, radiation oncology and cardiac surgery, which will be provided at the new Gold Coast University Hospital.

The foundations were also laid for improving our health care services in 2013-14 to achieve a world-class health service, including stronger integration of care, improved resource utilisation and creation of a world-class health knowledge technical precinct.

Our Facilities

There are over 800 beds across the Service's inpatient facilities, which include Gold Coast Hospital, Robina Hospital, and Carrara Health Centre. In addition, a range of facilities deliver multi-disciplinary services to the community.

Gold Coast Hospital

Gold Coast Hospital currently offers services including chemotherapy, coronary care, dialysis, elective and emergency surgery, emergency care, intensive care, obstetrics, oncology, outpatient services, paediatrics, specialist and general medical care, acute psychiatric and rehabilitation services.

In late September 2013, Gold Coast Hospital will transition to a new 750 inpatient bed tertiary facility as part of a 'move and grow strategy' to create the Gold Coast University Hospital. Australia's new, first named University Hospital, will provide complex care, research and teaching opportunities on the Gold Coast and will play a key role in training the clinical leaders of the future. The existing Gold Coast Hospital will be decommissioned when the Gold Coast University Hospital opens.

Robina Hospital

Robina Hospital offers services including surgery, general and specialist medicine, aged and dementia care, emergency medicine, intensive care, cardiology, mental health and ambulatory care services. The hospital also offers palliative care services for cancer patients and people with multiple sclerosis.

Robina Health Precinct

Robina Health Precinct provides a mix of community services including antenatal and post-natal care, cardiac rehabilitation, child and youth mental health, family health clinics, healthy aging clinic, and chronic disease and post-acute care.

Carrara Health Centre

Carrara Health Centre is a 63 bed inpatient facility providing single rooms for patients requiring rehabilitation and interim care. It features a rehabilitation gymnasium and both indoor and outdoor therapy areas to support 24 hour care in a therapeutic setting.

Community services

Community service facilities are located throughout the Gold Coast region providing a range of services including child health, mental health, oral health and sexual health. This includes community health centres at Palm Beach, Bundall and Helensvale, and mobile and fixed oral health facilities.

Our Governance Structure

Gold Coast Hospital and Health Board

Gold Coast Hospital and Health Service was established as a statutory body on 1 July 2012 under the *Hospital and Health Boards Act 2011*. The Service is governed by the Gold Coast Hospital and Health Board. The Board is responsible for setting the organisation's strategic direction and monitoring the Service to ensure it delivers quality health outcomes for the local community. The Board is accountable to the Minister for Health.

Chief Executive

The Health Service Chief Executive is responsible for leading the Service, including its overall management and performance. The Chief Executive is accountable to the Board.

Health service executive

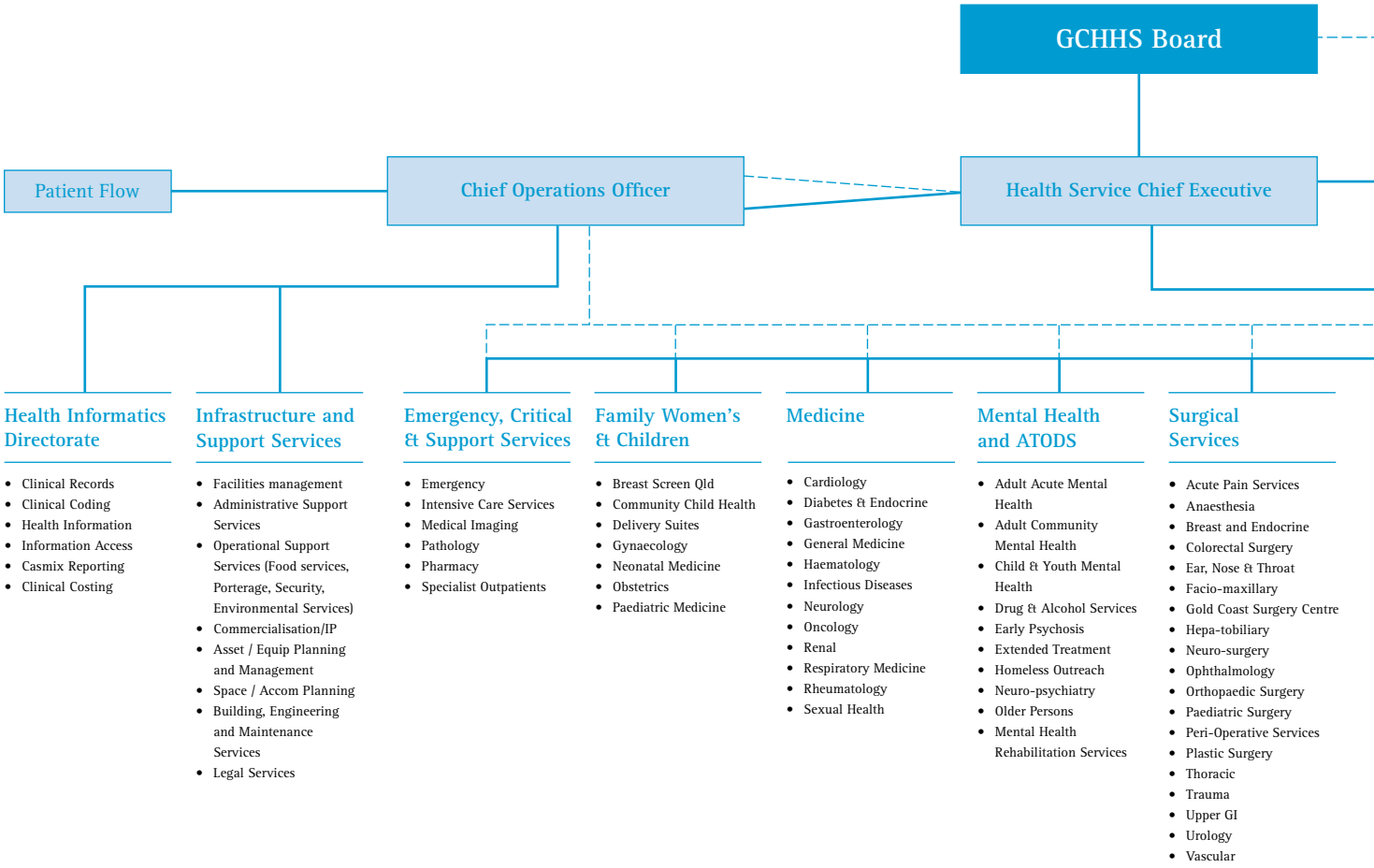
The Chief Executive is supported by a team of executive directors who are individually responsible for leading the delivery of health care and related services within their respective portfolios. Executive directors report to the Chief Executive.

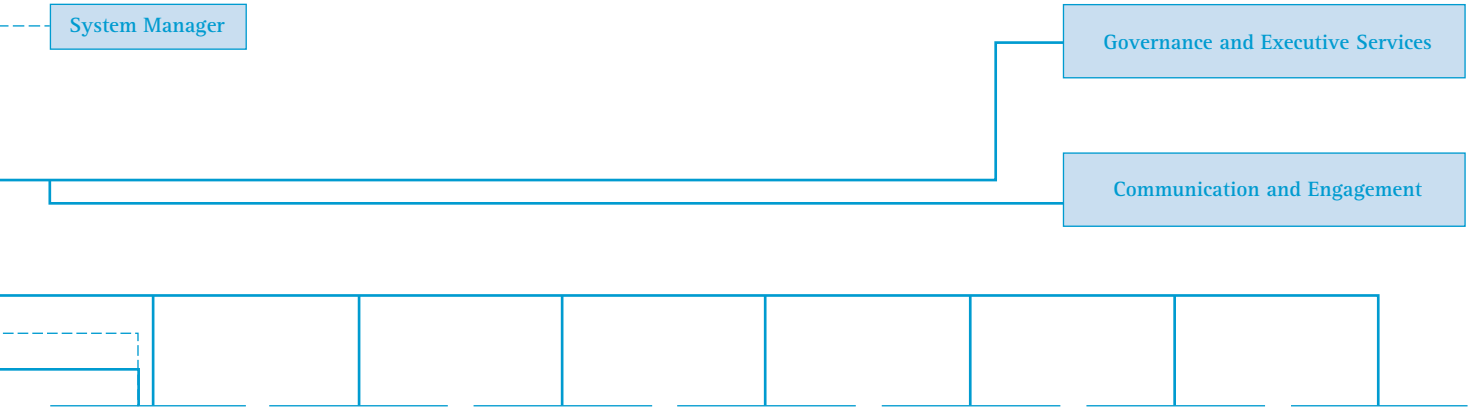
Reforming Our Health System

- Work with our partners to improve the health of our community.
- Work with our consumers and the community to allow a greater say over their hospital and local health service.

Organisation Structure

Figure 2: Gold Coast Hospital and Health Service's 2012-13 organisation structure





Community, Subacute and Aged Services

- Adult Community Health
- Aged Care
- Needle & Syringe Program
- Transition Care
- Community Hospital Interface Program
- Home and Community Care
- HACC Area Manager
- Community Rehabilitation
- Indigenous Health
- Interpreter Services
- Multicultural Liaison Officer
- Oral Health
- Palliative Care
- Rehabilitation and Aged Services
- Aged Care Assessment Team
- Subacute Assessment Team
- Transition Care Program
- Home Health Link
- General Practice Liaison Team

Allied Health Services

- Allied Health Standards
- Allied Health Workforce
- Allied Health Research
- Allied Health Education

Medical Services

- Accreditation
- Clinical Governance
- Library
- Credentials & Privileges
- Disaster & Emergency Management
- Medical Standards
- Medical Workforce
- Ethics & Research
- Medical Research
- Medical Education
- Patient Safety & Liaison
- Safety & Quality

Nursing and Midwifery Services

- Nursing Standards
- Nursing Workforce
- Nursing Education
- Patient Flow
- Nursing Research
- Nursing
- Pastoral Care

People, Systems and Performance

- Workforce Planning
- HR Client Services
- Recruitment
- Workplace Relations
- People Capability
- Volunteer services
- Safety and Wellbeing

Financial Services

- Strategic Financial Management
- Operational Finance
- Private Practice Coordination
- Revenue Optimisation
- Shared Services Provider Relationship Management for Finance & Supply Functions
- Establishment Management

Strategic Development

- Major Projects
- Health Service Planning
- Information Technology Services

Legend

Operational reporting line

Professional reporting line

The Board

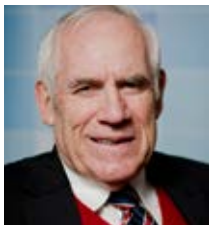
Mr Ian Langdon Chair,
Gold Coast Hospital and Health Service
Appointed 18 May 2012
to 17 May 2016

Mr Ian Langdon has extensive board experience encompassing roles such as board chairman, audit committee chairman and non-executive director with a wide range of companies.

He has been a member of the Board of Directors for the Peanut Company of Australia since 2005 and held the position of Chair since March 2008. He has held various positions on organisational boards and committees since 1989 including for Australian Co-operative Foods Ltd (the Dairy Farmers Group), Delta Electricity and Rabobank Australia Limited.

Mr Langdon has held various positions in tertiary education including Associate Professor and Dean of Business Faculty at Griffith University (Gold Coast Campus) and Dean of Business at The Darling Downs Institute of Technology (now University of Southern Queensland).

Mr Langdon is a Fellow of the Australian Institute of Company Directors, Certified Practising Accountant and Chartered Accountant. He holds a Bachelor of Commerce, Master of Business Administration and Diploma of Education.



Mr Kenneth Brown PSM
Deputy Chair and Board member
Appointed 29 June 2012
to 17 May 2016

Mr Kenneth Brown has a public health service background and extensive experience on health and hospital boards.

Mr Brown joined the New South Wales health service in 1953 and held numerous senior positions including the role of Chief Executive Officer. He was awarded the Public Service Medal in 2000 for his outstanding contribution to the public service.

Mr Brown is a member of the Queensland Health Audit Committee, as well as being a Board Director of the Gold Coast Hospital Foundation. He previously served as the Chair of the Gold Coast Health District Community Council, and as the Chair of the Board of Directors of Karitane Health Service.

Mr Brown is a qualified accountant with post graduate qualifications in cost accounting and has a Bachelor of Health Administration.

Professor Allan Cripps
Board member
Appointed 29 June 2012
to 17 May 2014

Professor Allan Cripps is the Pro-Vice Chancellor of Health at Griffith University. His major research interests are immunology and vaccines. He has had research articles published in leading medical journals and presented at international medical conferences.

Since 1976 he has held various academic positions with the University of Newcastle, the University of Canberra and Griffith University.

Professor Cripps is currently a member of the Health Services Support Agency and Advisory Board and the Pathology Senior Reference Group, Queensland Health. He has held memberships on the Griffith University/Queensland Health Medical Liaison Committee, the John Flynn Hospital Human Ethics Committee and the Queensland Health Education and Research Council.

He has a Bachelor of Science and Bachelor of Science (First Class Honours in Physiology) from University of New England and a PhD in immunology from University of Sydney.

Professor Cripps is a Fellow of the Australian Society of Microbiology, the Australian Institute of Medical Scientists (Immunology) and the Institute of Biomedical Scientists (UK) as well as an Associate Fellow of the Australian College of Health Service Management.

Ms Colette McCool

Board member
Appointed 29 June 2012
to 17 May 2014

Ms Colette McCool has over 20 years of diverse experience in public sector management as a senior executive in large and complex service-based organisations. Currently she is the Director of Community Services at the Gold Coast City Council.

Ms McCool is an experienced Board member and is currently Deputy Chair of Regional Development Australia Gold Coast and a Director of Gold Coast Hospital Foundation.

Ms McCool was awarded the 2007 Telstra Business Woman of the Year (Queensland) for the category Government and Community.

She is an accredited mediator, a Member of the Institute of Arbitrators and Mediators of Australia, and a Member of the St. James Ethics Centre.

Ms McCool is a Fellow of the Australian Institute of Company Directors. Her qualifications include a Bachelor of Arts, Graduate Diploma in Senior Executive Management, Master of International Management and Diploma of the Australian Institute of Company Directors.

Ms Pauline Ross

Board member
Appointed 29 June 2012
to 17 May 2016

Ms Pauline Ross has a strong health sector background as both a clinician and senior executive. A registered nurse by background, Pauline's career has included senior roles such as General Manager for Richmond Health Service (NSW), Deputy Director-General for the Department of Families and Chief Nursing Officer for Queensland Health.

As Chief Nursing Officer for Queensland, Ms Ross advised the Director-General and Minister for Health on all nursing and midwifery-related issues in the State. She developed state-wide policy frameworks and strategies for nursing and midwifery workforce development and retention; tertiary education; private and public partnerships with external agencies; practice development and standards across the state; and research grants for the nursing profession.

Ms Ross is an experienced board member, a Director of the community-based Southern Cross Credit Union and a member of its Audit and Risk Committee.

Ms Ross is member of the Australian Institute of Company Directors. Her qualifications include a Diploma in Nursing Administration, Bachelor of Health Administration, Master of Public Policy and a Diploma of Financial Services.

Dr Andrew Weissenberger

Board member
Appointed 7 September 2012
to 17 May 2014

Dr Andrew Weissenberger is an experienced medical practitioner and has more than two decades of clinical experience. Dr Weissenberger is currently Practice Principal at Hope Island Medical Centre.

During his medical career, Dr Weissenberger practised at the Mater Hospital in Brisbane before moving into community general practice in Brisbane and later at the Gold Coast.

Dr Weissenberger has special interests in the areas of aged care, chronic disease management, palliative care and research. He is currently involved in an Australian Government pilot testing strategy to improve diabetes care and is trialling in his practice a new information technology tool designed to improve coordination of patient care between doctors and allied health professionals.

Dr Weissenberger is an experienced board member, having previously served on the Board of Hopewell Services Inc. (which incorporates Hopewell Hospice and Paradise Kids) and the Gold Coast Division of General Practice.

Board member attendance

Table 1: **Number of Board and committee meetings attended**

	Board	Extraordinary Board Meeting	Executive	Finance and Performance	Audit and Risk	Safety Quality Engagement	Research and Education
Ian Langdon	12 of 12	2 of 2	7 of 7	NA	NA	NA	NA
Ken Brown	12 of 12	2 of 2	NA	9 of 10	5 of 5	8 of 9	NA
Pauline Ross	12 of 12	2 of 2	7 of 7	NA	NA	9 of 9	NA
Allan Cripps	9 of 12	2 of 2	6 of 7	7 of 10	4 of 5	NA	3 of 3
Andrew Wiesenberger*	8 of 10	2 of 2	4 of 7	NA	NA	8 of 9	NA
Colette McCool	12 of 12	1 of 2	NA	8 of 10	5 of 5	9 of 9	NA

*Board member since 7 September 2012

Executive Management Team

Chief Executive

Adjunct Professor Ron Calvert

Mr Ron Calvert commenced as Chief Executive of the Gold Coast Hospital and Health Service in October 2012.

Ron is an experienced Chief Executive, having previously led England's Doncaster and Bassetlaw National Health Service (NHS) Foundation Trust, which was rated among the county's top 20 per cent.

As Chief Executive of Trafford Healthcare NHS Trust, Ron introduced a quality regime that resulted in a significant reduction in mortality rates, resulting in Trafford being rated in the top 11 hospitals in England.

Ron's commitment to patient safety and quality health care has benefited the Gold Coast community. He has rejuvenated the Clinical Governance Committee and brought greater rigour to waiting list processes to significantly reduce the length of time our patients wait to receive care.

Ron holds a Masters of Business Administration and a Masters in Science: Zoology (Hons).

Chief Operations Officer

Adjunct Associate Professor Naomi Dwyer

Adjunct Associate Professor Naomi Dwyer has been the Chief Operations Officer since 2008.

Naomi is a values driven executive leader with a successful track record in strategically positioning health and other complex service organisations and teams to optimise performance, deliver results and leverage opportunities for innovation, growth and investment.

Naomi's passion for improving health care through leadership and strong engagement of people, has been recognised by a number of Queensland Health Excellence Awards. Her contribution to Bond University was also recognised by receiving the University's highly prestigious award for outstanding service.

Growing up on the Gold Coast, Naomi has a strong affinity with the local community.

Naomi provides support to the Gold Coast Hospital Foundation, holding the role of secretary since 2008. Naomi holds a Bachelor of Business, Graduate Certificate of Management and Masters of Business Law.

Chief Finance Officer

Mr Trevor Saunders CPA

Trevor has been Chief Finance Officer since 2008. He has previously worked in Chief Finance Officer roles for government organisations and also has management experience within strategic planning, policy reform and business improvement.

Trevor is a Certified Practicing Accountant and holds a Bachelor of Business (Accounting) and Master of Public Sector Executive Management.

Executive Director – Nursing and Midwifery

Professor Gerald Williams

Professor Gerald (Ged) Williams has been Executive Director Nursing and Midwifery Services since 2007. Ged is a registered nurse with qualifications in midwifery and critical care nursing,

Ged has led initiatives to transform bedside care and cultural change to promote better patient outcomes and improved team functioning. He has also led transformation projects such as eRoster to streamline nurse rostering.

Ged's research and publication interests include workforce planning, clinical practice, education and training program development and other management and leadership issues in nursing and healthcare.

Ged is also a graduate of the Australian Institute of Company Directors Course and holds a Masters in Health Administration and a Masters in Law.

Executive Director – Allied Health

Ms Morven Gemmill

Ms Morven Gemmill joined the executive team in 2011 as Executive Director Allied Health. Morven has 25 years' experience working in Scotland's NHS and local government where she managed and developed award winning services and models of care.

The focus of Morven's work is in improving services for people and harnessing the allied health contribution to patient care applying LEAN methodology and clinical improvement methodology to deliver reduced wait times for services and improved clinical care. Her particular areas of interests also include clinical leadership, workforce planning, and patient safety and experience.

Executive Director – People, Systems and Performance

Mr Damian Green

Mr Damian Green joined the executive team in January 2013 after 14 years as a consultant specialising in public sector transformation and human capital.

Damian is leading a number transformational change programs designed to improve the capability and capacity of the organisation and our people to implement major process, technology and workforce reforms.

Damian is also responsible for the communication and human resource portfolios, recognising the crucial link between proactive communications in supporting workforce engagement.

Damian is an Associate Fellow of the Australian College of Health Service Management and holds a Bachelor of Economic (Hons), Bachelor of Arts and qualifications in change management.

