Gold Coast Hospital and Health Service

2019–2020 ANNUAL REPORT

Queensland Government

Open data

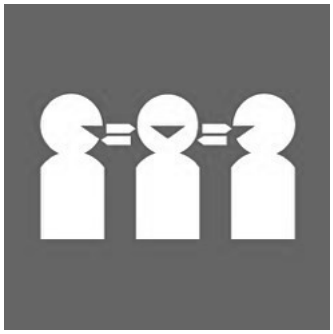
Information about consultancies, overseas travel, and the Queensland language services policy is available at the Queensland Government Open Data website (qld.gov.au/data).

Public availability statement

An electronic copy of this report is available at https://publications.qld.gov.au/dataset/gold-coast-health-annual-report. Hard copies of the annual report are available by phoning Strategic Communication and Engagement on 1300 744 284. Alternatively, you can request a copy by emailing goldcoasthealth@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 telephone (07) 5687 7100 or free-call 1300 744 284 and we will arrange an interpreter to effectively communicate the report to you.



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Acknowledgement to Traditional Owners

Gold Coast Health would like to acknowledge the Traditional Custodians of the Gold Coast, the Yugambeh-speaking people, whose land, winds and waters we all now share; and pay tribute to their unique values, and their ancient and enduring cultures, which deepen and enrich our community.

We pay our respects to Elders, past, present and emerging, and recognise those whose ongoing effort to protect and promote Aboriginal and Torres Strait Islander cultures will leave a lasting legacy for future Elders and leaders.

Recognition of Australian South Sea Islanders

Gold Coast Health formally recognises the Australian South Sea Islanders as a distinct cultural group within our geographical boundaries. Gold Coast Health is committed to fulfilling the *Queensland Government Recognition Statement for Australian South Sea Islander Community* to ensure that present and future generations of Australian South Sea Islanders have equality of opportunity to participate in, and contribute, to the economic, social, political and cultural life of the State.

Letter of compliance

7 September 2020

The Honourable Steven Miles MP

Deputy Premier, Minister for Health and Minister for Ambulance Services

GPO Box 48

Brisbane QLD 4001

Dear Deputy Premier

I am pleased to submit for presentation to the Parliament the Annual Report 2019–2020 and financial statements for 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 2019*, and
- the detailed requirements set out in the Annual report requirements for Queensland Government agencies.

A checklist outlining the annual reporting requirements is provided at page 119 of this annual report.

Yours sincerely

Mr Ian Langdon

Chair, Gold Coast Hospital and Health Board

Contents

Statement on Queensland Government objectives for the community

The Gold Coast Health *Strategic Plan 2016–2020* supports *Our Future State: Advancing Queensland's Priorities* and helps Gold Coast Health to align its activities with the Advancing Queensland's Priorities initiative.

Gold Coast Health contributes to the *Government's objectives for the community to Keep Queenslanders healthy* by promoting wellbeing, delivering responsive interconnected healthcare and at the same time providing a supportive environment for continuous innovation.

Key strategic enablers for contributing to the objectives include fostering a positive work environment; developing innovation, research capacity, capability and translation; maximising the use of our facilities and partnerships; and the effective management and utilisation of data.

This annual report details many of the ways Gold Coast Health has contributed to the *Advancing Queensland's Priorities* initiative throughout 2019–2020.

From the Chair and Chief Executive

From the Board Chair

Gold Coast Health was among the first health services in the country to treat patients with COVID-19. Our purpose-built negative-pressure rooms were put to the test caring for international visitors and returned travellers who were too sick to be in self-quarantine.

Our swift and agile COVID-19 response saw the temporary closure of some services while staff were up-skilled in the science of contact tracing and deployed to work with the Gold Coast Public Health Unit.

Gold Coast Health engaged with the broader community to build community confidence in our response. This was achieved through regular bulletins, social media and ongoing direct communication with key stakeholders including the Gold Coast Primary Health Network, general practitioners, multicultural networks and City of Gold Coast.

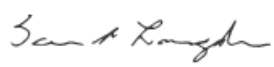
Building a culture of success for our organisation has always been a passion for me and there is no doubt that the work we have embarked upon in the professional accountability area, especially in relation to diversity and inclusion and living our values, is reflected in the overall success of our COVID-19 response to date.

At the end of the reporting period, our attention turns to services that were delayed during the COVID-19 preparation period.

I am assured that 2020–21 will see Gold Coast Health continue to be COVID-19 ready as we monitor hospital bed capacity, continue testing at our hospitals and in the community. We are focused on recovery and support for patients who were directly affected by delays.

Finally, thanks to my Deputy Chair Judy Searle and my Board colleagues for their commitment throughout the year as well as to Ron and his executive team for their diligence and focus during one of our most clinically challenging years.

Ian Langdon



Board Chair, Gold Coast Health

From the Chief Executive

This annual report outlines the progress Gold Coast Health has made in the 2019–2020 financial year to strengthen our agenda to improve outcomes for the Gold Coast community.

I would like to acknowledge the outstanding efforts of our staff in response to the COVID-19 pandemic – from the early identification and careful management of the first COVID-19 patients in Queensland through to establishing a ward fever clinic at short notice only to pivot again and build a dedicated fever clinic in just ten days. All staff involved across our service are to be congratulated for adapting their daily routine, and adhering to infection control practices and social distancing requirements with professionalism and skill.

The impact of COVID-19 pandemic response and recovery saw the Gold Coast Health shift focus in the second half of the 2019–2020 year towards business continuity planning and uptake of innovative service delivery methods; including virtual outpatients appointments, telehealth and virtual wards; and development of digital contact tracing tools.

Further to the COVID-19 response and recovery focus, this annual report also acknowledges the ongoing work across the health service throughout the past year, including our significant accomplishment in being awarded Magnet® recognition for superior quality in nursing and midwifery care. It is the highest international honour for nursing and midwifery excellence and we're proud to be Australia's first whole health service to receive this accolade. I commend our staff who have worked so hard over several years to bring it to fruition.

We undertook broad consultation with our staff, patients and community to support the development of our new strategic plan, which will drive our direction for the next four years.

We also made a greater commitment to Aboriginal and Torres Strait Islander health by introducing and building on a range of initiatives, which are detailed on page 17 of this report.

As we transition back to core business by reducing long waits and increasing outpatient clinics and elective procedures, we remain aware that the situation may change again rapidly and are ready to adjust our sails as necessary.

As always, thanks must go to our Chair, Ian Langdon, and the rest of the Board for their ongoing leadership and support.

Ron Calvert

Chief Executive, Gold Coast Health

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 and delivers a broad range of secondary and tertiary health services from three hospitals (Gold Coast University Hospital, Robina Hospital and Varsity Lakes Day Hospital), two major allied health precincts (Southport and Robina), and 13 community-located facilities.

Our vision is to have the best health outcomes in Australia as we strive to be leaders in compassionate, sustainable and highly reliable healthcare.

Gold Coast Health employs approximately 8,800 full-time equivalent staff, making it the city's largest employer. The health service had a final annual operating budget of $1.67 billion for 2019–2020. This was an increase of $95 million (6 per cent) from the initial 2019–2020 operating budget of $1.575 billion, as published in the June 2019 Service Delivery Statements.

A combination of world-class infrastructure, a highly talented and committed workforce and strong partnerships with universities, Gold Coast Primary Health Network and the private and non-government sector, creates a culture of innovation in healthcare delivery.

The Gold Coast Hospital and Health Board currently comprises Chair Mr Ian Langdon and nine members. The Board represents local community needs and expectations in addition to its governance role within the wider Queensland Health federated system.

A Consumer Advisory Group of community representatives also works with Gold Coast Health to improve our local health system, provide advice feedback and guidance on our service delivery and quality.

Across our campuses, we have a reputation as one of Australia's leading teaching hospitals, committed to training the next generation of doctors, nurses and allied health professionals. Working under the supervision of senior clinicians, nursing students become nurses, medical students become doctors, and doctors become specialists at Gold Coast Health's facilities.

Strategic direction

The Gold Coast Health Board sets the strategic priorities through the Strategic Plan which provides a roadmap for how the health service will evolve in order to meet the changing needs of the community.

In line with the *Gold Coast Health Strategic Plan 2016–2020 (2019 Update)*, the service's strategic direction has been guided by eight key themes:

- recognising the importance of promoting good health by supporting strong families and an active and healthy community
- enhancing patient outcomes through research and translating it into practice
- transforming service delivery using technology
- enabling innovation by challenging how we do things now
- maximising the use of our resources
- being inclusive and valuing diversity
- ensuring the safety and wellbeing of our workforce
- being known for our excellence.

Gold Coast Health recently completed a whole-of-health-service master planning process, which is now being used to drive planning of future new and expanded services to support growth, particularly in the northern Gold Coast.

During 2019–2020, Gold Coast Health completed broad consultation with our staff, patients and community to support the development of our new strategic plan, which will drive our direction for the next four years. The process unveiled our new organisational philosophy; Always Care. Moving into 2020–2021 and beyond, our Always Care philosophy will underpin everything we do and will provide a foundation for how we behave, every day.