Executive Director – Emergency, Critical Care and Support Services

Ms Jane Hancock

During her extensive career Ms Jane Hancock has held positions in various large scale complex healthcare organisations in both the public and private sectors as a clinician, educator, manager and director.

Jane has a particular interest in the relationship between, clinical leadership, team dynamics and patient outcomes. A key challenge and area of focus for Jane is working on the reform of the delivery of specialist outpatient services and improving access for emergency department patients.

Jane's skills and knowledge are underpinned by qualifications in nursing, critical care, education, project management, infrastructure development, and business and leadership. Jane is also a graduate of the Australian Institute of Company Director's Course and is company secretary of the Australian Intensive Care Foundation Board.

Executive Director (Acting) – Emergency, Critical Care and Support Services

Mr Dean Blond

From November 2012 Jane was seconded to the Gold Coast University Project Team to lead development of new services.

During Jane's absence Mr Dean Blond led the division and focused on key projects such as improving the wait times within the emergency departments and supporting the new Medical Assessment Unit at Southport.

Dean's qualifications include a Bachelor of Physiotherapy, a Masters of Physiotherapy/Sports and is an Assistant Professor within the School of Health Science and Medicine at Bond University.

Executive Director – Family, Women and Children

Dr Lance Le Ray

Dr Lance Le Ray commenced with the Service in 2010. Throughout 2012-13, Lance has led the Family Women and Children's team to change the way antenatal care is provided through a Maternity Assessment and Triage unit, increasing availability of midwifery clinics in the community and expanding the Midwifery Group Practice model to credential Private Practice Midwives. Lance has supported a day stay model of care in the paediatric ward to improve patient flow so more children can receive care more quickly.

Lance has led the Division of Surgery since January 2013 and during this time has also guided the recruitment of specialist positions and associated skill development in clinical and drug protocols in preparation for new services to commence in 2013-14.

Lance's qualifications include Bachelor of Medicine, Bachelor of Surgery, Masters of Public Health, Fellowship of the Royal Australian College of General Practitioners and the Royal Australasian College of Medical Administrators.

Executive Director – Mental Health and Alcohol, Tobacco and Other Drugs

Ms Karlyn Chettleburgh

Ms Karlyn Chettleburgh joined the Executive Team in 2010 after 28 years in the Victorian Mental Health system. She is a registered psychiatric nurse with postgraduate qualifications in Advanced Clinical Nursing (Mental Health).

Karlyn has extensive experience in both direct care and management roles in a wide range of settings including inpatient services, community mental health and rural psychiatry.

Under Karlyn's leadership, in 2012-13 the Mental Health and Alcohol, Tobacco and Other Drugs (ATODS) division has catered for a 12 per cent increase of the number of individuals receiving mental health services, with the significant increase in patient follow-up.

Karlyn is also chair of the Human Research and Ethics Committee.

Executive Director – Strategic Development

Mr Michael Allsopp

Mr Michael (Mike) Allsopp is an experienced health executive with over 30 years' experience in health administration and capital works.

Mike led the expansion of Robina Hospital, development of Robina Health Precinct and is currently finalising the Gold Coast University Hospital.

He is also responsible for health service planning, annual contract funding negotiations with the Department of Health and reviewing performance.

Mike's qualifications include a Bachelor of Business and Master of Business Administration. He has a fellowship with the Australian College of Health Service Managers.

Executive Director – Medicine

Vacant

During 2012-13 the vacant position of Executive Director, Medicine was capably acted in by Ms Lindsey Gough and Ms Paula Duffy.

Paula led the medicine division for the first half of the year. Paula is the division's Director of Nursing and has extensive experience in nursing and healthcare management.

Lindsey acted in the role of Executive Director Medicine from January 2013. She has 16 years of senior management experience within the public health systems of Australia and the United Kingdom. Lindsey has a Master of Public Sector Management and a Fellowship of the Institute of Biomedical Science.

Executive Director – Surgery

Ms Louise Fisher

Ms Louise Fisher led the surgical services division from 2010 until February 2013. In 2012-13 her leadership was focused on achievement of the National Elective Surgery Target (NEST) and managing change associated with Activity Based Funding – particularly aimed towards clinical education of the process and improvement of the activity recording process.

Executive Director – Community, Sub-acute and Aged Services

Dr Robert Pegram

Dr Robert Pegram was the Executive Director Community Subacute and Aged Services from 2010 until February 2013, when he temporarily filled the role of Executive Director Medical Services until May 2013. Robert has since taken the opportunity to move to New South Wales as the General Manager of Port Macquarie Base Hospital.

Executive Director – Medical Services

Dr Brian Bell

Dr Brian Bell is a Fellow and preceptor of the Royal Australasian College of Medical Administrators and an Associate Fellow with the Australian College of Health Service Executives.

Brian is a Member of Faculty Advisory Board, Bond University, Faculty of Health Sciences and Medicine since 2004, and an Associate Professor with both Griffith and Bond Universities.

A new structure for 2013-14

During 2012-13 the Board and executive management developed a new strategic direction for the Service. The new direction is articulated in the Strategic Plan 2013-2017.

During 2012-13 a new organisational structure was formulated to deliver upon this new direction and to support a patient focused culture with strong clinical leadership and staff engagement. This new structure realigns existing processes, units and capability with future need.

The new structure will commence in 2013-14 and responds effectively to both our challenges and opportunities by:

- adopting a more streamlined structure at the executive level and aligning clinical structures to support the delivery of organisational priorities such as integrated clinical care
- strengthening clinical governance, education and research
- activating the university health service status through the creation of shared leadership positions with our university partners.

In the latter half of 2012-13 Naomi Dwyer and Jane Hancock commenced operating in roles within the new organisational structure to lay the foundations for 2013-14.

Jane commenced acting in the new position Executive Director Operations. This role will lead Surgical and Specialty Services, Emergency Medicine, Clinical Support Services and Mental Health Community Services.

Naomi commenced acting in the new position of Executive Director, Organisational Development. In this new role Naomi will lead the development of public-private partnerships to provide our community with more timely, cost-effective health care services.

Board committees

The Board has created five committees to assist it in overseeing the Gold Coast Hospital and Health Service. Each Board committee is chaired by a Board member and consists of both Board members and members of the executive management team. The committees report to the Board and provide recommendations to assist the Board in effectively governing the Service.

Executive Committee

The Executive Committee works with the Chief Executive to progress strategic issues identified by the Board and reviews business cases associated with those strategic issues.

The Executive Committee also strengthens the relationship between the Board and Chief Executive to ensure accountability in the delivery of services. The committee:

- oversees the performance of the Service against measures within the Service Agreement
- supports the Board in the development of service plans for the Gold Coast and monitors implementation
- works with the Chief Executive to respond to critical emergent issues in the Gold Coast Hospital and Health Service.

The committee comprises of:

- Mr Ian Langdon (Chair)
- Dr Andrew Weissenberger (Board member)
- Ms Pauline Ross (Board member)
- Prof Allan Cripps (Board member)

The Chief Executive also attends all meetings of the Committee.

Finance and Performance Committee

The Finance and Performance Committee reviews the financial and non-financial performance of the Service. The committee:

- assesses the financial position of the Service in the current and future years
- analyses performance against the service agreement with the Department of Health
- monitors cashflow, adequacy of financial systems, benchmarking and financial metrics
- gives strategic advice and recommendations to the Chief Executive on developing, enhancing and managing the Service's financial management strategy
- ensures financial and performance improvement processes are coordinated and effective to lead the achievement of strategic objectives.

The committee comprises of:

- Mr Kenneth Brown (Board member and committee Chair)
- Ms Colette McCool (Board member)
- Prof Allan Cripps (Board member)
- Chief Executive
- Executive Director Operations
- Chief Finance Officer
- Executive Director Strategic Development
- Executive Director Medical Services.

Audit and Risk Committee

The Audit and Risk Committee directs the development and integration of a strategic approach to managing risks and embedding processes to ensure the organisation is compliant with statutory requirements. The committee focuses on improving governance and risk processes to maintain service continuity and resource security.

The key achievements of the committee in 2012-13 include:

- developing a Board approved Audit Committee Charter
- establishing an internal audit function within the Service
- overseeing development of a Board endorsed three year audit plan
- developed key performance indicators for the Board's consideration.

The committee comprises of:

- Mr Kenneth Brown (Board member and Committee Chair)
- Prof Allan Cripps (Board member)
- Ms Colette McCool (Board member)

Attendees at committee meetings include:

- Chief Executive
- Chief Finance Officer
- Executive Director Operations
- Executive Director Strategic Development
- Executive Director Medical Services
- External Auditor representative.

Safety Quality and Engagement Committee

The Safety Quality and Engagement Committee advises the Board on matters relating to the safety and quality of health services provided by the Gold Coast Hospital and Health Service to give the Board assurance it is complying with its responsibilities, including:

- minimising preventable patient harm
- reducing unjustified variation in clinical care
- monitoring governance arrangements relating to the safety and quality of health services
- monitoring the safety and quality of health services using National and State Standards
- monitoring access and waiting times to emergency departments, elective surgery, and other key clinical services
- monitoring the Board's Consumer and Community Engagement strategy and Clinician Engagement strategy
- collaborating with the Medicare Local Board to ensure a greater range of hospital services is provided in the community and in the home.

The committee comprises of:

- Ms Colette McCool (Board member and Committee Chair)
- Ms Pauline Ross (Board member)
- Dr Andrew Weissenberger (Board member)
- Mr Kenneth Brown (Board member)
- Executive Director Medical Services
- Executive Director Nursing and Midwifery
- an Executive Director from a clinical division.

Research and Education Committee

The Research and Education Committee exists to build long-term collaborations in research, clinical education and training programs. These programs are to help position the Service as a world class health and knowledge precinct of national and international significance.

The key achievements of the committee in 2012-13 include:

- audit of research and evaluation activity conducted within the Service
- development of a research strategy to provide the Board with a strategic direction for sustainable research partnerships and activity, particularly leveraging opportunities with the commencement of the Gold Coast University Hospital
- development of key performance indicators for research activity
- reviewed key strategic challenges and risks and opportunities in medical education, particularly relating to medical student placements.

Professor Allan Cripps (Board member) is the Chair of the committee, which is also comprised of representatives from:

- Bond University
- Griffith University
- Southern Cross University
- Gold Coast TAFE
- Gold Coast Medicare Local
- Healthscope
- Ramsay Healthcare.

Clinical Council

During 2012-13, the Clinical Council was re-constituted as the peak clinical leadership forum within the Service.

Clinical Council also works to facilitate authentic engagement of clinicians on planning, strategy development and other issues of clinical importance.

The Council provides advice to the Chief Executive and has the opportunity to embed clinician feedback in the governance, strategy and cultural development of the Service.

Clinical Council develops models of care that reflect best practice along with development of initiatives that achieve integrated health care delivery through clinical and commercial partnerships.

Clinical Council is currently chaired by Dr John Gerrard.

Executive management committees

Executive Management Team

The Executive Management Team assists the Chief Executive in managing the critical affairs of the Service. This committee is responsible for financial, corporate and clinical performance along with analysis of strategic options for presentation to the Board.

Clinical Governance Committee

The Clinical Governance Committee is the peak body responsible for clinical governance within the Service. It monitors, evaluates and improves performance in clinical practice to ensure optimal patient safety and high care quality.

The committee is co-chaired by Dr William Butcher and the Chief Executive Mr Ron Calvert. The committee reports to the Board's Safety Quality and Engagement Committee and comprises clinicians and senior managers across a number of disciplines including allied health, medicine, nursing and clinical governance.

Executive Control Group: Operations

Executive Control Group: Operations is led by the Executive Director Operations and provides leadership, management and review of day-to-day operations. The group adds value through service-wide implementation of strategies, proactively identifying and addressing service or business issues which have complex or system-wide significance.

Executive Control Group: Major Projects

Executive Control Group: Major Projects is responsible for the operational planning and commissioning of the Gold Coast University Hospital facilities and services. These tasks include service line planning, and preparing operational briefs and procedures, workforce strategy and budget allocation, budget activity and transition strategy.

The control group oversees a number of reference sub groups and service planning groups to ensure all aspects of major projects are appropriately governed.

Activity Based Funding Governance Board

The Activity Based Funding Governance Board oversees the processes and systems associated with activity-based funding, along with monitoring the funding model and recommending performance improvements for the health service funding system. The Committee focuses on delivery of purchasing initiatives, changes to the funding model, identifying clinical education opportunities and preparing the Service for future healthcare services and patient needs.

ICT Governance Board

The Information Communication Technology (ICT) Governance Board is responsible for planning, performance and benefits realisation of ICT systems across the Service. The governance board oversights the capacity, capability and solutions that are planned, procured, designed, implemented and evaluated by the Service.

The ICT Governance Board also advises the Chief Executive on investment decisions, including current systems and those planned as part of future expansion.

Healthcare Leadership Standards Committee

The Healthcare Leadership Standards Committee comprises a number of key executives and is responsible for oversighting the Service's preparedness and compliance with healthcare standards, including accreditation with the Australian Council of Healthcare Standards.

Safety and Wellbeing Committee

The Safety and Wellbeing Committee is responsible for oversighting the provision of a healthy and safe work environment for staff, patients and visitors. In particular the committee monitors rehabilitation and return to work, injury prevention, fire safety, occupational violence prevention and ergonomics.

Our Performance

Queensland Government's priorities for Queenslanders

Gold Coast Hospital and Health Service is committed to improving the health of Queenslanders in the Gold Coast regional community and contributing to the Queensland Government's priorities for health and the state's future prosperity.

The Queensland Government's overarching priorities for Queensland's future are detailed in G*etting Queensland Back on Track: Statement of Objectives for the Community*. The statement comprises five key themes to achieve a prosperous future for Queensland, these are:

1. Grow a four pillar economy
2. Lower the cost of living
3. Invest in better infrastructure and better planning
4. Revitalise front-line services
5. Restore accountability in government

In February 2013, the Queensland Government released a *Blueprint for better healthcare in Queensland*. The Blueprint is the Government's action plan to transform the Queensland healthcare system into a model for productivity, care and efficiency to meet and surpass national benchmarks.

The Blueprint has four principal themes:

1. Health services focused on patients and people
2. Empowering the community and our health workforce
3. Providing Queenslanders with value in health services
4. Investing, innovating and planning for the future

Our commitment

The Service's 2012-13 strategic plan and objectives link its service delivery with the Queensland Government's broader priorities and objectives. The service agreement between the Chair of the Gold Coast Hospital and Health Board and the Chief Executive of the Department of Health sets out the agreed services that will be provided to the community every year. A range of services and programs were implemented to deliver on the Service's strategic objectives for 2012-13. The Service's performance under each of the strategic objectives and key performance targets of the service agreement are detailed in this section of the annual report.

Strategic Plan 2013 – 2017

In June 2013, the Service released its Strategic Plan 2013-2017. The new plan articulates how the Service will deliver on the Blueprint, and provide the best services, at the best time, and in the best place to the Gold Coast community.

Key performance indicators

Table 2 provides a summary of the Service's performance against major key performance indicators defined in the Gold Coast Hospital and Health Service's service agreement with the Department of Health.

Table 2: Key performance indicators

Key Performance Indicator	Details	Target	Actual
Safety and quality			
Healthcare: associated infections	Healthcare associated staphylococcus aureus (including MRSA) bacteraemia	≤ 2.0 per 10,000 occupied bed days	1.26 per 10,000 occupied bed days
28 day mental health readmission rate	Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	≤14%	12.5%
Access			
Shorter stays in emergency departments[1]	National Emergency Access Target (NEAT): percentage of patients who attended an emergency department who depart within 4 hours of arrival	2012: 70% 2013: 77%	2012: 63% 2013:78% *(6 months)*
Shorter waits for emergency departments	**Emergency department patients seen within the clinically recommended timeframe for their category.**		
	Category 1: within 2 minutes	100%	100.00%
	Category 2: within 10 minutes	80%	79.85%
	Category 3: within 30 minutes	75%	47.34%
	Category 4: within 60 minutes	70%	63.01%
	Category 5: within 120 minutes	70%	86.11%
Shorter waits for elective surgery[1]	**National Elective Surgery Target (NEST):** percentage of patients receiving elective surgery who were treated within the clinically recommended timeframe for their urgency category.		
	Category 1: within 30 days	2012: 89% 2013: 100%	2012: 91% 2013: 91% *(6 months)*
	Category 2: within 90 days	2012: 81% 2013: 87%	2012: 83% 2013: 84% *(6 months)*
	Category 3: within 365 days	2012: 91% 2013: 94%	2012: 97% 2013: 95% *(6 months)*

Notes:
1. NEAT and NEST targets are set and reported on by calendar year, that is, from 1 January to 31 December. Actuals provided for 2013 show the performance for the first six months of the reporting year, from 1 January 2013 to 30 June 2013.

Key Performance Indicator	Details	Target	Actual
Access (cont)			
Fewer Long Waiting Patients[2]	Elective surgery patients waiting more than the clinically recommended timeframe for their category.		
	Category 1: within 30 days	0	5
	Category 2: within 90 days	0	3
	Category 3: within 365 days	0	8
Postnatal in-home visiting	Enhanced maternal and child health service – post natal in-home visiting	7,474	12,029
BreastScreen Queensland screening activity	Proportion of the annual breast screening target achieved	98%	101%
Closing the Gap indicators	Estimated level of completion of Indigenous status – specifically the reporting of 'not stated' on admission	<1%	0.4%
	Percentage of in-scope separations of Aboriginal and Torres Straits landers consumers from the health service's acute mental health inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated (in person or videoconference), was recorded in one to seven days immediately following that separation.	55%	56%
	The proportion of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice	1.1%	2.0%
	Percentage of Aboriginal and Torres Strait Islander cultural practice program participants by facility[3]	7.5%	1.2%
Efficiency and financial performance			
Operating position	Full Year Forecast Operating Position	Balanced or surplus	$5.98 million surplus
Average WAU cost[4]	Average cost per weighted activity unit (WAU) for activity based funding facilities	-	4,247.29
Purchased activity monitoring[4]	Variance between year to date purchased activity and actual activity	0% to +/-2% (148,726 WAUs)	-0.59% (147,855 WAUs)
MOHRI	Year to date number of Minimum Obligatory Human Resource Information (MOHRI) full time equivalent (FTE) staff	5047	5098

Notes:

2. This measure reflects a point in time snapshot of elective surgery patients waiting longer than recommended as at the end of June 2013.
3. Cultural practice program indicator is based on whole numbers of staff and does not capture the number of staff within the service who have undertaken training prior to 2012-13.
4. Activity for 2012-13 phase 15 WAUs as reported at 22 August 2013.

Strategic Objective 1:

To provide better services and access for our patients

Improving access to emergency departments

In 2012-13 the Gold Coast Hospital and Health Service emergency departments attended to approximately 125,700 presentations, an increase of five per cent compared to 2011-12.

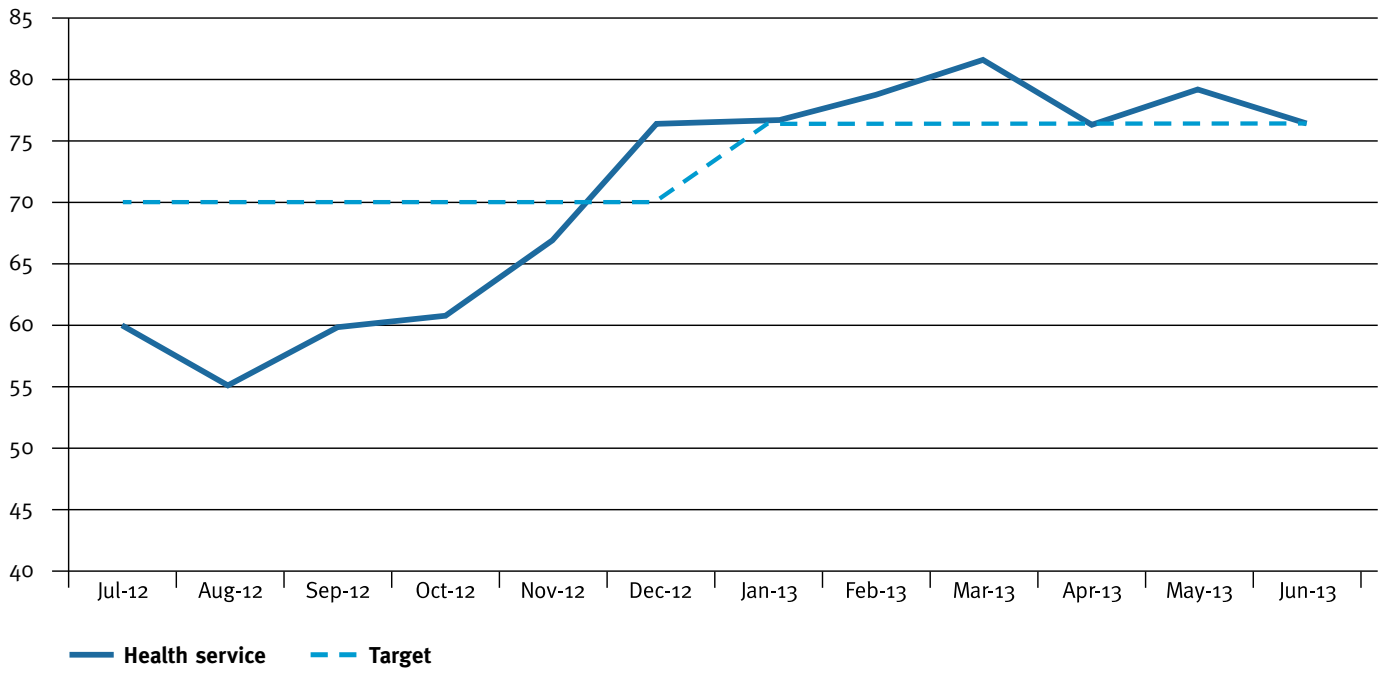
Throughout the year the emergency departments have worked hard towards improving the timely delivery of care and achieving the National Emergency Access Targets (NEAT) for the percentage of patients being treated within four hours of arrival. The targets are set for each state on a calendar year basis with the Queensland 2013 target set at 77 per cent, seven per cent higher than the 2012 target of 70 per cent. Since January 2013 the Service has met or exceeded the target, with seven out of 10 patients now consistently seen and treated within four hours of arrival in the emergency department.

These results have been achieved through a combination of management and clinician driven initiatives and new models of care including:

- implementation of the Patient Journey Project – a whole of system clinical redesign program implemented in partnership by clinicians and management
- establishment of medical assessment units
- strong workforce engagement with clinicians empowered to implement local changes focused on patient care.

It is anticipated that commissioning of the Gold Coast University Hospital in 2013-14, with its enhanced infrastructure will result in further improvements in both the number of patients seen within four hours and the proportion of patients seen within clinically recommended timeframes.

Chart 1: The Service's performance against NEAT

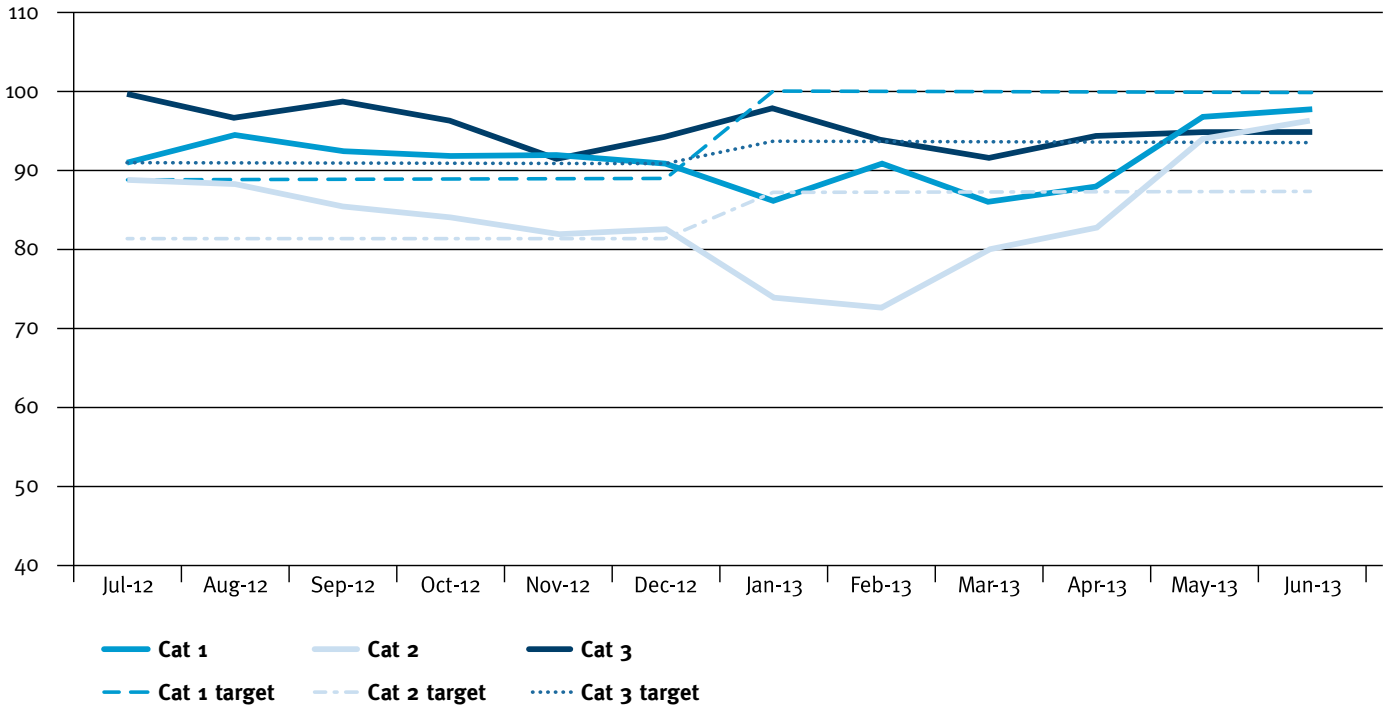


Improving access to elective surgery

In 2012-13 the Gold Coast Hospital and Health Service performed approximately 12,700 surgical procedures. This is an increase of six per cent compared to approximately 12,000 surgical procedures performed in 2011-12. More than 90 per cent of patients now have their elective surgery within the time frames recommended by their doctors.

The National Elective Surgery Targets (NEST) measure the percentage of elective surgery patients who are treated within their recommended clinical priority timeframe. During the year, the Service has continued to improve its elective surgery performance. Between the end of February and end of June 2013 elective surgery waiting lists reduced by 12 per cent. This reduction can be partially attributed to an additional operating theatre opened at Robina Hospital and an increase in the number of surgical beds.

Chart 2: The Service's performance against NEST (for clinical priority categories one to three)



Reducing the risk of hospital acquired infections

Hand hygiene has been identified as the single most important aspect of infection control. Throughout 2012-13, initiatives to improve hand hygiene compliance within the Service included:

- locating hand hygiene substances at increased proximity to patient care sites
- reducing signage clutter and installing clear hand washing instructions
- introducing a hand hygiene safety scrum on each nursing shift
- increasing real-time audits every week to check hand cleaning habits
- training more staff in the steps of hand hygiene to increase audit capability.

Success of the initiatives can be seen in the significant improvement of the hand hygiene compliance rate over 2012-13, which has consistently exceeded the national target since September 2012. The net effect of hand hygiene improvement has been a substantial reduction in the number of hospital acquired infections (clostridium difficile and VRE cases). The good practices of clinicians and support staff make Gold Coast hospitals amongst the cleanest and safest in Australia.

Performance is expected to increase with the commissioning of the Gold Coast University Hospital as infection prevention strategies have been designed into the facility. Chart 3 shows the corresponding decrease in hospital acquired infections achieved through increased hand hygiene compliance.

Reducing outpatient wait lists

During the year the Service received approximately 102,700 outpatient referrals, an increase of 21 per cent from the previous year.

A key focal point of the Board and management during the second half of the year has been reducing the average wait time for outpatient treatment. The initiatives implemented to reduce outpatient wait times included:

- Endoscopy waitlist project – this project reduced average wait times for an endoscopy at Gold Coast Hospital from two years to six months.
- ENT Pilot Project – working with the private sector to reduce wait times for patients requiring access to ear, nose and throat (ENT) specialists.

The Board has approved a strategy to invest in further initiatives to reduce outpatient wait times in 2013-14, enabled by the cost efficiencies realised in 2012-13.

Improving access to oral health services

Oral Health Services received $1.4 million of Federal Government funding from March to July 2013 under the National Partnership Agreement (NPA) for Treating More Public Dental Patients. The objective of the NPA was to reduce the long adult patient waiting times in the public system. To increase the number of patients being seen, the Service extended the hours and contracts of part time staff working in the dental clinics and introduced an outsourcing partnership program with private providers to treat emergency patients and general wait list patients.

The current average waiting for patients to be contacted for an appointment is two years. At the beginning of 2012 waiting lists were almost seven years long. The lists have been reduced to five years and all patients beyond two years have been offered care.

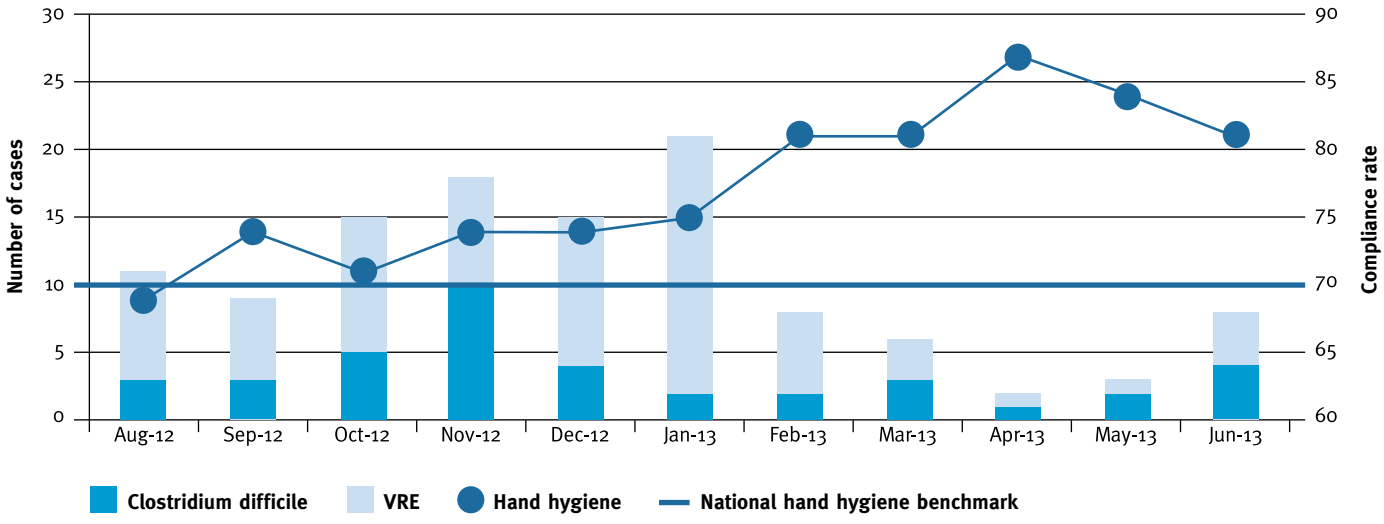
In 2012-13, Oral Health Services treated 267,517 Weighted Occasions of Service (WOoS). This was 5.4 per cent above the target WOoS of 253,801 and above the WOoS achieved in 2011-12 of 232,299 WOoS.

The Service will receive an additional $4.7 million in 2013-14 under the NPA to continue initiatives to further reduce long adult waiting times for Oral Health Services on the Gold Coast.

Extended scope of practice project

Robina Hospital was one of two pilot sites in Queensland to participate in a nationally funded Health Workforce Australia project to trial the use of advanced practice physiotherapists in emergency departments. The Service secured $287,000 for the trial to enable patients presenting with conditions such as strains sprains and 'simple' fractures to be seen by a physiotherapist in the first instance. A physiotherapist commenced at the Robina Hospital emergency department in October 2012. Over the nine month period to 30 June 2013, the physiotherapist assessed and treated more than 1100 patients with the majority of those patients discharged from the emergency department within four hours, significantly reducing their average stay. This has also contributed to the Service's improvement in performance against the NEAT. The project trial ends on 31 December 2013.

Chart 3: Hospital acquired infections and hand hygiene compliance



Enhancing services for birthing mums

In 2012-13 eligible private practice midwives were granted special access to Gold Coast Hospital, thereby expanding the birthing options for new mothers. Private practice midwives hold eligible credentials and can admit birthing mothers in their own right providing continuity of midwifery care for the mother, with support from our Birthing Services health professionals as required. This program enables private practice midwives to provide flexible care in the hospital and community to meet the needs of birthing mums. To date, 11 midwifes have been granted access.

Ambulatory Postnatal and Lactation Services provide care for all mothers who birth within the Gold Coast Hospital and reside within the Gold Coast region. During 2012-13 the Maternity Home Visiting Team provided 12,029 home visits to mothers and infants to support timely discharge from hospital. Following the home visits from maternity staff, all families are offered further visiting and clinic services with Child Youth and Family Health. The Lactation Consultant Team provided 1043 outpatient services for families through community venues during 2012-13.

A Breastfeeding Awareness Workshop was a new initiative introduced in 2012-13 to train staff from Aboriginal and Torres Strait Islander community organisations who have regular contact with breastfeeding mums. Thirteen staff from various community organisations took part in the workshop.

Adopting mental health initiatives

During 2012-13 the Mental Health Division worked in partnership with the Department of Health's Mental Health Directorate to implement the Working Together for Change clinical reform initiative and adopted state wide service models to promote and support a consistent approach to service delivery across mental health services.

Over the past 12 months, the Service has achieved a significant improvement in the key performance indicator of follow up appointments within seven days, which aims to ensure 55 per cent or more of consumers discharged from an acute mental health inpatient unit are seen within seven days. The monthly result consistently improved from a low of 36 per cent in August 2012 to a high of 74 per cent in May 2013 with a 12 month average result was 57 per cent.

Strategic Objective 2:

To work with our partners to improve the health of our community

Our partners

Primary health care partners

In 2012-13 the Board endorsed a Primary Health Care Protocol for the Service. This protocol builds upon the existing formal partnership between the Service, Gold Coast Medicare Local and other leading primary care organisations on the Gold Coast. The protocol serves as the foundation for all organisations to work collaboratively to improve the health and wellbeing of the Gold Coast population. The protocol recognises the important roles that both acute and primary care sectors play in the delivery of health services. By strengthening relationships and integration of health sectors, key objectives can be achieved which align with other performance requirements such as those set by the National Health Performance Authority. The protocol also aligns with the strategic outcomes outlined within the Bilateral Plan for Primary Health Care Services in Queensland.

University partners

Partnerships with Gold Coast universities were strengthened in 2012-13 through increased joint clinical and management appointments and formation of the Board Research and Education Committee. These relationships with Griffith University, Bond University and Southern Cross University are vital to the Service establishing the Gold Coast University Hospital and health and knowledge precinct in 2013-14 and becoming a world class health service.

Gold Coast Hospital Foundation

The Gold Coast Hospital Foundation is a community-based charity that raises funds to help improve the health of the Gold Coast community. The Board is grateful for all the support the Foundation provides to the Service's hospitals, community health service facilities, staff and patients. The Foundation also supports the entire Gold Coast Community through delivering health education and health promotion activities accessible to all community members.

During 2012-13 the Foundation granted a total of $288,200 by way of research, equipment and education.

Closing the gap in health outcomes for Aboriginal and Torres Strait Islander Queenslanders

The Service is committed to 'Making Tracks toward Closing the Gap in health outcomes' in supporting and guiding the delivery of culturally capable and responsive health services for our Aboriginal and Torres Strait Islander community. The Service works in partnership with internal and external stakeholders to deliver numerous initiatives and programs to improve Aboriginal and Torres Strait Islander health outcomes. This includes partnering with the local Aboriginal medical service, Kalwun Health Service, through the Karulbo Aboriginal and Torres Strait Islander Health Partnership on the Gold Coast in the delivery of programs such as Dietetic and Diabetes Education Outreach Clinics and Heart Health Screening.

Public private partnerships

The Service has responded to the *Blueprint for better healthcare in Queensland* by exploring opportunities for alternative service delivery models which improve value for money. Delivering value for money services will enable the Service to reinvest cost savings into new and improved clinical services, and to improving access to services through reductions in waiting times.

In 2012-13 the Service partnered with the private sector to treat over 400 ear, nose and throat (ENT) long wait patients. By simplifying and reducing the wait list and partnering with the private sector, unnecessary delays are avoided and more patients receive the care they need in a shorter period of time. The innovative use of resources through partnering with the private sector can be considered a genuine 'community dividend' for the better health of the local community.

Additionally, the Service engaged in the Surgery Connect program, enabling long wait patients to be seen in the private sector.

Public private partnerships (cont)

In preparation for commissioning the Gold Coast University Hospital, the Service has commenced two major public-private partnership initiatives. The first will ensure that the new radiation-oncology service is operated to the highest clinical standards to deliver the best value for money for the community. This new clinical service will enable patients to receive radiation-oncology services in their local community, rather than travelling to Brisbane for treatment. Further, because Gold Coast University Hospital is based upon a move then grow model, the private sector was invited to respond to an opportunity to partner with the Service through the lease of unused floor space, and other innovative partnering options in service delivery. By generating a return on investment on this unused space, the Service can offset the costs of constructed but unused infrastructure, and contribute the revenue to public services.

Mental health partnership

The Mental Health Service has been working with partners including Gold Coast Medicare Local and non-government organisations to provide a new service known as Partners in Recovery. The initiative aims to better support people with severe and persistent mental illness with complex needs as well as their carers and families by facilitating more streamlined access to the clinical and support services. It also assists service providers spread across multiple sectors to work in a more collaborative, coordinated, and integrated way to improve the system response to, and overall outcomes for people mental illness.

Research and education

A strong culture of research and education is a central pillar of high quality, safe, effective health care. During 2012-13, the Service strengthened its existing research and education foundations under the stewardship of the Board's Research and Education Committee. This increased focus on research and education will optimise opportunities across the organisation, including the new Gold Coast University Hospital.

Strategy

The Board has endorsed performance indicators for research which align with the Service's research strategy. These performance indicators have been embedded within the planning and performance framework in 2013-14 to enable the Service to measure performance against the Board's strategic research objectives, including attracting increased research grant income and increasing the number of staff with research higher degrees.

Human Research Ethics Committee

The Service operates a Human Research Ethics Committee (HREC) constituted under the National Statement on Ethical Conduct in Human Research (2007). The HREC ensures that research conducted within the Service's facilities accords with the National Statement and serves to:

- Protect the mental and physical welfare, rights, dignity and safety of participants of research.
- Facilitate ethical research through efficient and effective review processes.
- Promote ethical standards of human research.
- Ensure that all clinical and health research is conducted ethically and responsibly.

During 2012-13, the HREC reviewed 165 applications to conduct research.

The following table details the members and composition of the committee.

Table 3: Composition of the Human Research Ethics Committee

Position	Member
Chair	Ms Karlyn Chettleburgh
Deputy Chair and person with current research experience	Dr Jennifer Fenwick
Person with current research experience	Dr Roselyn Rose'Meyer
Lawyer	Ms Leisha Browning
Person who performs a pastoral care role	Rev Sid Rogers
Persons with knowledge of and current experience in professional care, counselling or treatment of people	Ms Wilma Sullivan Mr Simon Langston Dr Ezekiel Tan
Laypersons	Mr Robert Lee Dr Phil Gaffney Ms Helen Eager

Gold Coast Universities

During 2012-13 the Service strengthened its research partnerships with local universities, by increasing the number of joint appointments. The Service currently has joint appointments with both Griffith University and Bond University, with the aim of strengthening the research focus of our clinicians and to support the education and training of our current and future clinical workforce. The Service currently has joint-appointments in the areas of:

- emergency medicine
- obstetrics and gynaecology
- intensive care
- medicine
- mental health
- midwifery
- nursing
- paediatrics
- surgery.

Our Research

Professor of Midwifery and Clinical Chair Jennifer Fenwick has a joint-appointment with Griffith University and the Service.

Professor Fenwick and her colleagues were successful in securing a large National Health and Medical Research Council (NHMRC) grant to test the effectiveness of a midwifery psycho-education intervention to reduce childbirth related fear and women's preference for caesarean section births.