The *Gold Coast Health Strategic Plan 2020–2024*:

- recognises the challenges our health service will face as the local population continues to grow at a very rapid rate
- aims to embrace the opportunities of the future as knowledge, technology and partnerships rapidly develop
- commits us to continuing our journey towards world-class care
- recognises the need to work seamlessly with partners across the health care continuum in order to meet our vision.

The strategic planning process uncovered our new vision statement – for Gold Coast Health to have the best health outcomes in Australia.

Vision, purpose and values

Our vision

Gold Coast Health will be recognised as a centre of excellence for world-class healthcare.

Our purpose

Providing excellence in sustainable and evidence-based healthcare that meets the needs of the community.

Our values

Our work is driven by our six core values:

Integrity
To be open and accountable to the people we serve.

Community first
To have the patient's and the community's best interest at heart.

Respect
To listen, value and acknowledge each other.

Excellence
To strive for outstanding performance and outcomes.

Compassion
To treat others with understanding and sensitivity.

Empower
To take ownership and enable each other to achieve more.

Priorities

The Gold Coast population is growing at a much faster rate than the Queensland state average (2.2 per cent for the Gold Coast compared to 1.68 per cent for Queensland):

- by 2026, we will have an additional population the size of Mackay – 118,037 additional residents
- by 2031, we will have an additional population the size of Townsville – 192,273 additional residents.

(Source: ABS 3218.0, Regional Population Growth, Australia 2018, various editions)

Much of our population growth is in those age groups who use health services the most – children and older residents. We also cater for a growing number of tourists and non-Gold Coast residents.

The reporting period saw completion of the two-year $11 million upgrade at Robina Hospital, ensuring the hospital is a modern and digital-ready facility, construction commencement of the first stage of a new hybrid theatre at GCUH, establishment of new COVID-19 fever clinics and an upgrade of the GCUH Emergency Operation Centre.

These improvements, along with the following priorities, see us laying the foundations to ensure we can continue to provide world-class service as our population continues to grow.

Implementing digital care solutions

Gold Coast Health is committed to transforming service delivery using technology. We have been focused on developing reliable, secure systems and digital care solutions that promote patient-focused integrated healthcare. Technology plays a crucial role in addressing these challenges and is a key enabler to improving outcomes, increasing patient engagement in their own care, empowering clinicians and curbing the rising cost of healthcare.

Throughout the reporting period, we have undertaken continual optimisation of the integrated electronic medical record (ieMR), with more than 100 changes per month implemented within the ieMR. These changes have led to improvements in reliability, security and processes that support coordinated care delivery.

Development of clinical dashboards provided staff working within wards with real-time visibility of key clinical information pertinent to the safe and timely delivery of care to patients.

Build and maintain partnerships with GPs and health service providers

Through partnerships with General Practitioners, non-government organisations and child health services, Gold Coast Health delivered antenatal and postnatal services in accessible community settings, and established the Maternity Hospital in the Home, a service designed to support women with complex pregnancies to receive the right care, in the right place, at the right time.

Collaborate with key partners on projects for integrated care and mental health services

Joint Regional Plan for Mental Health Services

Gold Coast Health and Gold Coast Primary Healthcare Network (PHN) collaborated with a range of stakeholders to develop the Joint Regional Plan for Mental Health Services.

The plan forms a significant part of the PHN response to the commitment made by the Commonwealth and State governments in the Fifth National Mental Health and Suicide Prevention Plan. It is key to supporting sustainable acute mental health service provision by Gold Coast Health.

Gold Coast Health's Zero Suicide-informed Suicide Prevention Pathway

Gold Coast Health partnered with the Australian Institute for Suicide Research and Prevention (AISRAP) to conduct a qualitative investigation of client and carer experiences of Gold Coast Health's Zero Suicide-informed Suicide Prevention Pathway. The study found that clients and their carers viewed their experiences on the pathway as largely positive; they felt safe and valued and were appreciative of the care and follow-up engagement they received.

The pathway was found to be a satisfactory experience for aiding their recovery from suicidal thoughts and behaviours.

Norfolk Village State School partnership

An increase in demand for complex children's health services on the Gold Coast has motivated Gold Coast Health to 'think outside the box'.

Australian Early Development Census data shows vulnerability of children on one or more domains on the Northern Gold Coast has increased by 2.5 per cent since 2012, compared to the State average which has decreased by 0.3 per cent. Children who are delayed in receiving care may have more complex and ongoing adverse health outcomes when compared to their peers who receive immediate proactive or preventative care.

The Gold Coast's rapidly changing demographic has led to a partnership with Norfolk Village State School to deliver a pilot program for specialised psychology services designed for vulnerable children and families.

Rapid response and engagement are a fundamental part of this service, achieved by co-locating a psychologist within the Norfolk Village State School. This partnership allows us to delivery wraparound education and healthcare in a familiar setting. The pilot program operates in addition to the existing Community Child Health program.

Actively support research and the translation of knowledge into practice

Research continues to be more embedded into clinical practice and health service delivery to ensure Gold Coast Health delivers evidence-based care to patients that is timely and sustainable across all operational areas. Endorsement of the Gold Coast Health Research Strategy, 2019–2022 reinforces this commitment and ensures alignment with the health service strategic plan.

To further embed research, development staff were introduced across divisions. These positions, funded through the Study, Education and Research Trust Account for three years, will help drive research strategy across the organisation.

Throughout 2019–2020, 151 research projects were authorised to commence, representing a 40 per cent increase on the previous year. The total funding for all projects was $2.7 million.

Reflecting the high-quality research being undertaken at Gold Coast Health, 344 peer-reviewed articles were published since July 2019, many describing the implementation or evaluation of new interventions or changes in practice that lead to improved health outcomes.

More than 400 Gold Coast Health staff engaged with the Evidence-Based Practice Professorial Unit (Bond University) are based at the Gold Coast University Hospital, benefiting from modern and innovative educational approaches in evidence-based practice training.

Forming new and strengthening existing partnerships continued to prove critical to research growth, from engaging with consumers through to building on our professional partnerships. Gold Coast Health's key research partners and collaborators included nine commercial companies, 49 universities, two Government departments, 27 other Hospital and Health Services, 17 not-for-profit organisations and seven international partners.

Supporting the National Safety and Quality Health Standard: Partnering with Consumers, physiotherapists from the Neurosurgical Screening Clinic collaborated with researchers from Griffith University, Australia and Vrije University, Amsterdam to conduct research collaboratively with patients experiencing persistent lower back pain.

Encourage health literacy and engage with all members of our community

Across the organisation, more than 500 external engagement activities took place, contributing to a connected, engaged and healthier community.

Gold Coast Health's Consumer Advisory Group (CAG) continued to make a positive impact through best-practice consumer and community engagement. The CAG continued to achieve consumer-led service improvements by facilitating consumer, carer and community participation in Gold Coast Health strategy, operations, planning and policy development.

This included consumer representation on more than 50 Gold Coast Health committees, where consumer and community voices were heard alongside management and clinicians to make decisions with patient's best interests at heart and develop person-centred models of care. The CAG also reviewed hundreds of patient information publications to ensure they were useful and easy to understand, which helps our community stay well in hospital and at home.

Gold Coast Health published its *Consumer and Community Engagement Strategy 2020–2023.* Underpinning the strategy is a desire that community and consumer engagement will continue to shape Gold Coast Health's services well into the future. At Gold Coast Health, we want our consumers to be empowered to be actively involved in their own care.

We are grateful for the continued partnership and support of community service providers, non-government organisations and our key external stakeholders.

Building a culture of success

The Magnet® Recognition Program is a four-yearly international organisational credential that recognises excellence in nursing and midwifery care and health care organisations for dedication to quality patient care. It is a highly prestigious credential attained by only a small number of organisations worldwide and is the highest international honour for nursing and midwifery excellence.

In February 2020, Gold Coast Health hosted a successful site visit, welcoming four Magnet appraisers from the United States. Over four days, the appraisers met with more than 900 staff, visited 102 units across our three hospitals and two health precincts, and held virtual visits by videoconference with our community services.

On 29 April 2020, four and a half years after commencing the Magnet journey, Gold Coast Health was informed that we had been unanimously voted a Magnet organisation by the Commission on Magnet Recognition. Dr Jeanette Ives Erickson, Commission on Magnet Recognition Chair, announced the designation via teleconference.

During the announcement, Gold Coast Health was recognised for five exemplars:

- 82.8 per cent of nurses and midwives holding bachelor or higher degrees.
- Dedication and commitment to culturally sensitive care for Aboriginal and Torres Strait Islander women and children through the Waijungbah model-of-care.
- Consistently outperforming national benchmarks for glycated haemoglobin (HbA1C) markers in the Diabetes Education program run through the Chronic Disease Programs service.
- Consistently outperforming national benchmarks for peritonitis infection rates in the Home Therapies Dialysis Unit.
- Consistently outperforming national benchmarks for patient satisfaction with coordination of care in 100 per cent of inpatient units.

Other Magnet facilities in Australia are individual, stand-alone hospitals. With this designation, we became the first whole health service in Australia to achieve Magnet Recognition®, which includes our three hospitals and multiple community sites.

COVID-19 preparedness and response

Gold Coast Health prioritised business continuity planning and produced of detailed operational plans throughout the response to COVID-19.