To date, 1410 pregnant women have been screened for fear. Preliminary analysis is very positive with the women randomised to the intervention group having significantly lower levels of fear at 36 weeks gestation.

Strategic Objective 3:

To work with our consumers and the community, to allow a greater say over their hospital and local health service

During 2012-13, Gold Coast Hospital and Health Service reinforced its proud tradition of partnering with the community to deliver quality health outcomes.

Partnering with our community

The strong community support enjoyed by the Gold Coast Hospital and Health Service has historically been a critical factor in our successes. In 2012-13 this relationship was further strengthened with the Board endorsed Community and Consumer Engagement Strategy 2013-15, which serves to:

- Improve patient safety outcomes through consumer involvement.
- Build a better understanding of expectation among patients, the community, health providers and health services.
- Grow community confidence and awareness of services provided by Gold Coast Health.
- Develop community partnerships to create new opportunities for information sharing.
- Expand our engagement activities and highlight the benefits of community engagement to staff and the community.

The strategy was developed in line with the requirements of the *Hospital and Health Boards Act 2011* and related regulations. It is supported by a detailed operational plan and quarterly updates on its implementation are provided to the Board.

Community participation in service planning, decision-making and evaluation was enhanced during 2012-13 through the establishment of the Board's Safety Quality and Engagement Committee, which was vested with responsibility for the community engagement strategy. On-going participation of community representatives in various corporate and divisional committees, and appointment of specific Community Liaison roles such as in Mental Health Services have been key factors in improving the participation of the community.

Volunteers

The Service is highly appreciative of the contribution from its dedicated volunteers, many of whom have had a significant relationship with the Service spanning many years. Nearly 300 volunteers worked across a number of facilities and provided about 30,000 hours of service assisting our patients and staff in the delivery of quality healthcare in 2012-13. This devoted team of quiet achievers are an integral part of the Service, whose contribution has been recognised externally by being awarded the Volunteer Organisation of the Year and internally at the annual Volunteers Thank You ceremony. In May 2013, the Service celebrated service milestones for a number of volunteers, including three individuals who have given their time for over 20 years.

Table 4: Volunteers presented with service certificates 2012-13

10 Years of Service	15 Years of Service
Barbara Brown	June Beddow
Ann Hitchon	Yvonne Collett
Ruth Salter	Dorothy Gilligan
	Jan Gregory
	Gwenda Pearson
	Eileen Rydings
	Robyn Stobbie

20 Years of Service	25 Years of Service
Mervyn Murphy	Jan Hamilton
	Edna Seferi

Community partnership in service planning

In 2012-13, the Service continued to engage the community in planning for the new Gold Coast University Hospital (GCUH) through the GCUH Stakeholder Advisory Group. This forum provided feedback on a range of issues including artwork, access and way-finding for patients and visitors, car parking and access for volunteers.

Providing the community with performance information

Informing the community and consumers about the safety and quality performance of the Service is important to an effective partnership. In 2012-13, the Service's performance data was provided on the National Health Performance Authority My Hospital website, and the Queensland Health My Performance website.

Patient satisfaction

Understanding patients' experience of the Service is important to identify how well their needs and preferences are being met, and where services can be improved. This year, the annual inpatient satisfaction survey, sampling patients discharged in the prior month, highlighted that over 90 per cent of patients would recommend the care of Gold Coast Hospital and Robina Hospital to others. A standout area of performance was the question 'Were staff friendly?', with 88 and 92 per cent answering yes to this criterion at Gold Coast and Robina hospitals respectively. The overall rating of care provided at the hospitals received a positive outcome, with over 95 per cent of all patients answering Excellent, Very Good or Good to this criteria.

Patient Liaison Service reported in 15 per cent reduction in the number of complaints received in 2012-13 compared to 2011-12. This is in conjunction with a 76 per cent increase in recorded compliments. A complaints and compliments training program is delivered to clinical and clinical-support staff, along with communication and patient safety (CAPS) training.

Strategic Objective 4:

To improve efficiency and deliver better infrastructure

Improved efficiency

The Service has implemented a number of strategies to ensure positive return on investment for the community. Investment in the Service's workforce accounts for the most significant area of expenditure, and therefore management systems have been implemented to ensure staffing is within budget, and effective workforce utilisation practices are in place. Work has also been undertaken by clinical leaders to ensure the appropriate use of clinical resources such as evidence based pathology, blood, and clinical supplies.

Better infrastructure

More than $2 billion has been invested in Service infrastructure over the past five years. The result has been that the Gold Coast community now has outstanding modern hospitals and community based health facilities, which include an expanded Robina Hospital, the Robina Health Precinct and the soon to open Gold Coast University Hospital.

Robina Hospital

Service expansion at Robina Hospital continued during 2012-13. These services have been designed and implemented to achieve efficiency across the Gold Coast Hospital and Health Service. In November 2012, an additional operating theatre and 10 beds in the Short Stay Unit opened at Robina Hospital. A further operating theatre and 10 surgical orthopaedic beds opened at Robina Hospital in April 2013. The introduction of the theatres and beds has seen a reduction in procedures being postponed and the types of surgery being undertaken expanded to include: appendix and gall stone removal, minor orthopaedics, and ear, nose and throat and gynaecology procedures requiring overnight recovery.

Medical assessment units

The establishment of Medical Assessment Units (MAU) in the Robina and Gold Coast hospitals occurred as part of a suite of initiatives to improve patient access to emergency departments and improve patient flow through the emergency admission process. Initially, a MAU was introduced at Robina Hospital in September 2011. Since its introduction, the Robina MAU has contributed significantly to the Service's improved emergency access results. The MAU has showed sustained success in exceeding emergency access targets. On the success of the Robina MAU, a general medical ward was converted into a MAU at Gold Coast Hospital and commenced operation in February 2013. Since opening, the MAU has improved patient flow and contributed to improved emergency access times. A MAU has been integrated into the new Gold Coast University Hospital.

Robina Health Precinct

The Robina Health Precinct was officially opened by the Minister for Health, the Honourable Lawrence Springborg MP, on 18 July 2012. The $36.3 million facility located in the heart of Robina offers a mix of services including child, youth and family clinics, mental health, community rehabilitation, cardiac rehabilitation antenatal and postnatal care, palliative care, ageing and other support services. The Precinct is well positioned to respond to community demand and to support acute care provision in hospitals particularly as allied health services are recognised as an increasingly important aspect of integrated, patient centred models of care.

Improved maternity infrastructure

During 2012-13 Gold Coast Hospital successfully established a short stay unit within the Maternity ward. This four bed unit improves patient flow by transferring mothers from maternity ward beds while they are awaiting tests and preparing for discharge.

A maternity assessment and triage unit was introduced that provides assessment services for pregnant women who are not in established labour and do not need a birthing area. This unit is valuable in cases such as women with pregnancy concerns, GP reviews and urgent follow up after ultrasound or blood tests. This unit further ensures that birthing suites are available for women in labour.

Strategic Objective 5:

To empower frontline staff and value our employees

Workforce snapshot

As at June 2013:

- 5098 full time equivalent (FTE) staff were employed by the Service
- 72 per cent of staff are in clinical roles
- 28 per cent of staff are in non-clinical and clinical support roles.

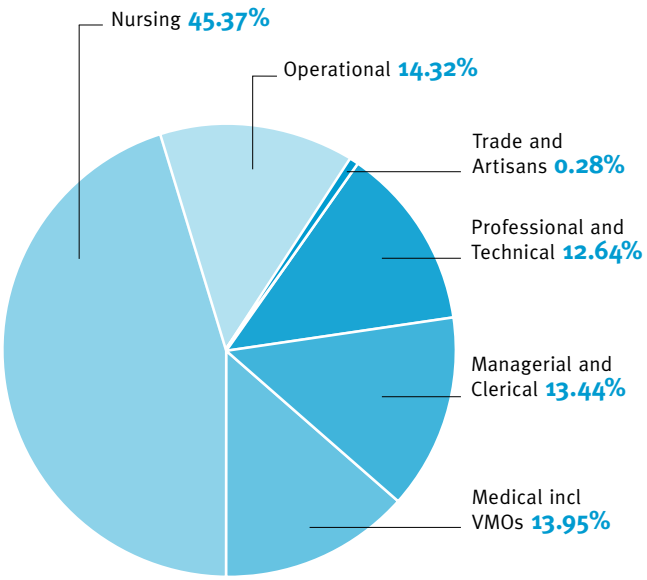
During 2012-13:

- 594 new staff were employed
- 823 staff separated.

Our workforce at a glance

The Gold Coast Hospital and Health Service's workforce consists of 5098 FTE staff who work within a number of different occupational streams as detailed in Chart 4.

Chart 4: Employees by professional stream

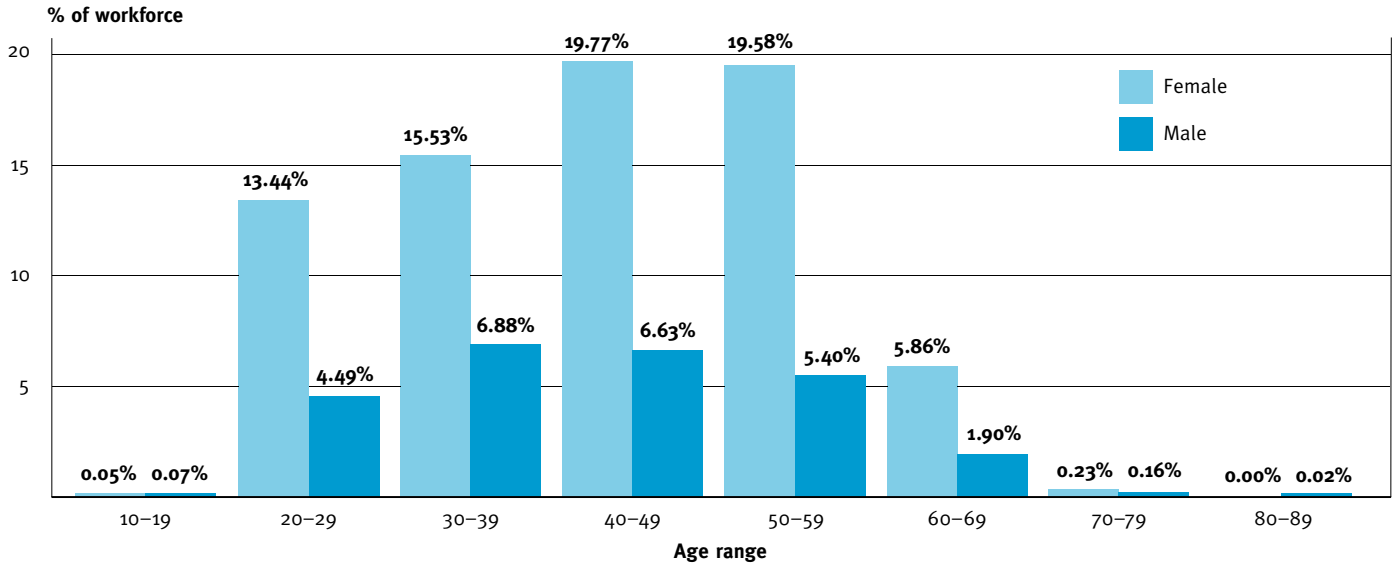


The average age and gender of a Service employee is 42 years old and female. The Service's youngest employee is a male aged 18 and the oldest employee is a male age 82.

Table 5: Age profile as at June 2013

Age range	Percentage of workforce %
19 and under	0.11
20 – 29	17.93
30 – 39	22.41
40 – 49	26.40
50 – 59	24.98
60 – 69	7.76
70 – 79	0.39
80 and over	0.02

Chart 5: Gender and age profile as at June 2013



The above graph details the Service's workforce composition by age and gender.

Women in the workforce

Women comprise a total of 74.46 per cent of the Service's workforce, and are represented in professions as follows:

- 87 per cent of the nursing workforce
- 37 per cent of the medical workforce, including Visiting Medical Officers (VMOs)
- 76 per cent of the allied health workforce
- 74 per cent of the non-clinical and clinical support workforce.

Building our team

During the financial year, a total of 529 employment vacancies were advertised. Table 6 details the number of vacancies advertised across employment streams. The retention rate of permanent staff is 96 per cent.

Table 6: Employment vacancies advertised in 2012-13

Employment stream	Vacancies advertised[1]
Managerial and clerical	85
Medical including VMOs	89
Nursing	260
Operational	17
Trade and artisans	0
Professional, technical, allied health	78
Total	**529**

1. Advertised vacancies for executive level positions or as an expression of interest are excluded from these figures.

Vacancies for base grade and temporary vacancies were filled through internal processes in accordance with relevant policy.

To attract highly skilled applicant pools, vacancies are advertised in specialty industry media outlets as well as on websites such as CareerOne.com and Mycareer.com. The industry media utilised in 2012-13 includes the Royal Australasian College of Physicians; Royal Australian and New Zealand College of Psychiatrists; Australian and New Zealand College of Anaesthetists; Royal Australian College of Surgeons; Australian and New Zealand Association of Paediatric Surgeons; and Australian Psychological Society.

Unscheduled leave

The unscheduled leave rate for 2012-13 was 1.95 per cent. This equates to an average of 3.8 days off as unplanned leave per each FTE employee. Unscheduled leave is inclusive of sick leave, family leave and special leave.

This has increased from 1.75 per cent in 2011-12 where staff took an average of 3.4 days off as unplanned leave.

Equal employment opportunity

The Service is committed to providing a workplace which is free from unlawful discrimination, and where equal employment opportunity practices are adopted. It recognises the four categories of people who have historically been disadvantaged in employment. These categories are Aboriginal and Torres Strait Islander people, people from non-English speaking backgrounds, people with a disability and women. As part of an ongoing process to identify the extent to which its employment practices are responsive to these groups, the Service undertakes a census of all new employees.

As of June 2013, 6.27 per cent of staff identified themselves as being from a non-English speaking background.

Recruitment, selection and appointment

Recruitment, selection and appointment practices are focused on ensuring the right skill mix and competence of staff to meet the needs of the Service. Human resource management policies and procedures ensure that legislative and policy considerations are met and managers are provided with training to ensure the required competencies are reliably assessed. These practices aim to generate applicant pools of the best talent.

Systems for ensuring the requirements of pre-employment checks, professional registration, credentialing and scope of clinical practice are well established.

Workforce management and development

The performance of all staff, including volunteers, is critical to the overall success and outcomes of the Service. To achieve this, the Service adopts a range of contemporary strategies including workforce planning, recruitment, induction, credentialing, education, talent management, and performance management. New employees are required to attend an orientation program that provides general information on the Service as well as mandatory non-clinical training modules. In addition, the development of an on-line learning platform is in the advanced stages and will enable new employees undertake self-paced learning modules. Line managers play a critical role in ensuring that new employees are effectively inducted into their workplace. In addition to these workplace training requirements, significant work has been undertaken to prepare staff for the transition to the new Gold Coast University Hospital.

The Service recognises the importance of aligning the effort and contribution of its employees with the strategic objectives of the organisation. The performance management framework adopted by the Service is focused on defining goals and identifying development needs in a way that builds positive relationships and promotes retention. Support for skills development is provided through schemes such as study leave, regular in–service training, support for conference attendance and focused in house development programs.

The Service uses the Queensland Heath Leadership and Management Framework to foster management and leadership talent. Over the last three years, the Service has successfully partnered with the international Advisory Board to deliver the Leading Transformation Program. Delivered over five months, the program is designed to build leadership capability, particularly in the implementation of change. During the period 2012-13, 60 participants enrolled in the program.

Recognition

Employee's being recognised and appreciated for their contribution to the Service and community is important.

The Service's Staff Excellence Award Ceremony has been undertaken annually for many years to recognise the outstanding contribution of individuals and teams. Talent management and recognition is an area of increased focus in the Service's Strategic Plan 2013-2017. Recognition of valued staff also supports effective recruitment and retention of staff and staff satisfaction in the workplace. Employees are encouraged to participate in annual Quality Awards through the Health Round Table and the Australian Council on Healthcare Standards Quality programs. Various work units have initiated their own informal recognition and reward programs as initiatives of the Better Workplaces Staff Opinion Survey, which also ensures staff recognition is timely and local.

Employee support and workplace relations

The Service recognises the management of workplace relations is essential to its performance. A number of strategies are adopted to enhance satisfaction and morale, including flexible working arrangements to enable employees to balance their work commitments with their family responsibilities. Employees may have access to flexible work, rostering and leave arrangements including part-time work and job sharing.

Regular staff forums were held across the Service's facilities throughout 2012-13. The forums provide an informal opportunity for the Chief Executive to meet staff, share information and answer questions. Chief Executive podcasts were also introduced to expand the communication opportunities given the 24/7 workforce.

The Service continued to meet monthly with Unions and employees through the District Consultative Forum.

In 2012-13 there was only one formal dispute notice lodged with the Queensland Industrial Relations Commission, which did not proceed to a hearing. This positive result is a reflection of the effective workplace relations that are in place with employees and their representative Unions.

Employee support and workplace relations (cont)

A program of redundancies was implemented during 2012-13. During this period, 120 employees received redundancy Employee support and workplace relations packages at a cost of $8.35 million. Employees who did not accept an offer of a redundancy were offered case management for a set period of time, where reasonable attempts were made to find alternative employment placements. At the conclusion of this period, and where it was deemed that continued attempts of ongoing placement were no longer appropriate, employees yet to be placed were terminated and paid a retrenchment package. During the period, no employees received retrenchment packages. The program of redundancies was undertaken as part of the public sector renewal program. Additionally, there were no voluntary separations processed in 2012-13 under the Voluntary Separation Program implemented during 2011-12.

Ensuring an ethical culture

The Service's employees must observe the Code of Conduct for the Queensland Public Service. The Code articulates the standard of conduct expected of staff when dealing with patients, consumers and colleagues in the workplace. It also helps to ensure that decision making is consistent with the principles of *Public Sector Ethics Act 1984*. The importance of these conduct requirements is emphasised for new staff during induction and embedded within employee role descriptions.

The Code of Conduct is available to all existing staff through the Service's intranet site. Line managers are encouraged to regularly remind staff of their obligations under the Code of Conduct. In 2013-14 the Service will commission an online learning system which will provide all staff with access to mandatory, annual Code of Conduct refresher training.

The Service's administrative procedures and management practices comply with the *Public Sector Ethics Act 1994* and with the Code of Conduct.

Clinician engagement

In accordance with the *Hospital and Health Boards Act 2011* and related regulations the Service developed the Clinician Engagement Strategy 2012-15. The purpose of the strategy is to promote consultation with health professionals working with the Service and to provide a clear pathway for clinicians to have a voice in the planning, implementation and review of services provided by Gold Coast Hospital and Health Service. The Service recognises that people who directly provide clinical services are best placed to identify improvements to service delivery and patient care outcomes.

Accountability

Summary of financial performance

2012-13 was the first financial year that the Gold Coast Hospital and Health Service operated as a statutory body. Services are provided under a purchaser-provider model whereby the Department of Health purchases health services from the Service, which is facilitated and monitored through a service level agreement and underpinned by a performance framework.

How the money was spent

The Service achieved an operating surplus of $5.98 million and delivered on key performance indicators relating to activity, which are measured by weighted activity units (WAU). An additional operating theatre and 10 surgical short stay beds opened at Robina Hospital in November 2012 and a further operating theatre and 10 surgical orthopaedic beds opened at Robina Hospital in April 2013. In April 2013 one additional operating theatre opened at Gold Coast Hospital on weekends for additional trauma surgery. There was a change in the model of service delivery at Gold Coast Hospital with 28 medical beds converted to 28 medical assessment beds to assist in improving patient flow through the emergency department. This was based on a model which was successful at Robina Hospital.

Income

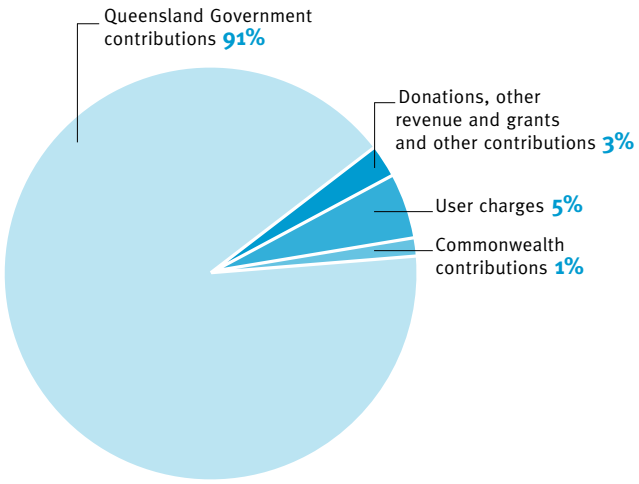
The Service's total income for 2012-13 was $863 million comprised of:

- Queensland Government contributions ($785 million)
- Commonwealth contributions ($12 million)
- user charges ($44 million)
- donations, other revenue and grants and other contributions (22 million).