Clinical excellence in clot retrieval service

2019–2020 saw Gold Coast Health complete 100 endovascular clot retrievals. The team remove large blood clots from inside the brain without having to operate on the skull. In 2013, the first year Gold Coast Health started using the revolutionary treatment, we performed four of these procedures. Gold Coast University Hospital is one of three hospitals in South East Queensland that runs a 24/7 Endovascular Clot Retrieval Service, supporting a state-wide service for Far North Queensland-based patients who sustain a serious stroke. We are the first

and only hospital in Queensland to meet the criteria for a comprehensive stroke service during a stroke audit.

Aboriginal and Torres Strait Islander Health

Gold Coast Health is committed to improving health outcomes to Close the Gap for Aboriginal and Torres Strait Islander People. Gold Coast Health contributes to state-wide reporting requirements through the submission of bi-annual reports detailing our progress against the key performance indicators and other relevant activity.

Through collaboration, Gold Coast Health has developed and continues to implement culturally appropriate and innovative programs, models of care and services.

Our work supports the *Queensland Government's Making Tracks Towards Closing the Gap in Health Outcomes* along with Gold Coast Health's *Aboriginal and Torres Strait Islander Cultural Capability Plan* and *Diversity and Inclusion Action Plan*.

Gold Coast Health's commitment to increase the number of Aboriginal and Torres Strait Islander employees to 3.5 per cent by 2022 was supported by the new Waijungbah Jarjums maternity and child health service. This service employs 13 Aboriginal and Torres Strait Islander midwives, student midwives, nurses, health workers and administrative staff.

During 2019–2020, Gold Coast Health made advances towards improving Aboriginal and Torres Strait Islander health outcomes:

- Established Waijungbah Jarjums, a co-designed, culturally safe maternity and child health service for Aboriginal and Torres Strait Islander people, based on Aboriginal and Torres Strait Islander Models of Care – 'Birthing on Country' and 'First 1000 Days Australia'.
- Sustained improvement in the percentage of completed courses of oral health care, well above the +1 per cent variance benchmark.
- Established a new rotational system to have a full-time Aboriginal and Torres Strait Islander health liaison officer at Robina Hospital.
- Appointed a nurse navigator to support Aboriginal and Torres Strait Islander people with chronic disease and complex care needs.
- Professor Cindy Shannon, a proud Ngugi woman, joined Gold Coast Health's Board. Professor Shannon's insights and experience will improve Aboriginal and Torres Strait Islander health services across the Gold Coast.
- Continued community engagement through the Karulbo Aboriginal and Torres Strait Islander Health and Wellbeing Community Partnership, bringing together community members on a quarterly basis to discuss health challenges and strengths.
- Trained staff were co-facilitators of the 'Courageous Conversations About Race' Beyond Diversity One program to support sustainable delivery of the program to address institutional racism.
- Continued delivery of healthy lifestyle programs, including the Strong and Deadly Wellness program, bush tucker calendar and Mungulli Aboriginal and Torres Strait Islander Exercise program.
- Delivered dietetic outreach clinics in collaboration with Kalwun, the local Aboriginal and Torres Strait Islander community-controlled health service.

- Employed a temporary Midwifery Navigator to provide continuity of care for pregnant Aboriginal and Torres Strait Islander women and their families, along with supporting smoking cessation during pregnancy.
- Developed a validated Cultural Capability Measurement Tool (CCMT) in partnership with Griffith University, with Gold Coast Health ethics approval provided.
- Established an in-hospital community outreach program, including attendance at Krurungal, Centrelink, Department of Housing and the National Disability Insurance Scheme.
- Culturally inclusive artworks were designed by Aboriginal artist Narelle Urquhart for mobile dental vans, following a grant from the 2018 Improvers staff innovation awards.
- Developed the *Gold Coast Health Aboriginal and Torres Strait Islander Closing the Gap Plan*, in line with the Queensland Government's strategies following the *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services* report.

Key Performance Indicators for 2019–2020	Performance to June 2020
Workforce - The Queensland Health Aboriginal and Torres Strait Islander workforce strategy employment target is 3 per cent by 2022 for all Hospital and Health Services, with Gold Coast Health setting a stretch target of 3.5 per cent by 2022.	1.41 per cent of workforce – 155 staff across all streams. Diversity and Inclusion Action Plans developed to achieve 3.5 per cent stretch target by 2022.
Increase in the number of completed courses of oral health care for Aboriginal and Torres Strait Islander adult patients in the current financial year to date from the previous financial year.	57 (total of 268) *Note: This is for the period July 2019 – February 2020. Oral Health services were suspended for the rest of the financial year due to COVID-19.*
Proportion of babies born of low birthweight to Aboriginal and Torres Strait Islander women (<2500 grams at birth).	• Total was 2.3 per cent for Waijungbah Jarjums midwifery service • Total was 12 per cent for Gold Coast Health in 2019–2020

Our community-based and hospital-based services

The Gold Coast Health catchment area takes in one of Australia's most iconic holiday destinations and its community is diverse in culture, age, race, socio-economic status and healthcare needs. We care for nearly 690,000 people who live in the Gold Coast region and northern New South Wales as well as approximately 13.5 million visitors each year.

Gold Coast Health delivers a broad range of secondary and tertiary health services across our three hospital facilities at Gold Coast University Hospital, Robina Hospital and Varsity Lakes Day Hospital. These include surgery, trauma, paediatric, general and specialist medicine, maternity and intensive neonatal care, aged and dementia care, emergency medicine, intensive care, cardiology, mental health, oral health, outpatients, environmental health, public health services, and more.

We also deliver a wide range of services in diverse community settings – in our health precincts, community centres, schools, residential aged-care facilities, correctional centres, and in the home. These services include post-birth midwifery visits, home-based palliative care, hospital in the home, and school dental health appointments.

As our population grows, we continue to find innovative ways to provide patients with sustainable and contemporary health care at the right time and at the right place.

Gold Coast University Hospital is the city's premier tertiary-level facility. The facility has seven buildings covering 170,000 square metres, and provides modern, world-class tertiary hospital care, with more than 70 per cent of private rooms. It is located (together with Griffith University and Gold Coast Private Hospital) in the Gold Coast Health and Knowledge Precinct.

Robina Hospital is a major regional health facility and serves as a patient base for emergency, medical, palliative care and mental health. It is also home to the Clinical Education and Research Centre, a joint project between Queensland Health and Bond University's Faculty of Health Sciences and Medicine.

Varsity Lakes Day Hospital features six theatres for endoscopy, plastics, orthopaedic and other surgery, as well as women's health clinics.

Car parking concessions

Car parking concessions at Queensland Health hospital facilities improve access and affordability of car parking spaces to eligible patients and their carers.

In 2019–2020, 39,659 one-day concession passes were issued and 148 five-day concession passes were issued. The cost of concession incurred by Gold Coast Health was $185,370.

Targets and challenges

Target:

Collaborate with key partners on projects for integrated care and mental health services

Challenge:

Increased social restriction has been reported to have resulted in increased incidence of mental health problems, increased substance use and increased incidences of domestic violence. Throughout the COVID-19 response and recovery phases, care of vulnerable population groups from a community and health care perspective is integral. While there has been a slight reduction in the number of the community members that are accessing Gold Coast Mental Health and Specialist Services acute services, a review of available literature has resulted in an expectation that Gold Coast Health's Mental Health and Specialist Services will see an increase in community need for services in several vulnerable population groups areas.

Outcome:

In response to this, a COVID-19 plan has been developed, which presents a new 'business as usual approach', including focused clinical services for vulnerable groups post the acute phase of the COVID-19 pandemic response on the Gold Coast.

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Target:

Improve and report key performance indicators for 'Closing the Gap' in health inequalities for Aboriginal and Torres Strait Islander people

Challenge:

Approximately 180 Aboriginal and Torres Strait Islander babies are born each year at Gold Coast University Hospital. Fundamental to working towards 'Closing the Gap' for women and their babies is the development of services that are culturally safe.

Outcome:

Gold Coast Health established a new community-based culturally safe birthing and early years service for Aboriginal and Torres Strait Islander families. It is called Waijungbah Jarjums, a Yugambeh language name gifted by Traditional Custodians, meaning "place of mothers".

The midwifery-led model of continuity of care was developed by our Aboriginal and Torres Strait Islander community, staffed by Aboriginal and Torres Strait Islander people.

The model was developed through community consultation and incorporates 'Birthing on Country' and the 'First 1000 Days' principles, providing continuity of care to our Aboriginal and Torres Strait families until their babies are two years of age.

The preliminary results of the first six months of service are impressive, with clear evidence of the success of the program in closing the gap measures. With 80 per cent of women engaged in the program before 20 weeks of pregnancy, a significant reduction in both low birth weight (down to 2.7 per cent) and premature babies (down to 11 per cent), and an increase in smoking cessation (up to 20 per cent) during pregnancy has resulted.

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Target:

Maintain or improve access and treatment within clinically recommended timeframes

Challenge:

Gold Coast Health has experienced continued growth in demand. The COVID-19 elective surgery ramp-down had a significant effect on elective case numbers in the March–May 2020 period. However, Gold Coast Health returned to full capacity in June 2020 with ramped-up internal capacity to address the high-acuity long-wait patients resulting from the COVID-19 ramp-down.