Chart 6 details the extent of these funding sources for 2012-13.

Chart 6: Income by revenue sources

Expenditure

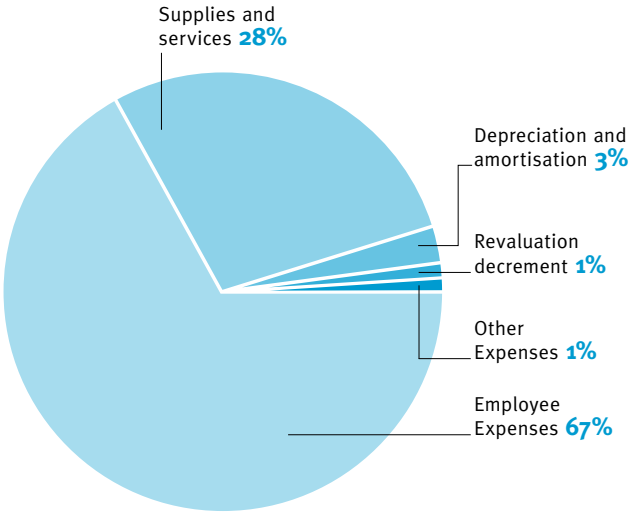


Expenditure

Chart 7 details the expenses from continuing operations.

Total expenses were $857.05 million, averaging $2.35 million per day to provide public health services. Expenditure in all categories increased towards the latter part of the financial year as the Service prepares for the move from the Gold Coast Hospital to the Gold Coast University Hospital in September 2013.

Chart 7: Expenses by major categories



1 Employee expenses includes expenses relating to health service executives and health service employees

Activity Based Funding

From 1 July 2012, the services provided by Gold Coast Hospital and Health Service have been purchased by the Department of Health, with activity to be purchased detailed within the service level agreement. The basic measure of activity is the weighted activity unit (WAU). In 2012-13, WAU activity reporting is based on the phase 15 iteration of the case-mix model in Queensland.

The Service produced 147,855 WAUs which was 0.6 per cent below the purchased activity (148,726 WAUs) and within the allowed tolerance of plus or minus two per cent. Chart 8 shows the breakup of activity by purchasing category, while Chart 9 illustrates the monthly performance to the agreed target phased through the year. The rise in mental health activity in July 2012 and subsequent reduction in following months was due to the separation of Robina and Gold Coast hospitals for activity reporting purposes.

Chart 8: Weighted activity units by category

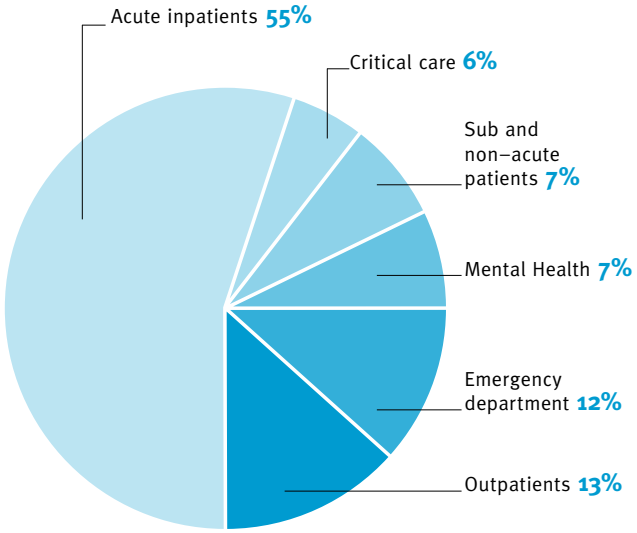
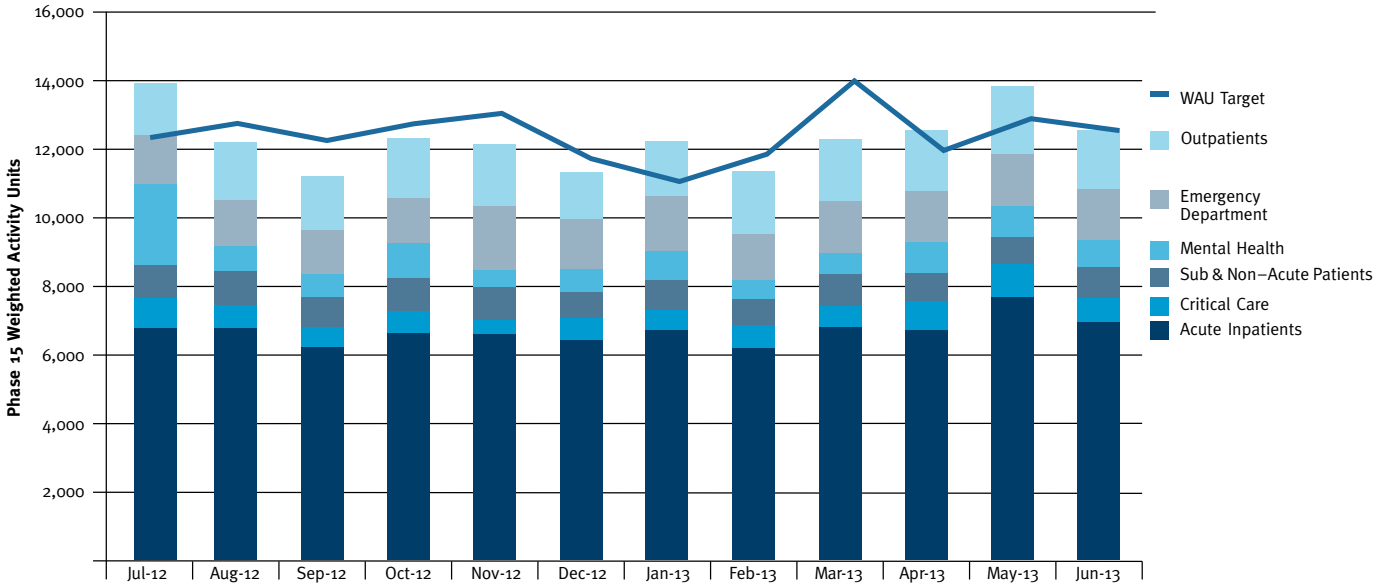


Chart 9: Weighted activity units by month



Chief Finance Officer statement

For the financial year ended 30 June 2013 the Chief Finance Officer provided a statement about the Service to the Board and Chief Executive in relation to financial internal controls, compliance with prescribed requirements for establishing and keeping the financial accounts and preparation of the financial statements to present a true and fair view, in accordance with accounting standards.

Risk management and accountability

Risk management

The Gold Coast Hospital and Health Service's risk management framework is based upon the Australian/New Zealand ISO Standard 31000:2009 for risk management. The framework outlines the Service's intent, roles and responsibilities and implementation requirements. Within the Service, responsibility for identifying and managing operational risks lies with the management of each operational division. Each operational division has a safety and quality coordinator who assists management in identifying, recording and mitigating risks. Strategic, enterprise-wide and the highest rated risks are escalated to senior executives, with oversight from the Board's Audit and Risk Committee.

In terms of oversighting risk management, the Audit and Risk Committee ensures that the Service has:

- A risk management plan that identifies how the Service will manage, record and monitor risk, including procedures for escalating risk reports to the Chief Executive.
- A system where risk management planning is a part of the strategic, operational and annual business planning activity of the Service, its facilities and/or networks.
- A risk register that is used to record, rate, monitor and report risk.
- A process for monitoring and reviewing risk control and governance systems.

During 2012-13 the Service transitioned from the Queensland Health's risk management framework as it established its own framework and commenced regular reporting to the Audit and Risk Committee. A priority for the Service in 2013-14 is to embed and strengthen risk management throughout the Service.

External scrutiny

In 2012-13, the Queensland Audit Office conducted a number of cross-sector and cross-service audits which included coverage of the Service.

Report to Parliament 4: 2012-13 – Queensland Health eHealth

An audit was undertaken to determine whether the eHealth Program was being implemented as intended, and was achieving its planned outcomes and realising expected benefits.

The audit found that Gold Coast Hospital and Health Service's experiences in implementing its electronic medical record are informing development and implementation of the integrated electronic medical record (ieMR) system across all state hospital and health services.

Report to Parliament 9: 2012-13 – Fraud risk management

This report examined whether selected Queensland public sector agencies are effectively managing fraud risks.

In response to this report, the Service participated in Queensland Health's fraud prevention program, including raising awareness of fraud related matters and encouraging employees to report instances of suspected fraud. The Service's ability to prevent and detect fraud has been enhanced with the establishment of an internal audit function.

Report to Parliament 1: 2013-14 – Right of private practice in Queensland public hospitals

This performance audit of the right of private practice arrangements examined whether the intended health and financial benefits of the scheme are being realised and whether the arrangements are being administered efficiently.

The first of two reports to be produced as part of the performance audit was tabled in Parliament in July 2013. The second report is expected to be tabled in late 2013 and the Service will respond to recommendations made.

Internal audit

The Service has established an internal audit function in line with Section 29 of the *Financial and Performance Management Standard 2009*. The Service's internal audit function is co-sourced with Protiviti, an external consulting firm specialising in internal audit services.

The internal audit function provides an independent and objective assurance on the adequacy and effectiveness of the Service's systems for risk management, internal control and governance by undertaking the following activities:

- Reviewing and appraising the soundness, adequacy and application of financial and other operating controls.
- Ascertaining compliance with established policies, procedures and statutory requirements.
- Ascertaining that assets are accounted for and safeguarded from loss.
- Identifying opportunities to improve the operations and processes and recommending improvements to existing systems of internal controls.
- Carrying out investigations and special reviews requested by the Board, the Audit and Risk Committee and/or management.

The Director Internal Audit has direct access to the Chair of the Audit and Risk Committee. The internal audit function operates independently of management under a mandate approved by the Audit and Risk Committee and has full access to all records, property and personnel of the Service. The Audit and Risk Committee met six times in 2012-13.

The internal audit function adheres to the Queensland Treasury and Trade's Audit Committee Guidelines which provides the best practice principles for audit committee members, accountable officers and personnel.

Internal audit activities are executed based on a risk-based internal audit plan which is presented to the Audit and Risk Committee annually for approval. The annual internal audit plan is developed in consultation with key stakeholders and takes into account key risks identified by management, directs the activities of internal audit and provides a framework to operate effectively. The implementation of audit recommendations that address risk mitigation are monitored and reported to the Audit and Risk Committee.

During the year, four internal audits were commenced covering areas including financial controls assurance, own source revenue and payroll. Two were completed with the remaining two (on payroll) to be finalised in 2013-14.

Machinery of government

Creation of the Gold Coast Hospital and Health Service as a statutory authority saw significant machinery of government changes with a range of corporate functions and assets transferred to the Service from the Department of Health. While a strong connection is maintained with the Department of Health, these changes enable the Service to set its own strategic direction and respond to the specific health needs of the Gold Coast community. During 2012-13 the Board and management took the opportunity to re-cast the Service's strategic direction to deliver improved healthcare services for the Gold Coast community which align with the *Blueprint for better health care in Queensland*.

Occupational health and safety

The Occupational Health, Safety and Injury Management Performance Measures Scorecard has been developed to assist members of the Board and management monitor the Service's performance against the Queensland Health Safety and Assurance Assessment Model and EQuIPNational Accreditation Criteria.

The scorecard uses key performance indicators (KPIs) to measure the Service's performance. Data is divided into three tiers:

- Tier one KPIs are aligned to the Queensland Health's strategic priorities and provide the framework for performance management and reporting.
- Tier two system support services division KPIs are designed to assist management assess legislative and service agreement compliance.
- Tier three service improvement KPIs enable the Service to monitor legislative compliance and foster continual improvement.

The scorecard enables the Board and management to monitor the effectiveness of safety and wellbeing systems, practices and outcomes. The scorecard is reported to the Board and management each month.

Changes to recordkeeping practices

In 2012-13 ownership of clinical and administrative records transferred from the Department of Health to the Gold Coast Hospital and Health Service.

In preparation for the commissioning of Gold Coast University Hospital and de-commissioning of the current Gold Coast Hospital, significant work has been undertaken to ensure records are safely transitioned. This includes implementing the Paperlite Transition Strategy where paper records are transitioning to electronic format.

During 2012-13 the Service also commenced preparations to transition from its existing Electronic Medical Record (EMR) system to the new Integrated Electronic Medical Record (iEMR).

Recordkeeping role and responsibilities

Within the Service roles and responsibilities for recordkeeping are articulated to ensure:

- Full and accurate records are made, managed and retained for as long as they are required for business, legislative, accountability and cultural purposes.
- The records management practices are regularly monitored, audited and evaluated for accountability, compliance and continuous improvement.
- Security provisions are implemented to maintain record integrity and authenticity by preventing unauthorised access, damage, alteration or misuse.
- Recordkeeping systems are managed to enable reliable, timely and accurate retrieval of records.
- Recordkeeping is systematic and comprehensive across all business units that create and maintain records.

Clinical records are maintained in accordance with the Health Sector (Clinical Records) Retention and Disposal Schedule 2012.

During 2012-13 the Service continued development of its capacity and capability in relation to statutory recordkeeping requirement including the *Public Records Act 2002* and State Government Information Standards.

Privacy and confidentiality

The Service has a Privacy Officer who is responsible for receiving and managing issues related to privacy of information.

Open data

The Queensland Government's Open Data Initiative aims to make as much public service data available for members of the public to access through: www.qld.gov.au/data

On the open data website, the Service has published data about its:

- performance against the Queensland Multicultural Action Plan 2011-14
- expenditure on consultancies
- expenditure on staff overseas travel and the reasons for travel.

Gold Coast Hospital and Health Service Financial statements 2012-13

General Information

The Gold Coast Hospital and Health Service was established as a statutory body on 1 July 2012 under the *Hospital and Health Boards Act 2011*.

The Gold Coast Hospital and Health Service is domiciled in Australia and its principal place of business is:

Gold Coast Hospital
108 Nerang Street
Southport QLD 4215

A description of the nature of the Gold Coast Hospital and Health Service's operations and its principal activities is included in the notes to the financial statements.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Statement of Comprehensive Income
for the year ended 30 June 2013

	Notes	2013 $'000
Revenue		
User charges	3	44,225
Grants and other contributions	4	810,124
Other revenue	5	8,684
Total Revenue		**863,033**
Expenses		
Employee expenses	6	3,265
Health service employee expenses	7	570,140
Supplies and services	9	242,930
Grants and subsidies	10	1,125
Depreciation and amortisation	11	24,653
Impairment losses	12	2,015
Revaluation decrement	13	9,342
Other expenses	14	3,580
Total Expenses		**857,050**
Operating Result		**5,983**
Total Comprehensive Income		**5,983**

The accompanying notes form part of these statements.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Statement of Financial Position
as at 30 June 2013

	Notes	2013 $'000
Current Assets		
Cash and cash equivalents	15	49,169
Receivables	16	17,187
Inventories	17	5,550
Prepayments		446
Total Current Assets		**72,352**
Non-Current Assets		
Intangible assets	18	2,084
Property, plant and equipment	19	469,431
Total Non-Current Assets		**471,515**
Total Assets		**543,867**
Current Liabilities		
Payables	20	64,173
Accrued employee benefits	21	122
Unearned revenue		289
Provisions	22	302
Total Current Liabilities		**64,886**
Total Liabilities		**64,886**
Net Assets		**478,981**
Equity		
Contributed equity		472,998
Accumulated surplus		5,983
Total Equity		**478,981**

The accompanying notes form part of these statements.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Statement of Changes in Equity
for the year ended 30 June 2013

	Notes	Accumulated Surplus	Contributed Equity	Total
		$'000	$'000	$'000
Balance at the beginning of the financial year		-	-	-
Operating result from continuing operations		5,983	-	5,983
Transactions with Owners as Owners				
Net assets received*	2(v)	-	460,443	460,443
Equity injections**		-	31,038	31,038
Asset transfers		-	6,151	6,151
Equity withdrawals***		-	(24,634)	(24,634)
Net Transactions with Owners as Owners		**-**	**472,998**	**472,998**
Balance at the end of the financial year		**5,983**	**472,998**	**478,981**

* Transferred on 1 July 2012 pursuant to the *Hospital and Health Boards Act 2011*. Refer to note 2(v) for further details on the transfer.

** Equity injections relate to cash funding for minor capital works and work-in-progress amounts relating to property, plant and equipment during 2012-13.

*** Equity withdrawals relate to non-cash funding to offset depreciation and amortisation expense during 2012-13.

The accompanying notes form part of these statements.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Statement of Cash Flows
for the year ended 30 June 2013

	Notes	2013 $'000
Cash and cash equivalents at the beginning of the financial year		-
Cash flows from operating activities		
Inflows:		
User charges		40,277
Grants and other contributions		785,471
Other		8,684
GST collected from customers		1,333
GST input tax credits from Australian Taxation Office		9,425
Outflows:		
Employee expenses		(3,174)
Health service employee expenses		(550,609)
Supplies and services		(217,804)
Grants and subsidies		(1,125)
GST paid to suppliers		(11,097)
GST remitted to Australian Taxation Office		(1,185)
Other		(2,598)
Net cash provided by operating activities	23	**57,598**
Cash flows from investing activities		
Inflows:		
Sales of plant and equipment		41
Outflows:		
Payments for plant and equipment		(42,014)
Net cash (used in) investing activities		**(41,973)**
Cash flows from financing activities		
Inflows:		
Transfer of cash and cash equivalents*		2,506
Equity injection		31,038
Net cash provided by financing activities		**33,544**
Cash and cash equivalents at end of financial year	15	**49,169**

* Transferred on 1 July 2012 pursuant to the *Hospital and Health Boards Act 2011*. Refer to note 2(v) for further details on the transfer.

The accompanying notes form part of these statements.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

1. Objectives and Principal Activities of the Gold Coast Hospital and Health Service

The Gold Coast Hospital and Health Service ("the GCHHS") was established as a not-for-profit statutory body on 1 July 2012 under the *Hospital and Health Boards Act 2011*.

The GCHHS aims to provide safe, sustainable, efficient, quality and responsive health services for the Gold Coast and surrounding communities. The GCHHS provides emergency, acute, sub-acute and community services to patients with health needs, across the lifespan and in a variety of settings. This is reflected in the following five objectives:

- to provide better services and access for our patients;
- to work with our partners to improve the health of our community;
- to work with our consumers and the community, to allow a greater say over their hospital and local health service;
- to improve efficiency and deliver better infrastructure; and
- to empower frontline staff and value our employees.

2. Summary of Significant Accounting Policies

(a) Statement of Compliance

The GCHHS has prepared these financial statements in compliance with section 62(1) of the *Financial Accountability Act 2009* and section 43 of the *Financial and Performance Management Standard 2009*. These financial statements are general purpose financial statements and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury and Trade's *Minimum Reporting Requirements* for the year ended 30 June 2013, and other authoritative pronouncements. With respect to compliance with Australian Accounting Standards and Interpretations, the GCHHS has applied those requirements applicable to not-for-profit entities, as the GCHHS is a not-for-profit entity. Except where stated, the historical cost convention is used.

(b) Basis of Preparation

The GCHHS has prepared these financial statements on a going concern basis, which assumes that the GCHHS will be able to meet the payment terms of its financial obligations as and when they fall due. The GCHHS is economically dependent upon its Service Agreement with the Department of Health. The Service Agreement for 2013-14 has been agreed by the GCHHS with the Department of Health and the total contract of offer for 2013-14 is $919,376,779, effective 1 July 2013. Moreover, a Service Agreement Framework is in place for three years in order to provide the GCHHS with committed funding for 2013-14 and a level of guidance regarding funding commitments and purchase activity for 2014-15 and 2015-16. Management believe that the terms and conditions of its funding arrangements under the Service Agreement Framework will provide the GCHHS with sufficient cash resources to meet its financial obligations for at least the next three years.

In addition to the GCHHS's funding arrangements under the Service Agreement Framework:

- the GCHHS has no intention to liquidate or to cease operations; and
- under section 18 of the *Hospital and Health Services Act 2011*, the GCHHS represents the State of Queensland and has all the privileges and immunities of the State.

(c) The Reporting Entity

The financial statements include the value of all revenue, expenses, assets, liabilities and equity of the GCHHS. The GCHHS does not have any controlled entities.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

2. Summary of Significant Accounting Policies (cont)

(d) Trust Transactions and Balances

The GCHHS manages patient trust accounts transactions as trustee. As the GCHHS acts only in a custodial role in respect of these transactions and balances, they are not recognised in the financial statements. Patient funds are not controlled by the GCHHS but trust activities are included in the annual audit performed by the Auditor-General of Queensland and disclosed in Note 28.

The GCHHS undertakes certain roles in relation to Right of Private Practice (RoPP) transactions as administrator of the funds. As the GCHHS acts only in an agency role in respect of these transactions and balances, they are not recognised in the financial statements. Fees collected under the RoPP scheme must be deposited initially into the RoPP bank accounts and later distributed in accordance with the policy governing the RoPP scheme. Right of private practice funds are not controlled by the GCHHS but the activities are included in the annual audit performed by the Auditor-General of Queensland and disclosed in Note 28.

(e) User Charges, Fees and Fines

User charges for hospital fees controlled by the GCHHS (mainly from private patients and patients ineligible for Medicare) are recognised as revenues when the revenue has been earned and can be measured reliably with a sufficient degree of certainty. User charges for the sale of goods and services (mainly Pharmaceutical Benefits Scheme items and food catering) involve either invoicing for related goods and services or the recognition of accrued revenue based on charges yet to be invoiced.

(f) Grants and Contributions

Grants, contributions, donations and gifts that are non-reciprocal in nature are generally recognised as revenue in the year in which the GCHHS obtains control over them. Where grants are received that are reciprocal in nature, revenue is progressively recognised as it is earned, according to the terms and conditions of the grants. Where the GCHHS is required to repay part or all of a grant contribution due to failure to meet specific conditions, a liability and an expense is recognised for the amount.

Commonwealth contributions and grants are received based on individual funding agreements. Each funding agreement includes conditions upon which the funding has been provided along with an acquittal which is required to be submitted outlining compliance with conditions. During 2012-13, no funding received was required to be repaid based on the acquittal processes.

State contributions and grants are received in accordance with the Service Agreement between the GCHHS and the Department of Health. The Department of Health transferred all cash relating to funding for 2012-13 prior to balance date, with the exception of a technical adjustment relating to funding for employee termination expenses, amortisation and depreciation and other transition costs. All additional funding relating to the technical adjustment were approved prior to balance date and were appropriately recognised as accrued revenue.

Contributed assets are recognised at fair value.

Contributed services are recognised only when a fair value can be determined reliably and the services would have been purchased if they had not been donated.

(g) Special Payments

Special payments relate to ex-gratia expenditure that the GCHHS is not contractually or legally obligated to make to other parties (refer to Note 14). In compliance with the *Financial and Performance Management Standard 2009,* the GCHHS maintains a register setting out details of all special payments greater than $5,000.

2. Summary of Significant Accounting Policies (cont)

(h) Cash and Cash Equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted that are readily convertible to cash within three months but are not banked at 30 June 2013. The GCHHS bank accounts form part of the whole-of-Government banking arrangement with the Commonwealth Bank of Australia. Under this arrangement, the GCHHS have access to the whole-of-Government cash overdraft facility with a limit of $8.5 million.

(i) Receivables

Trade debtors are recognised at the amounts due at the time of sale or service delivery. Settlement of these amounts is required within 30 days from the invoice date. The collectability of receivables is assessed periodically with provisions made for impairment. Increases in the allowance for impairment are based on loss events as disclosed in Note 27(c).

(j) Inventories

Inventories consist mainly of pharmaceutical medical supplies and clinical supplies held for distribution. Inventories are measured at cost and assessed periodically for obsolescence. Where damaged or expired items have been identified, provisions are made for impairment.

(k) Acquisition of Assets

Actual cost is used for the initial recording of all non-current physical and intangible 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.

Where assets are received for no 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 at the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation.

Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are recognised at their fair value at date of acquisition in accordance with AASB 116 *Property, Plant and Equipment*.

(l) Property, Plant and Equipment

As a result of the National Health Reform, the control of land and buildings used by the GCHHS were transferred to the GCHHS from the Department of Health for an initial three year term from 1 July 2012 via a Deed of Lease arrangement. Although legal ownership remains with the Department of Health, the property is reported on the statement of financial position of the GCHHS as the GCHHS substantially holds all the risks and rewards incidental to ownership of the land and building assets during the term of the lease arrangement.

The GCHHS has full use of the assets, managerial control of assets, and is responsible for maintenance however, proceeds from the sale of these assets cannot be retained by the GCHHS.

Any revaluation surpluses or decrements associated with these assets are recognised by the GCHHS. Refer to Note 2(n) for significant accounting policies on the revaluation of these assets.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

2. Summary of Significant Accounting Policies (cont)

(l) Property, Plant and Equipment (continued)

Items of property, plant, and equipment with a cost or other value equal to or in excess of the following thresholds are recognised for financial reporting purposes in the year of acquisition:

Buildings	$10,000
Land	$1
Plant and Equipment	$5,000

Items with a lesser value are expensed in the year of acquisition. Land improvements undertaken by the GCHHS are included with buildings.

Gold Coast University Hospital

The new Gold Coast University Hospital campus is expected to be completed and ready for service delivery capacity in September 2013. The cost of work-in-progress relating to the Gold Coast University Hospital is currently being held within the Department of Health's asset register and on its Statement of Financial Position as at 30 June 2013. Transfer of the Gold Coast University Hospital Campus from the Department of Health to the GCHHS will be completed once the hospital is ready for service delivery capacity. Work-in-progress amounts of $27,544,825 relating to property, plant and equipment held for the Gold Coast University Hospital is included in the GCHHS's asset register and on its Statement of Financial Position as at 30 June 2013. However, in accordance with AASB 116 *Property, Plant and Equipment,* these assets are not being depreciated until the site is ready for service delivery capacity.

(m) Intangibles

Intangible assets with a cost or other value equal to or greater than $100,000 are recognised in these financial statements, items with a lesser value being expensed. Each intangible asset, less any anticipated residual value, is amortised over its estimated useful life to the GCHHS. The residual value is zero for all intangible assets.

Software Purchased

The purchase cost of software has been capitalised and is being amortised on a straight-line basis over the period of expected benefit to the GCHHS. Refer to Note 2(o) for further details on the amortisation rate applied.

(n) Revaluations of Non-Current Physical and Intangible Assets

Land and buildings are measured at fair value in accordance with AASB 116 *Property, Plant and Equipment* and Queensland Treasury and Trade's *Non-Current Asset Policies for the Queensland Public Sector.* Land is measured at fair value each year using independent revaluations, desktop market revaluations or indexation by the State Valuation Service (SVS) within the Department of Natural Resources and Mines. Independent revaluations are performed with sufficient regularity to ensure assets are carried at fair value.

Buildings are measured at depreciated replacement cost utilising either independent revaluation or applying an interim revaluation methodology developed by the appointed independent valuer. Assets under construction are not revalued until they are ready for use. Reflecting the specialised nature of the GCHHS's buildings (comprising health service buildings and hospital residential facilities), depreciated replacement cost is determined as the replacement cost less the cost to bring to current standards.

The methodology applied by the appointed independent valuer is a financial simulation in lieu of market value as these assets cannot be bought and sold on the open market. Replacement cost is estimated by creating a cost plan (cost estimate) of the asset through the measurement of key quantities including:

- Gross floor area
- Number of floors
- Girth of the building
- Height of the building
- Number of lifts and staircases

2. Summary of Significant Accounting Policies (cont)

(n) Revaluations of Non-Current Physical and Intangible Assets (continued)

The model developed by the valuer creates an elemental cost plan using these quantities and the model includes multiple building types and is based on the valuer's experience of cost managing construction contracts.

The cost model is updated each year and tests are performed to compare the model outputs on actual recent projects to ensure it produces a true representation of the cost of replacement. The costs are at Brisbane prices and published location indices are used to adjust the pricing to suit local market conditions. Live project costs from across the state are also assessed to inform current market changes that may influence the published factors.

The key assumption on the replacement cost is that the estimate is based on replacing the current form of the building with a building of the same form (size and shape). This assumption has a significant impact if an asset's function changes.

The cost to bring to current standard is the estimated cost of refurbishing the asset to bring it to current standards and a new condition. For each of the five condition ratings the estimate is based on professional opinion as well as having regard to historical project costs.

In assessing the cost to bring to current standard, a condition rating is applied based upon the following information:

- Visual inspection of the asset
- Asset condition data provided by the Department of Health
- Verbal guidance from the asset manager
- Previous reports and inspection photographs if available (to show the change in condition over time).

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

These condition ratings are linked to the cost to bring to current standards.

The methodology of the appointed independent valuer in 2012-13 has changed from prior year revaluations of these assets in that category 2 and category 3 condition ratings were significantly influenced by the age of the asset. The financial effect on depreciated replacement cost values from this change in condition criteria has been modelled and has been assessed as immaterial (i.e. in the range of 1 per cent and 2 per cent).

The standard useful life of a health facility is generally 30 years and is adjusted for those assets in extreme climatic conditions which have historically shorter lives, or where assets such as residences generally have longer lives.

Estimates of remaining useful life are based on the assumption that the asset remains in its current function and will be maintained.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

2. Summary of Significant Accounting Policies (cont)

(n) Revaluations of Non-Current Physical and Intangible Assets (continued)

No allowance has been provided for significant refurbishment works in the estimate of remaining useful life as any refurbishment should extend the life of the asset.

Buildings have been valued on the basis that there is no residual value.

Any revaluation increment arising on the revaluation of an asset is credited to the asset revaluation surplus of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense. A decrease in the carrying amount on revaluation is charged as an expense, to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class. On revaluation, accumulated depreciation is restated proportionately with the change in the carrying amount of the asset and any change in the estimate of remaining useful life.

The GCHHS has adopted the gross method of reporting comprehensively revalued assets. This method restates separately the gross amount and related accumulated depreciation of the assets comprising the class of revalued assets. Accumulated depreciation is restated proportionally in accordance with the advice of the appointed independent valuer. The proportionate method has also been applied to those assets that have been revalued by way of indexation.

Plant and equipment is measured at cost in accordance with Queensland Treasury and Trade's *Non-Current Asset Policies for the Queensland Public Sector.*

Non-current physical assets measured at fair value are revalued by the appointed independent valuer, at least once every five years. However, if a class of asset experiences significant or volatile changes in fair value (i.e. where indicators suggest that the value of the class of asset may have changed by 20 per cent or more from one reporting period to the next), it is subject to such revaluations in the reporting period, where practicable, regardless of the timing of the previous revaluation.

Materiality concepts under AASB 1031 *Materiality* are considered in determining whether the difference between the carrying amount and the fair value of an asset is material.

Separately identified components of assets are measured on the same basis as the assets to which they relate however, their useful lives are independently assessed in accordance with the *Non-Current Asset Policies for the Queensland Public Sector.*

(o) Amortisation and Depreciation of Intangibles and Property, Plant and Equipment

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

All intangible assets of the GCHHS have finite useful lives and are amortised on a straight-line basis.

Property, plant and equipment is depreciated on a straight-line basis so as to allocate the net cost or revalued amount of each asset, less its estimated residual value, progressively over its estimated useful life to the GCHHS.

Work-in-progress amounts (i.e. assets under construction) are not depreciated until they reach service delivery capacity. Service delivery capacity relates to when construction is complete and the asset is first put to use or is installed ready for use in accordance with its intended application. These assets are then reclassified to the relevant classes of property, plant and equipment. Where assets have separately identifiable components that are subject to regular replacement, these components are assigned useful lives distinct from the asset to which they relate and are depreciated accordingly.

Any expenditure that increases the originally assessed capacity or service potential of an asset is capitalised and the new depreciable amount is depreciated over the remaining useful life of the asset.

2. Summary of Significant Accounting Policies (cont)

(o) Amortisation and Depreciation of Intangibles and Property, Plant and Equipment (continued)

The depreciable amount of improvements to or on leasehold land is allocated progressively over the estimated useful lives of the improvements or the unexpired period of the lease, whichever is the shorter. The unexpired period of a lease includes any option period where exercise of the option is probable.

Items comprising the GCHHS's library are expensed on acquisition.

For each class of depreciable asset the following depreciation and amortisation rates are used:

Class	Rate %
Buildings	3.3%
Plant and equipment:	
Computer Hardware	20.0%
Engineering	10.0%
Furniture and Fittings	5.0%
Leasehold improvements	6.7% - 20.0%
Medical equipment < $200,000	10.0%
Medical equipment > $200,000	12.5%
Office equipment	10.0%
Motor vehicles	20.0%
Intangible assets:	
Software purchased	20.0%
Software developed	20.0%

(p) Impairment of Non-Current Assets

All non-current physical and intangible assets are assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, the GCHHS 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, 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 to the carrying amount.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

2. Summary of Significant Accounting Policies (cont)

(q) Leases

A distinction is made between finance leases that effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership, and operating leases, under which the lessor retains substantially all risks and benefits of ownership.

The GCHHS does not have any finance leases.

Operating lease payments are representative of the pattern of benefits derived from the leased assets and are expensed in the periods in which they are incurred.

Incentives received on entering into operating leases are recognised as liabilities. Lease payments are allocated between rental expense and reduction of the liability.

(r) Payables

Trade creditors are recognised upon receipt of the goods or services ordered and are measured at the agreed purchase or contract price, net of applicable trade and other discounts. Amounts owing are unsecured and are generally settled on 30 to 60 day terms.

(s) Financial Instruments

Recognition

Financial assets and financial liabilities are recognised in the Statement of Financial Position when the GCHHS 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
- Receivables - held at amortised cost
- Payables - held at amortised cost

The GCHHS does not enter into derivative and other financial instrument transactions for speculative purposes, nor for hedging. Apart from cash and cash equivalents, the GCHHS holds no financial assets classified at fair value through profit or loss. Other disclosures relating to the measurement and financial risk management of financial instruments held by the GCHHS are included in Note 27.

(t) Employee Benefits

Health Service Employee Expenses

Overall management of the public sector health system is the responsibility of the Department of Health pursuant to section 80 of the *Hospital and Health Boards Act 2011*. The Department of Health provides employees to the GCHHS, referred to as health service employees, via its Service Agreement with the Department of Health. Under this arrangement:

- The health service employees remain as employees of the Department of Health;
- The GCHHS is responsible for the day to day management of these Department of Health employees;
- The GCHHS reimburses the Department of Health for salaries and certain on-costs of these Department of Health employees.

As a result of this arrangement, the GCHHS treats reimbursements to the Department of Health for their employees in these financial statements as health service employee expenses, rather than employee expenses.

2. Summary of Significant Accounting Policies (cont)

(t) Employee Benefits (continued)

Employee Expenses

Unless a Health Service Executive is contracted to the GCHHS from the Department of Health, the GCHHS directly engages Health Service Executives in accordance with section 67(2) of the *Hospital and Health Boards Act 2011*.

Employer superannuation contributions, annual leave levies and long service leave levies are regarded as employee benefits. 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.

Wages, Salaries and Sick Leave

Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at the current salary rates. For unpaid entitlement expected to be paid within 12 months, the liabilities are recognised at their undiscounted values. 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

The Queensland Government's Annual Leave Central Scheme (ALCS) became operational on 30 June 2008. Under this scheme, levies are payable to the Department of Health to cover the cost of employees' annual leave (including leave loading). The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave are claimed from the scheme quarterly in arrears. No provision for annual leave is recognised in the GCHHS's financial statements as the liability 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.*

Long Service Leave

Under the Queensland Government's Long Service Leave Scheme, levies are payable to the Department of Health to cover the cost of employees' long service leave. The levies are expensed in the period in which they are payable. Amounts paid to employees for long service leave are claimed from the scheme quarterly in arrears. No provision for long service leave is recognised in the GCHHS financial statements as the liability is being held on a whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

Superannuation

Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable. The GCHHS's obligation 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.*

(u) Provisions

Provisions are recorded when the GCHHS has a present obligation, either legal or constructive as a result of a past event. They are recognised at the amount expected at reporting date for which the obligation will be settled in a future period. Where the settlement of the obligation is expected after 12 or more months, the obligation is discounted to the present value using an appropriate discount rate.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

2. Summary of Significant Accounting Policies (cont)

(v) Major Events

On 2 August 2011, Queensland, as a member of the Council of Australian Governments signed the National Health Reform Agreement, committing to major changes in the way that health services in Australia are funded and governed. Certain balances were transferred from the Department of Health to GCHHS effective 1 July 2012. This was effected via a transfer notice signed by the Minister for Health. The transfer notices were approved by the Director-General of the Department of Health, the Board Chair and the Chief Executive of the GCHHS. Balances transferred materially reflect the closing balances of the Hospital Service Districts that existed as at 30 June 2012. These balances represent the balances transferred pursuant to the *Hospital and Health Boards Act 2011* and are recorded as such in these financial statements. The cash balance transferred to the GCHHS was the amount required to ensure the GCHHS commenced operations with a balanced working capital position.

The balances transferred on 1 July 2012 from the Department of Health pursuant to the *Hospital and Health Boards Act 2011* were:

	2012 $'000
Current Assets	
Cash and cash equivalents	2,506
Receivables	13,472
Inventories	7,587
Prepayments	2,398
Total Current Assets	**25,963**
Non-Current Assets	
Intangible assets	2,615
Property, plant and equipment	455,346
Total Non-Current Assets	457.961
Total Assets	**483,924**
Current Liabilities	
Payables	23,419
Accrued employee benefits	31
Unearned revenue	31
Total Current Liabilities	**23,481**
Total Liabilities	**23,481**
Net Assets	**460,443**

The transfer of net assets to the GCHHS were on a non-reciprocal basis.

2. Summary of Significant Accounting Policies (cont)

(w) Insurance

The GCHHS's non-current physical assets and other risks are insured through the Queensland Government Insurance Fund, premiums being paid on a risk assessment basis. All premiums are paid to the Department of Health as a fee for service arrangement (refer to Note 9).

(x) Services Received Free of Charge or for Nominal Value

Contributed services are recognised only if the services would have been purchased if they had not been donated and their fair value can be measured reliably. Where this is the case, an equal amount is recognised as revenue and an expense.

(y) Contributed Equity

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland State Public Sector entities as a result of machinery-of-Government or other involuntary transfers are adjusted to Contributed Equity in accordance with Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities*.

(z) Taxation

The GCHHS is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). The GCHHS, other Queensland Hospital and Health Services and the Department of Health are grouped for the purposes of Section 149-25 *A New Tax System (Goods and Services Tax) Act 1999*. Therefore all transactions made between the entities in the tax group do not attract GST, and all transactions external to the group are required to be accounted for GST where applicable. GST credits receivable from, and GST payable to the Australian Taxation Office are recognised and accrued (refer to Note 16).

(aa) Issuance of Financial Statements

These financial statements are authorised for issue by the Board Chair and Chief Executive of the GCHHS at the date of signing the Management Certificate.

(ab) Accounting Estimates and Judgements

The preparation of financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions, and management judgements that have the potential to cause a material adjustment to the carrying amount of assets and liabilities within the next financial year. Such estimates, judgements and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised and in future periods as relevant.

Estimates and assumptions that have a potential significant effect include the valuation of property, plant and equipment (refer to Note 19.)

(ac) Rounding and Comparatives

Amounts included in these financial statements are in Australian dollars and have been rounded to the nearest $1,000 or, where the amount is less than $500, to zero, unless disclosure of the full amount is specifically required. No comparative information is available for the GCHHS 2012-13 financial statements due to the commencement of the statutory body on 1 July 2012.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

2. Summary of Significant Accounting Policies (cont)

(ad) New and Revised Accounting Standards

Australian Accounting Standard changes applicable for the first time for 2012-13 have had minimal effect on the GCHHS's financial statements, as explained below.