Outcome:

As part of the Gold Coast Health Service Plan 2016–2026, and in response to predicted procedural and surgical elective activity over this period, the Varsity Lakes Day Hospital provided staged, flexible service delivery options that were responsive to specific demand. Increased use of clinic space and ongoing review of services continued to provide improved outcomes across patient flow, waitlist reduction and theatre capacity.

The work undertaken with the Queensland Treasury Corporation (QTC) saw the health service introduce Rigorous Referral Management and Scheduling Optimisation, targeting the reduction of waiting times and introduction of sustainable system-wide solutions.

The Rigorous Referral Management program focuses on:

- implementation of the state-wide Clinical Prioritisation Criteria (CPC)
- implementation of the state-developed Smart Referrals referral delivery solution which incorporates digital solutions from the GP desktop through to specialist categorisation and wait list addition
- a local 'Refer Your Patient' web page to support both external and internal referrers with specialty specific service and referral information
- health pathways to support refers with clinical advice, service navigation and pathways to support patient care in the community.

The Scheduling Optimisation program will focus on:

- clinic template redesign incorporating realignment of new to review ratios and widen the implementation of ‘virtual’ appointment types
- introduction of digital solutions to streamline patient and GP communication
- review and enhancement of underlying processes to support optimal clinic delivery and improve the patient, clinician and staff experience.

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Target:

Maintain or improve access and treatment within clinically recommended timeframes.

Challenge:

Gold Coast Health emergency departments continue to be among the busiest in Australia, with an increase of more than 7 per cent in presentations during 2019–2020. Managing more than 25,000 presentations related to COVID-19, in addition to increasing complexity and acuity of presenting patients, had a significant impact on the emergency departments.

Outcome:
Strategies to more efficiently manage patients presenting to emergency departments and assist in meeting targets while experiencing increasing demand included:

- Expansion of the Mental Health Co-Responder Team.
- Introduction of the Mental Health Rapid Response Team across both emergency departments.
- Development of two fever clinics as an extension of the emergency departments to re-direct flow of people presenting with flu-like symptoms and other indicators of COVID-19 screening criteria.
- Expansion of medical and nursing workforce across both emergency departments.
- Implementation of Transfer Initiative Nurses across both emergency departments to assist with presentations arriving via Queensland Ambulance Services to improve patient off stretcher times and availability of ambulances back to the community.
- Re-purposing of the Acute and Clinical Decisions Unit assessment area to assist with patient flow and timeliness of treatment of patients presenting with symptoms suggestive of COVID-19 in both emergency departments.
- Gold Coast University Hospital’s Emergency Department commenced a major redesign program to modify and simplify the current flow of patients to an ambulatory/non-ambulatory model. The aim is to better manage demand for emergency services and ensure a more efficient distribution of workload and bed occupancy across the department. The implementation of the new model of care was significantly impacted by the COVID-19 pandemic as both Emergency Departments were required to provide separate entrances and treatment areas for suspected COVID-19 patients.
- Re-purposed six beds in the Gold Coast University Hospital Medical Assessment Unit dedicated to patients with suspected COVID-19 to improve flow through the emergency department.

- Implementation of direct admission pathways for patients being admitted to inpatient units at the Gold Coast University Hospital. Work continues with the clinical teams to refine the direct admission pathways.

Managing strategic risks

Gold Coast Health continues to experience an increasing population and demand for public health services on the Gold Coast, including market shifts between the private and public sector and growing expectations of Gold Coast Health as a tertiary health service provider.

We must prioritise and balance financial resources as healthcare demand grows and be prepared to respond to emerging or unforeseen local or global challenges to ensure we can provide equitable healthcare that maintains and improves health outcomes. We must optimise and grow our infrastructure as healthcare demand grows to avoid a reduced ability to provide equitable, safe, reliable access to healthcare.
Gold Coast Health has committed to adopting a transformational culture that encourages agility, innovation and rapid knowledge translation if we are to ensure high reliability healthcare delivery that meets community needs and ensures patient safety. This requires ongoing performance monitoring against key indicators and continuous improvements to service delivery.

In 2019, Gold Coast Health partnered with Queensland Treasury Corporation (QTC) to identify sustainable ways to address the challenges facing our health service in coming years.

A Transformation Office was established to support a structured, consistent and transparent approach to business change. The creation of future-focused initiatives will ensure improvement is long-lasting and brings the HHS another crucial step closer to providing high-reliability care.

The program is being delivered to address clinical demand management, clinical teaming and innovation, value-adding corporate functions and digitally enabled health services.

Governance

Our people

Board membership

The Gold Coast Hospital and Health Board is appointed by the Governor-in-Council on the recommendation of the Minister and derives its authority from the *Hospital and Health Boards Act 2011* and the Hospital and Health Boards Regulation 2012.