AASB 2011-9 *Amendments to Australian Accounting Standards - Presentation of Items of Other Comprehensive Income* (AASB 1, 5, 7, 101, 112, 120, 121, 132, 133, 134, 1039 and 1049) became effective from reporting periods beginning on or after 1 July 2012. The only impact for the GCHHS is that, in the Statement of Comprehensive Income, items within the 'Other Comprehensive Income' section are now presented in different subsections, according to whether or not they are subsequently classifiable to the operating result. Whether subsequent reclassification is possible depends on the requirements or criteria in the accounting standards and interpretations that relate to the item concerned.

The GCHHS is not permitted to early adopt a new or amended accounting standard ahead of the specified commencement date unless approval is obtained from Queensland Treasury and Trade. Consequently, the GCHHS has not applied any Australian Accounting Standards and Interpretations that have been issued but are not yet effective. The GCHHS applies standards and interpretations in accordance with their respective commencement dates.

At the date of authorisation of the financial report, the expected impacts of new or amended Australian Accounting Standards with future commencement dates are as set out below.

AASB 13 *Fair Value Measurement* applies from reporting periods beginning on or after 1 January 2013. AASB 13 sets out a new definition of 'fair value' as well as new principles to be applied when determining the fair value of assets and liabilities. The new requirements will apply to all of the GCHHS's assets and liabilities (excluding leases) that are measured and / or disclosed at fair value or another measurement based on fair value. The potential impacts of AASB 13 relate to the fair value measurement methodologies used and financial statements disclosures made in respect of such assets and liabilities.

The GCHHS has commenced reviewing its fair value methodologies for all items of property, plant and equipment measured at fair value to determine whether those methodologies comply with AASB 13. To the extent that the methodologies don't comply, changes will be necessary.

A revised version of AASB 119 *Employee Benefits* applies from reporting periods beginning on or after 1 January 2013. The revised AASB 119 is generally to be applied retrospectively. The revised AASB 119 includes changed criteria for accounting for employee benefits as 'short-term employee benefits'. However, as the GCHHS is a member of the Queensland Government central schemes for annual leave and long service leave, this change in criteria has no impact on the GCHHS's financial statements as the employer liability is held by the central scheme. The revised AASB 119 also includes changed requirements for the measurement of employer liabilities / assets arising from defined benefit plans, and the measurement and presentation of changes in such liabilities / assets. The GCHHS makes employer superannuation contributions only to the QSuper defined benefit plan, and the corresponding QSuper employer benefit obligation is held by the State. Therefore, those changes to AASB 119 will have no impact on the GCHHS.

The revised AASB 119 clarifies the concept of 'termination benefits', and the recognition criteria for liabilities for termination benefits will be different. If termination benefits meet the timeframe criterion for 'short-term employee benefits', they will be measured according to the AASB 119 requirements for 'short-term employee benefits'. Otherwise, termination benefits will need to be measured according to the AASB 119 requirements for 'other long-term employee benefits'.

2. Summary of Significant Accounting Policies (cont)

(ad) New and Revised Accounting Standards (continued)

AASB 1053 *Application of Tiers of Australian Accounting Standards* applies as from reporting periods beginning on or after 1 July 2013. AASB 1053 establishes a differential reporting framework for those entities that prepare general purpose financial statements, consisting of two Tiers of reporting requirements - Australian Accounting Standards (commonly referred to as 'Tier 1'), and Australian Accounting Standards - Reduced Disclosure Requirements (commonly referred to as 'Tier 2'). Tier 1 requirements comprise full range of AASB recognition, measurement, presentation and disclosure requirements that are currently applicable to reporting entities in Australia.

AASB 1053 acknowledges the power of a regulator to require application of the Tier 1 requirements. The Queensland Treasury and Trade has exercised its power as regulator to require the adoption of Tier 1 reporting by all Queensland Government Departments and Statutory Bodies (including the GCHHS) that are consolidated into the whole-of-Government financial statements. Therefore, the release of AASB 1053 and associated amending standards will have no impact on the GCHHS.

AASB 1055 *Budgetary Reporting* and 2013-14 Amendments to AASB 1049 R*elocation of Budgetary Reporting Requirements* applies from reporting periods beginning on or after 1 July 2014. This standard specifies budgetary disclosure requirements for the whole of government, General Government Sector (GGS) and not-for-profit entities within the GGS of each government. Disclosures made in accordance with this standard will provide users with information relevant to assessing performance of an entity, including accountability for resources entrusted to it. The GCHHS will be required to include the original budgeted financial statements as presented to parliament in the same format as the statutory financial statements together with explanations of major variances between the actual amounts presented in the financial statements and the corresponding original budget amounts. The GCHHS does not intend to adopt the revised standard before its operative date, which means that it would be first applied in the annual reporting period ending 30 June 2015.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

	2013 $'000
3. **User Charges**	
Hospital fees	24,037
Sales of goods and services	20,188
Total	**44,225**
4. **Grants and Other Contributions**	
State contributions and grants:	
Activity based funding*	568,345
Block funding*	84,872
Other state grants*	131,295
	784,512
Commonwealth contributions and grants	11,947
Other grants	3,225
Other minor capital funding	8,600
Donations - other	1,817
Donations - assets	23
Total	**810,124**

* State contributions and grants are received in accordance with the Service Agreement between the GCHHS and the Department of Health. Refer to Note 2(f) for further details on the Service Agreement.

	2013 $'000
5. Other Revenue	
External service recoveries*	8,003
Rental income	299
Interest	112
Other	270
Total	**8,684**

* External service recoveries relate to payments for health service employees of the GCHHS seconded to third parties such as universities, private hospitals and other government agencies.

6. Employee Expenses	
Wages and salaries	2,608
Employer superannuation contributions	118
Annual leave	303
Long service leave	39
Termination payments	140
Other employee entitlements	57
Total	**3,265**

The number of employees of the GCHHS as at 30 June 2013, including both full-time employees and part-time employees, measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information) is 11.

7. Health Service Employee Expenses

The number of health service employees as at 30 June 2013, including both full-time employees and part-time employees, measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information) is 5,087.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

8. Key Management Personnel and Remuneration

(a) Key Management Personnel

The following details for key management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of the GCHHS as at 30 June 2013. The complete list of key management personnel who had authority and responsibility for planning, directing and controlling the activities of the GCHHS during 2012-13 is disclosed in Note 8(b). Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Position & Name	Responsibilities	Contract Classification & Appointment Authority	Date appointed
Board Chair – *Ian Langdon*	Perform duties of Chair as prescribed in the *Hospital and Health Boards Act 2011*. Chair of Executive Committee.	Governor-in-Council	01/07/2012
Board Member – *Kenneth Brown*	Perform duties of Deputy Chair as prescribed in the *Hospital and Health Boards Act 2011*. Chair of: Finance and Performance Committee; and Audit and Risk Committee. Member of Safety, Quality and Engagement Committee.	Governor-in-Council	01/07/2012
Board Member – *Allan Cripps*	Perform duties of Board Member as prescribed in the *Hospital and Health Boards Act 2011*. Chair of Research and Education Committee. Member of: Executive Committee; Finance and Performance Committee; and Audit and Risk Committee.	Governor-in-Council	01/07/2012
Board Member – *Colette McCool*	Perform duties of Board Member as prescribed in the *Hospital and Health Boards Act 2011*. Chair of Safety, Quality and Engagement Committee. Member of: Finance and Performance Committee; and Audit and Risk Committee.	Governor-in-Council	01/07/2012
Board Member – *Pauline Ross*	Perform duties of Board Member as prescribed in the *Hospital and Health Boards Act 2011*. Member of: Executive Committee; and Safety, Quality and Engagement Committee.	Governor-in-Council	01/07/2012
Board Member – *Andrew Weissenberger*	Perform duties of Board Member as prescribed in the *Hospital and Health Boards Act 2011*. Member of: Executive Committee; and Safety, Quality and Engagement Committee.	Governor-in-Council	07/09/2012
Chief Executive – *Ron Calvert*	Responsible for the overall management of the GCHHS through major functional areas to ensure the delivery of key government objectives in improving the health and well being of patients. This position is accountable to the Board.	SESL Contract. Section 33 of the *Hospital and Health Boards Act 2011*	01/10/2012
Chief Operations Officer – *Naomi Dwyer* [1]	Responsible for the strategic leadership and management of all non-clinical and clinical support functions for the GCHHS.	HES3L Contract. Section 67 of the *Hospital and Health Boards Act 2011*	01/10/2012
Chief Finance Officer – *Garry Button*	Responsible for the financial and budget management of the GCHHS.	HES2L Contract. Section 67 of the *Hospital and Health Boards Act 2011*	27/06/2013

Notes:

1. On 25 March 2013, Ms Dwyer commenced transitioning to the role of Executive Director, Organisational Development as part of the new organisational structure submitted to the Department of Health for approval.

8. Key Management Personnel and Remuneration (cont)

(a) Key Management Personnel (continued)

Position & Name	Responsibilities	Contract Classification & Appointment Authority	Date appointed
Executive Director, Allied Health – *Morven Gemmill*	Responsible for the strategic management of the services provided under the Allied Health Division of the GCHHS.	**District Health Service Employees' Award**	01/07/2012
Executive Director, Community and Sub-Acute Services – *Elizabeth Carr*	Responsible for the strategic management of the community, Sub-Acute and Aged Services Division of the GCHHS.	**HES2L Contract. Section 67 of the** *Hospital and Health Boards Act 2011*	21/01/2012
Executive Director, Emergency Critical and Support Services – *Dean Blond*	Responsible for the strategic management of all Emergency, Critical and Support Services provided by the GCHHS.	**HES2H Contract. Section 67 of the** *Hospital and Health Boards Act 2011*	29/10/2012
Executive Director, Emergency Critical and Support Services – *Jane Hancock* [1]	Responsible for the strategic management of all Emergency, Critical and Support Services provided by the GCHHS.	**HES2H Contract. Section 67 of the** *Hospital and Health Boards Act 2011*	01/07/2012
Executive Director, Family, Women's and Children – *Lance Le Ray*	Responsible for the strategic management of the services provided under the Family, Women's and Children Division of the GCHHS.	**HES2L Contract. Section 67 of the** *Hospital and Health Boards Act 2011*	01/07/2012
Executive Director, Medicine – *Lindsey Gough*	Responsible for the strategic management of the services provided under the Medicine Division of the GCHHS.	**HES2H Contract. Section 67 of the** *Hospital and Health Boards Act 2011*	21/01/2013

Notes:
1. From 29 October 2012 to 24 March 2013, Ms Hancock worked on the GCHHS's public, private and partnerships project. On 25 March 2013, Ms Hancock commenced transitioning to the role of Executive Director of Operations as part of the new organisational structure submitted to the Department of Health for approval.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

8. Key Management Personnel and Remuneration (cont)

(a) Key Management Personnel (continued)

Position & Name	Responsibilities	Contract Classification & Appointment Authority	Date appointed
Executive Director, Mental Health & ATODS – *Karlyn Chettleburgh*	Responsible for the strategic management of the services provided under the Mental Health and ATODS (Alcohol, Tobacco and Other Drugs) Division of the GCHHS.	HES2H Contract. Section 67 of the *Hospital and Health Boards Act 2011*	01/10/2012
Executive Director Nursing & Midwifery Services – *Gerald Williams*	Responsible for the strategic management of Nursing and Midwifery Services provided by the GCHHS.	Queensland Public Hospital Nurses' Award	01/07/2012
Executive Director, People Systems and Performance – *Damian Green*	Responsible for the strategic management of the GCHHS's information communication technology resources as well as human resource capacity and capability.	HES2H Contract. Section 67 of the *Hospital and Health Boards Act 2011*	07/01/2013
Executive Director, Strategic Development – *Michael Allsopp*	Responsible for the strategic management of health service planning for the GCHHS including contract funding negotiations with the Department of Health.	HES2H Contract. Section 67 of the *Hospital and Health Boards Act 2011*	01/07/2012
Executive Director, Surgical Services – *Lance Le Ray*	Responsible for the strategic management of Surgical Services provided by the GCHHS.	HES2L Contract. Section 67 of the *Hospital and Health Boards Act 2011*	25/02/2013

8. Key Management Personnel and Remuneration (cont)

(b) Remuneration

Remuneration policy for the GCHHS's key management personnel is set by the Director-General of the Department of Health as provided for under the *Hospital and Health Boards Act 2011*. The remuneration and other terms of employment for the key management personnel are specified in employment contracts.

Remuneration packages for key management personnel comprise the following components:

- Short term employee benefits which include: Base salary, allowances and annual leave entitlements expensed for the entire year or for that part of the year during which the employee occupied the specified position. Non-monetary benefits consisting of provision of vehicle together with fringe benefits tax applicable to the benefit.
- Long term employee benefits include amounts expensed in respect of long service leave.
- Post-employment benefits 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 includes base and non-monetary benefits, long term employee benefits and post-employment benefits.

		Short Term Benefits					
Position and Name	Period of Service	Base $'000	Non-Monetary Benefits $'000	Long Term Benefits $'000	Post-Employment Benefits $'000	Termination Benefits $'000	Total Remuneration $'000
Board Chair – *Ian Langdon*	01/07/2012 to 30/06/2013	76	-	-	8	-	84
Board Member – *Kenneth Brown*	01/07/2012 to 30/06/2013	33	-	-	3	-	36
Board Member – *Allan Cripps*	01/07/2012 to 30/06/2013	33	-	-	2	-	35
Board Member – *Colette McCool*	01/07/2012 to 30/06/2013	33	-	-	3	-	36
Board Member – *Pauline Ross*	01/07/2012 to 30/06/2013	33	-	-	-	-	33
Board Member – *Andrew Weissenberger*	07/09/2012 to 30/06/2013	33	-	-	3	-	36
Chief Executive – *Ron Calvert*	01/10/2012 to 30/06/2013	243	15	-	25	-	283

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

8. Key Management Personnel and Remuneration (cont)

(b) Remuneration (continued)

Position and Name	Period of Service	Short Term Benefits		Long Term Benefits	Post-Employment Benefits	Termination Benefits	Total Remuneration
		Base $'000	Non-Monetary Benefits $'000	$'000	$'000	$'000	$'000
Chief Executive – *Naomi Dwyer*	01/07/2012 to 30/09/2012	55	-	-	6	-	61
Chief Operations Officer – *Naomi Dwyer* [1]	01/10/2012 to 30/06/2013	152	-	-	16	-	168
Chief Operations Officer – *Karlyn Chettleburgh*	01/07/2012 to 30/09/2012	45	-	-	4	-	49
Chief Finance Officer – *Garry Button*	27/06/2013 30/06/2013	2	-	-	-	-	2
Chief Finance Officer – *Trevor Saunders*	01/07/2012 to 26/06/2013	175	-	-	15	-	190
Executive Director, Allied Health – *Morven Gemmill*	01/07/2012 30/06/2013	164	3	-	19	-	186
Executive Director, Community & Sub-Acute Services – *Elizabeth Carr*	21/01/2013 to 30/06/2013	54	-	2	7	-	63
Executive Director, Community & Sub-Acute Services – *Robert Pegram*	01/07/2012 to 20/01/2013	122	5	-	11	-	138
Executive Director, Emergency Critical & Support Services – *Dean Blond*	29/10/2012 to 30/06/2013	121	-	2	11	-	134
Executive Director, Emergency Critical & Support Services – *Jane Hancock* [2]	01/07/2012 to 30/06/2013	188	-	4	18	-	210

Notes:

1. On 25 March 2013, Ms Dwyer commenced transitioning to the role of Executive Director, Organisational Development as part of the new organisational structure submitted to the Department of Health for approval.
2. From 29 October 2012 to 24 March 2013, Ms Hancock worked on the GCHHS's public, private and partnerships project. On 25 March 2013, Ms Hancock commenced transitioning to the role of Executive Director of Operations as part of the new organisational structure submitted to the Department of Health for approval.

8. Key Management Personnel and Remuneration (cont)

(b) Remuneration (continued)

Position and Name	Period of Service	Short Term Benefits		Long Term Benefits	Post-Employment Benefits	Termination Benefits	Total Remuneration
		Base $'000	Non-Monetary Benefits $'000	$'000	$'000	$'000	$'000
Executive Director, Family, Women's and Children & Executive Director, Surgical Services - *Lance Le Ray*	01/06/2013 to 30/06/2013; 01/07/2012 to 06/01/2013 25/02/2013 to 30/06/2013	283	16	7	35	-	341
Executive Director, Family, Women's & Children – *Richard Christensen*	07/01/2013 to 31/05/2013	65	-	-	-	8	73
Executive Director Medical Services – *Brian Bell*	01/07/2012 to 10/05/2013	339	-	4	27	-	370
Executive Director, Medicine – *Lindsey Gough*	21/01/2013 to 30/06/2013	54	16	-	5	-	75
Executive Director, Medicine – *Paula Duffy*	01/07/2012 to 20/01/2013	80	-	2	11	-	93
Executive Director, Mental Health & ATODs – *Karlyn Chettleburgh*	01/10/2012 to 30/06/2013	151	-	-	15	-	166
Executive Director, Mental Health & ATODs – *Diana Grice*	01/07/2012 to 30/09/2012	48	-	-	5	-	53

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

8. Key Management Personnel and Remuneration (cont)

(b) Remuneration (continued)

Position and Name	Period of Service	Short Term Benefits		Long Term Benefits	Post-Employment Benefits	Termination Benefits	Total Remuneration
		Base $'000	Non-Monetary Benefits $'000	$'000	$'000	$'000	$'000
Executive Director Nursing & Midwifery Services – *Gerald Williams*	01/07/2012 to 30/06/2013	209	-	-	22	-	231
Executive Director, People and Culture – *Damian Green*	07/01/2013 to 30/06/2013	74	-	-	8	-	82
Executive Director, Strategic Development – *Michael Allsopp*	01/07/2012 to 30/06/2013	150	-	4	19	-	173
Executive Director, Surgical Services – *Louise Fisher*	01/07/2012 to 22/02/2013	106	-	19	13	140	278

	2013 $'000
9. Supplies and Services	
Consultants and contractors	6,584
Clinical supplies and services	119,383
Drugs	35,176
Catering and domestic supplies	15,977
Computer services	3,370
Insurance premiums - Queensland Government Insurance Fund	7,759
Workers' compensation premium	8,746
Repairs and maintenance	9,228
Travel	5,599
Communications	7,614
Expenses relating to capital works	1,878
Utilities	6,249
Operating lease rentals	10,860
Motor vehicles	579
Building services	488
Other	3,440
Total	**242,930**
10. Grants and Subsidies	
Public hospital support services	651
Other grants	474
Total	**1,125**
11. Depreciation and Amortisation	
Depreciation expenses were incurred in respect of:	
Buildings	16,552
Plant and equipment	7,570
	24,122
Amortisation expenses were incurred in respect of:	
Intangibles	531
	531
Total	**24,653**

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

	2013 $'000
12. **Impairment Losses**	
Impairment losses on trade receivables	1,245
Bad debts written off	770
Total	**2,015**
13. **Revaluation Decrement**	
Land	4,537
Buildings	4,805
Total	**9,342**

The asset revaluation decrement, not being a reversal of a previous revaluation increment in respect of the same class of assets, has been recognised as an expense in the Statement of Comprehensive Income. The GCHHS commenced as a statutory body on 1 July 2012. During 2012-13, no asset revaluation surplus was transferred to the GCHHS hence, no asset revaluation surplus was available to offset the revaluation decrements.

14. **Other Expenses**	
Insurance - other	129
External audit fees	247
Internal audit fees	77
Bank fees and charges	23
Legal fees	135
Advertising	81
Administration	1,372
Interpreter fees	184
Inventory written off	388
Losses from disposal of plant and equipment	597
Ex-gratia payments*	11
Other	336
Total	**3,580**

* Ex-gratia payments include payments made by the GCHHS to patients and employees for damaged or lost properties.

	2013 $'000
15. Cash and Cash Equivalents	
Cash at bank	45,152
Queensland Treasury Corporation cash fund*	3,605
Trust accounts**	412
Total	**49,169**

* Cash deposited with the Queensland Treasury Corporation earns interest at a rate of 3.96% per annum.
** Cash in trust accounts are set aside for the specified purposes and restricted in accordance with trusts' policies.

16. Receivables	
Trade debtors	11,715
State contributions and grants receivables	6,116
Less: Allowance for impairment loss	(2,168)
	15,663
GST receivable	1,672
GST payable	(148)
Net GST receivables	**1,524**
Total	**17,187**

Refer to Note 27(c) for an analysis of movements in the allowance for impairment loss.

17. Inventories	
Medical supplies	5,613
Less: Allowance for impairment loss	(369)
	5,244
Catering and domestic supplies	199
Engineering supplies	17
Other supplies	90
Total	**5,550**

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

	2013 $'000
18. Intangible Assets	
Software Purchased:	
At cost	3,510
Less: Accumulated amortisation	(1,426)
Total	**2,084**

Intangibles Reconciliation

	Notes	Software Purchased $'000	Total $'000
Carrying amount at the beginning of the financial year		-	-
Assets received on 1 July 2012*		2,615	2,615
Acquisitions		-	-
Disposals		-	-
Amortisation	11	(531)	(531)
Carrying amount at the end of the financial year		**2,084**	**2,084**

* Transferred pursuant to the *Hospital and Health Boards Act 2011*. Refer to Note 2(v) for further details on the transfer.

	2013 $'000
19. **Property, Plant and Equipment**	
Land:	
At fair value	109,132
	109,132
Buildings:	
At fair value	464,844
Less: Accumulated depreciation	(184,948)
	279,896
Plant and equipment:	
At cost	93,919
Less: Accumulated depreciation	(41,471)
	52,448
Work-in-progress:	
At cost	27,955
Total	**469,431**

Land:
Land was fair valued at 30 June 2013 using the appropriate indices sourced from the State Valuation Service (SVS). These indices are based on actual market movements for the relevant location and asset category. Management consider the use of these indices provided by the SVS as appropriate for the GCHHS. The revaluation program resulted in a decrement of $4,537,161 representing a 4.0 per cent decrease from the value of land as at 30 June 2012. This corresponds to the overall percentage decrease in the value of land across the Gold Coast. Refer to Note 13 for the total revaluation decrements resulting from the revaluation program in 2012-13.

Buildings:
In 2012-13, the appointed independent valuer performed comprehensive revaluations on 45.5 per cent of the gross value of the buildings portfolio at 30 June 2012. The valuation of buildings is based on depreciated current replacement cost. Cost escalation indices developed by the appointed independent valuer were applied to buildings which were not comprehensively revalued during 2012-13. These indices were developed based on a review of cost escalation across the industry whilst noting any regional variances due to specific market conditions. A review of the indices developed by the appointed independent valuer showed strong correlations with the Department of Public Works Building Price Index. Management consider the use of these indices provided by the appointed independent valuer as appropriate for the GCHHS.

Buildings fair valued at 30 June 2013 resulted in a net decrement to the GCHHS's building portfolio of $4,805,383 representing a 1.0 per cent decrease of the gross value of the building portfolio at 30 June 2012. Refer to Note 13 for the total revaluation decrements resulting from the revaluation program in 2012-13.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

19. Property, Plant and Equipment (cont)

Property, Plant and Equipment Reconciliation

	Notes	Land	Buildings	Plant and Equipment	Work-in-Progress	Total
		$'000	$'000	$'000	$'000	$'000
Carrying amount at the beginning of the financial year		-	-	-	-	-
Assets received on 1 July 2012*		113,669	295,905	44,099	1,672	455,345
Acquisitions		-	834	14,897	26,283	42,014
Asset transfers		-	4,514	1,637	-	6,151
Donations received		-	-	23	-	23
Disposals		-	-	(638)	-	(638)
Donations made		-	-	-	-	-
Transfers between classes		-	-	-	-	-
Revaluation increments		-	-	-	-	-
Revaluation decrements		(4,537)	(4,805)	-	-	(9,342)
Impairment losses recognised in operating surplus		-	-	-	-	-
Depreciation	11	-	(16,552)	(7,570)	-	(24,122)
Carrying amount at the end of the financial year		**109,132**	**279,896**	**52,448**	**27,955**	**469,431**

* Transferred pursuant to the *Hospital and Health Boards Act 2011*. Refer to Note 2(v) for further details on the transfer.

In addition to assets received on 1 July 2012, asset transfers and donations received during 2012-13 were non-cash acquisitions.

The new Gold Coast University Hospital campus is expected to be completed and ready for service delivery capacity in September 2013. Once the process for determining which items of plant and equipment are to be relocated to the new Gold Coast University Hospital is finalised, any remaining items of plant and equipment at the Southport campus of the Gold Coast Hospital will be prepared for disposal and their useful lives reduced accordingly.

Pursuant to the Deed of Lease arrangement with the Department of Health for land and buildings at the Southport campus of the Gold Coast Hospital, the GCHHS has no obligations for building demolition, remediation or other preparation of the site. In November 2013, it is anticipated that the Southport campus of the Gold Coast Hospital will be transferred to the Department of Health at its carrying amount.

The transfer of the new Gold Coast University Hospital campus to the GCHHS will occur during 2013-14 under a Deed of Lease arrangement. Subsequent to the transfer, the GCHHS will be subject to the terms and conditions attached to a privately owned car park located on the site.

As at 30 June 2013, work-in-progress amounts of $27,544,825 relate to property, plant and equipment held for the Gold Coast University Hospital.

	2013 $'000
20. Payables	
Trade creditors	12,255
Accrued expenses	17,341
Accrued health service employee expenses	31,160
Department of Health payables	3,318
Other creditors	99
Total	**64,173**
21. Accrued Employee Benefits	
Wages outstanding	122
Total	**122**
Refer to Note 2(t) for further details.	
22. Provisions	
Restoration costs	302
Total	**302**

The GCHHS has an obligation to repair and reinstate leased premises at the Pacific Private Hospital. At present, the premises are expected to be reinstated and returned to the lessor in September 2013.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

	2013 $'000
23. Reconciliation of Operating Surplus to Net Cash from Operating Activities	
Operating surplus	5,983
Non cash items:	
Depreciation and amortisation	24,653
Revaluation Decrement	9,342
Losses from disposal of plant and equipment	597
Other contributions*	(24,634)
Other non-cash items	(19)
Change in assets and liabilities:	
(Increase) in trade receivables	(2,191)
(Increase) in GST input tax credits receivable	(1,524)
Decrease in inventories	2,037
Decrease in prepayments	1,952
Increase in payables	21,220
Increase in accrued employee benefits	91
Increase in accrued health service employee benefits	19,531
Increase in provisions	302
Increase in revenue received in advance	258
Net cash from operating activities	**57,598**

* Other contributions relate to non-cash funding to offset depreciation and amortisation expense.

24. Commitments for Expenditure

(a) Operating Leases

As at 30 June 2013, operating leases entered into by the GCHHS as a means of acquiring access to office accommodation and storage facilities contain no restrictions on cancellation. Lease payments are generally fixed, but with inflation escalation clauses on which contingent rentals are determined. As at 30 June 2013, the GCHHS does not have any non-cancellable operating lease commitments.

(b) Capital Expenditure Commitments

As at 30 June 2013, the GCHHS does not have any capital expenditure commitments. The new Gold Coast University Hospital campus and associated capital expenditure commitments are currently held by the Department of Health. Transfer of the capital expenditure commitments from the Department of Health to the GCHHS will take place once the new hospital is ready for service delivery capacity.

25. Contingencies

As at 30 June 2013, the following cases were filed in the courts naming the State of Queensland acting through the GCHHS as defendant:

Supreme Court	1
District Court	4
Tribunals, commissions and boards	33
Total cases	**38**

It is not possible to make a reliable estimate of the final amount payable, if any, in respect of the litigations before the courts at this time. Tribunals, commissions and boards represent matters that have been referred to the Queensland Government Insurance Fund (QGIF) for management during 2012-13. The maximum exposure to the GCHHS under the QGIF policy is $20,000 for each insurable event however, some of these matters may never be litigated or result in payments to claims.

26. Events Occurring After Balance Date

The new Gold Coast University Hospital campus is expected to be completed and ready for service delivery capacity in September 2013. The cost of work-in-progress relating to the Gold Coast University Hospital is currently being held within the Department of Health's asset register and on its Statement of Financial Position as at 30 June 2013. Transfer of the Gold Coast University Hospital Campus from the Department of Health to the GCHHS will be completed once the hospital is ready for service delivery capacity.

27. Financial Instruments

(a) Categorisation of Financial Instruments

The Gold Cost Hospital and Health Service has the following categories of financial assets and financial liabilities:

Category	Notes	2013 $'000
Financial Assets		
Cash and cash equivalents	15	49,169
Receivables	16	17,187
Total		**66,356**
Financial Liabilities		
Payables	20	64,173
Total		**64,173**

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

27. Financial Instruments (cont)

(b) Financial Risk Management

The GCHHS's activities expose it to a variety of financial risks – credit risk, liquidity risk and market risk.

Financial risk management is implemented pursuant to the GCHHS's Financial Management Practice Manual. Overall financial risk is managed by the GCHHS in accordance with written principles of the Department of Health for overall risk management, as well as policies covering specific areas.

(c) Credit Risk Exposure

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. As such, the gross carrying amount of cash and cash equivalents as well as receivables represent the maximum exposure to credit risk.

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

Impairment loss for the current year regarding the GCHHS's receivables is $2,015,294 and is based on a specific review of individual trade debtors at risk for either actual loss events or past experiences in relation to these loss events. These loss events mainly relate to unrecoverable debts from private businesses and patients ineligible for Medicare.

Aging of past due but not impaired as well as impaired financial assets are disclosed in the following tables:

2013 Financial Assets Past Due But Not Impaired

		Not past due	Past due but not impaired			
	Notes	Less than 30 Days $'000	30 - 60 Days $'000	61 - 90 Days $'000	More than 90 Days $'000	Total $'000
Receivables	16	15,190	995	383	619	17,187
Total		**15,190**	**995**	**383**	**619**	**17,187**

2013 Financial Assets Individually Impaired

			Overdue			
	Notes	Less than 30 Days $'000	30 - 60 Days $'000	61 - 90 Days $'000	More than 90 Days $'000	Total $'000
Receivables (gross)	16	15,207	1,080	406	2,662	19,355
Allowance for impairment	16	(17)	(85)	(23)	(2,043)	(2,168)
Carrying amount		**15,190**	**995**	**383**	**619**	**17,187**

27. Financial Instruments (cont)

(c) Credit Risk Exposure

Movements in Allowance for Impairment

	2013 $'000
Balance at the beginning of the financial year	-
Transfer of allowance for impairment*	1,324
Bad debts written off	(401)
Increase in allowance recognised in operating result	1,245
Balance at the end of the financial year	**2,168**

* Transferred on 1 July 2012 pursuant to the *Hospital and Health Boards Act 2011*. Refer to Note 2(v) for further details on the transfer.

(d) Liquidity Risk

Liquidity risk is the risk that the GCHHS will not have the financial resources required at a particular time to meet its obligations to settle its financial liabilities.

The GCHHS is exposed to liquidity risk through its trading in the normal course of business. The GCHHS 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 GCHHS has an approved overdraft facility of $8.5 million under whole-of-Government banking arrangements to manage any short term cash shortfalls.

Total payables at 30 June 2013 are due in one year or less (refer to Note 20).

(e) Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises: foreign exchange risk; interest rate risk; and other price risk.

The GCHHS is exposed to interest rate risk through its cash deposited in interest bearing accounts. The GCHHS does not undertake any hedging in relation to interest risk. Changes in interest rates have a minimal impact on the operating result of the GCHHS.

GOLD COAST HOSPITAL AND HEALTH SERVICE

Notes to and forming part of the Financial Statements 2012-13

28. Trust Transactions and Balances

The GCHHS acts as a trustee for general patient trust accounts and the GCHHS's Right of Private Practice (RoPP) bank account. Refer to Note 2(d) for further information. As the GCHHS performs only a custodial role in respect of these transactions and balances, they are not recognised in the financial statements but are disclosed in these notes for information purposes.

	2013 $'000
(a) Patient trust transactions and balances	
Receipts:	
Amounts receipted on behalf of patients	193
Total	**193**
Payments:	
Amounts paid to or on behalf of patients	227
Total	**227**
Current Assets:	
Cash held and bank deposits	36
Total	**36**
(b) Agency right of private practice transactions and balances	
Revenue:	
Private practice revenue	11,896
Interest revenue	26
Total	**11,922**
Expenses:	
Payments to doctors	3,520
Payments to the GCHHS for recoverables	2,614
Payments to the GCHHS for Option A	4,007
Trust Payments for SERTA*	1,766
Total	**11,907**
Current Assets:	
Cash held and bank deposits	1,256
Total	**1,256**

* Study, education and research trust account (SERTA) funds are generated by doctors reaching the ceiling allowable under the option B arrangements. The allocation of these funds is managed by a Specialists' Advisory Committee.

CERTIFICATE OF THE GOLD COAST HOSPITAL AND HEALTH SERVICE

These general purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), relevant sections of the *Financial and Performance Management Standard 2009* and other prescribed requirements.

In accordance with section 62(1)(b) of the Act, we certify that in our opinion:

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

(b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Gold Coast Hospital and Health Service ("the Service") for the financial year ended 30 June 2013 and of the financial position of the Service at the end of that year.

Ian Langdon
Board Chair

28 August 2013

Ron Calvert
Chief Executive

28 August 2013

INDEPENDENT AUDITOR'S REPORT

To the Board of Gold Coast Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of Gold Coast Hospital and Health Service, which comprises the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and certificates given by the Board Chair and the Chief Executive.

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 Gold Coast Hospital and Health Service for the financial year 1 July 2012 to 30 June 2013 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.

QUEENSLAND
30 AUG 2013
AUDIT OFFICE

D R Adams FCPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane

Appendix 1:

Index of charts, figures and tables

Figures

Tables

Charts

Appendix 2:

Glossary of terms

Accessible	Accessible healthcare is characterised by the ability of people to obtain appropriate healthcare at the right place and right time, irrespective of income, cultural background or geography.
Activity Based Funding	A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by: • capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery • creating an explicit relationship between funds allocated and services provided • strengthening management's focus on outputs, outcomes and quality • encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level • in the context of improving efficiency and effectiveness • providing mechanisms to reward good practice and support quality initiatives.
Acute	Having a short and relatively severe course.
Acute Care	Care in which the clinical intent or treatment goal is to: • manage labour (obstetric) • cure illness or provide definitive treatment of injury • perform surgery • relieve symptoms of illness or injury (excluding palliative care) • reduce severity of an illness or injury • protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function • perform diagnostic or therapeutic procedures.
Admission	The process whereby a hospital accepts responsibility for a patient's care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment.
Admitted Patient	A patient who undergoes a hospital's formal admission process as an overnight-stay patient or a same-day patient.
Allied health staff	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; leisure therapy; medical imaging; music therapy; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Benchmarking	Involves collecting performance information to undertake comparisons of performance with similar organisations.
Best practice	Cooperative way in which organisations and their employees undertake business activities in all key processes, and use benchmarking that can be expected to lead sustainable world-class positive outcomes.
Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.
Clinical workforce or staff	Employees who are or who support health professionals working in clinical practice, have healthcare specific knowledge/experience, and provide clinical services to health consumers, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.

Emergency department waiting time	Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.
Full-time Equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Health outcome	Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.
Health reform	Response to the National Health and Hospitals Reform Commission Report (2009) that outlined recommendations for transforming the Australian health system, the National Health and Hospitals Network Agreement (NHHNA) signed by the Commonwealth and states and territories, other than Western Australia, in April 2010 and the National Health Reform Heads of Agreement (HoA) signed in February 2010 by the Commonwealth and all states and territories amending the NHHNA.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Boards	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.
Hospital and Health Service	Hospital and Health Services are separate legal entities established by Queensland Government to deliver public hospital services. Seventeen Hospital and Health Services commenced on 1 July 2012 replacing existing health service districts.
Immunisation	Process of inducing immunity to an infectious agency by administering a vaccine.
Incidence	Number of new cases of a condition occurring within a given population, over a certain period of time.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.
Medicare Locals	Established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. Work closely with Hospital and Health Services to identify and address local health needs.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.
Non-admitted patient	A patient who does not undergo a hospital's formal admission process.
Nurse practitioner	A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessing and managing clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient service	Examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.

Overnight-stay patient (also known as inpatient)	A patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).
Patient flow	Optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.
Performance indicator	A measure that provides an 'indication' of progress towards achieving the organisation's objectives usually has targets that define the level of performance expected against the performance indicator.
Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers patients admitted to private hospitals are treated by a doctor of their choice.
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
Registered nurse	An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.
Statutory bodies	A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.
Sustainable	A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.
Triage category	Urgency of a patient's need for medical and nursing care.
Weighted Activity Unit	A standard unit used to measure all patient care activity consistently. The more resource intensive an activity is, the higher the weighted activity unit. This is multiplied by the standard unit cost to create the "price" for the episode of care.

Appendix 3:

Glossary of abbreviations and acronyms

ABF	Activity based funding
ARRs	*Annual report requirements for Queensland Government agencies*
ATODS	Alcohol, Tobacco and Other Drugs
CALD	Culturally and linguistically diverse
CAPS	Communication and patient safety
CFO	Chief Finance Officer
EMR	Electronic medical record
EMT	Executive Management Team
ENT	Ear, nose and throat
FAA	*Financial Accountability Act*
FPMS	*Finance and Performance Management Standard 2009*
FTE	Full-time equivalent
GCHHS	Gold Coast Hospital and Health Service
GCUH	Gold Coast University Hospital
GP	General Practitioner
HHS	Hospital and Health Service
Hons	With Honours
HR	Human resources
HREC	Human Research Ethics Committee
ICT	Information communication technology
ICU	Intensive Care Unit
ieMR	Integrated electronic medical record
ISSN	International Standard Serial Number
KPI	Key performance indicators
MAU	Medical Assessment Unit
MOHRI	Minimum Obligatory Human Resource Information
MP	Member of Parliament
NEAT	National Emergency Access Target
NEST	National Elective Surgery Target
NHMRC	National Health and Medical Research Council
NHS	National Health Service (United Kingdom)
NICU	Neonatal Intensive Care Unit
NPA	National Partnership Agreement
NSW	New South Wales
OSR	Own source revenue
PPP	Public private partnership
VMO	Visiting Medical Officer
WAU	Weighted activity unit
WOoS	Weighted Occasions of Service

Appendix 4:

Compliance checklist

Summary of requirement		Basis for requirement	Annual report reference (page number)
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 8	iv
Accessibility	Table of contents Glossary	ARRs – section 10.1	1 95-98
	Public availability	ARRs – section 10.2	iii
	Interpreter service statement	Queensland Government Language Services Policy ARRs – section 10.3	iii
	Copyright notice	*Copyright Act 1968* ARRs – section 10.4	iii
	Information Licensing	Queensland Government Enterprise Architecture – Information licensing ARRs – section 10.5	iii
General information	Introductory Information	ARRs – section 11.1	2-3
	Agency role and main functions	ARRs – section 11.2	5-8
	Operating environment	ARRs – section 11.3	2-3; 5-11
	Machinery of Government changes	ARRs – section 11.4	47
Non-financial performance	Government objectives for the community	ARRs – section 12.1	5-7; 23
	Other whole-of-government plans / specific initiatives	ARRs – section 12.2	23
	Agency objectives and performance indicators	ARRs – section 12.3	5; 27-42
	Agency service areas, service standards and other measures	ARRs – section 12.4	24-25
Financial performance	Summary of financial performance	ARRs – section 13.1	43-45
	Chief Finance Officer (CFO) statement	ARRs – section 13.2	45
Governance – management and structure	Organisational structure	ARRs – section 14.1	9-13
	Executive management	ARRs – section 14.2	15-19
	Related entities	ARRs – section 14.3	Not applicable
	Boards and committees	ARRs – section 14.4	20-22; 73
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	42

Summary of requirement		Basis for requirement	Annual report reference (page number)
Governance – risk management and accountability	Risk management	ARRs – section 15.1	46
	External Scrutiny	ARRs – section 15.2	46
	Audit committee	ARRs – section 15.3	20; 47
	Internal Audit	ARRs – section 15.4	46-47
	Public Sector Renewal Program	ARRs – section 15.5	42
	Information systems and recordkeeping	ARRs – section 15.7	48
Governance – human resources	Workforce planning, attraction and retention and performance	ARRs – section 16.1	38-42
	Early retirement, redundancy and retrenchment	Directive No.11/12 Early Retirement, Redundancy and Retrenchment ARRs – section 16.2	42
	Voluntary Separation Program	ARRs – section 16.3	42
Open Data	Open Data	ARRs – section 17	48
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	49-91
	Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	90-91
	Remuneration disclosures	Financial Reporting Requirements for Queensland Government Agencies ARRs – section 18.3	70-76

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