The Board governs Gold Coast Health and is responsible for its quality of healthcare services, strategic direction, financial performance and strengthening community partnerships.

The Board has a range of functions including:

- setting the strategic direction and priorities for the operation of Gold Coast Health
- monitoring compliance and performance
- ensuring safety and quality systems are in place which are focused on the patient experience, quality outcomes, evidence-based practice, education and research
- developing targets, goals and standardised care plans to use public resources wisely
- ensuring risk management systems are in place and overseeing the operation of systems for compliance and risk management reporting to stakeholders
- establishing and maintaining effective systems to ensure that the health services meet the needs of the community within the resource envelope.

As research plays an integral role in the strategic direction of the organisation, the health service also recognises the Research Committee as a formal Committee of the Board.

The Gold Coast Health Board consists of ten independent members, who bring a wealth of experience and knowledge in public, private and not-for-profit sectors, as well as a range of clinical, health and business experience.

Professor Cindy Shannon was appointed by the Minister as an adviser to the Board on 21 August 2019 until her appointment as a Board member on 17 May 2020.

Mr Ian Langdon – Board Chair MBA, BComm, Dip Ed (Melb Uni), FCPA, FAIM

Appointed 18 May 2012. Current term 18 May 2020 to 17 May 2024.

Ian Langdon has extensive Board experience, encompassing roles such as Chair, Audit Committee Chair and Non-Executive Director with a wide range of companies in agribusiness, food production, marketing and health. Ian has held various academic positions including Associate Professor and Dean of Business at Griffith University (Gold Coast campus).

Ms Teresa Dyson LLB(Hons), BA, MTax, MAppFin, CTA, GAICD

Appointed 18 May 2016. Current term 18 May 2019 to 31 March 2022.

Teresa Dyson is a Non-Executive Director, with a portfolio of directorships across listed companies, government entities and not-for-profit entities. She sits on Boards in the media, energy and finance sectors. She is also a member of the Foreign Investment Review Board and the Takeovers Panel. Teresa has previously been a Partner of a global law firm and a global accounting firm. Teresa is a former Chair of the Board of Taxation.

Mr Robert Buker FCA, AMIIA

Appointed 18 May 2016. Current term 18 May 2017 to 17 May 2021.

Robert Buker has more than 47 years' expertise as a Chartered Accountant, with extensive experience delivering internal and external audit, accounting services, corporate governance, project management, as well as providing financial and management consulting. Rob's extensive experience includes both the public and private sectors in local, national and international markets.

Professor Helen Chenery BSpThy, MspThy, PhD, GAICD, FQA

Appointed 18 May 2016. Current term 18 May 2017 to 17 May 2021.

Helen Chenery has extensive strategic and operational experience in executive leadership roles within the higher education and health sectors and has led policy and practice reform in dementia care, health workforce and service design, and interprofessional education/practice. She is a leading language and rehabilitation researcher, with a particular interest in the application of digital technologies in healthcare and was previously Executive Dean of the Faculty of Health Sciences and Medicine at Bond University.

Dr Cherrell Hirst AO, FTSE, MBBS, BEdSt, D.Univ (Hon)

Appointed 18 May 2014. Current term 18 May 2018 to 17 May 2021.

Cherrell Hirst practised medicine for 30 years in community health and paediatrics, with a focus on the screening and diagnosis of breast cancer and support for women and families. Since 1990, Cherrell has a consultant and a Non-Executive Director in a wide range of private and public entities in the health, education, insurance and biotechnology sectors and in various not-for-profit organisations. She was Chancellor of QUT from 1994 – 2004 and was named Queenslander of the Year in 1995.

Michael Kinnane ESM, FAICD, FAIM

Appointed 18 May 2018. Current term 18 May 2019 to 31 March 2022.

Michael Kinnane has had an accomplished career as Director-General of several Queensland government departments, including emergency services for more than 12 years and was CEO of the Queensland Ambulance Service for five years. Michael is a strategic change leader who is community and outcomes-focused with a record of achievements resulting in positive patient outcomes for the community.

Colette McCool PSM, MIM, BA, GAICD, FAICD

Appointed 29 June 2012. Current term 18 May 2018 to 17 May 2021.

Colette McCool has more than 25 years' experience as a senior executive in large and complex public sector organisations. She has held senior leadership positions across economic, cultural and social portfolios in state, territory and local governments, in diverse areas such as community services and health, waste management and transport. On behalf of the Board Chair, Colette was a Director of the Gold Coast Hospital Foundation until 30 June 2020.

Professor Judy Searle BMBS, FRANZCOG(ret), MD, GAICD

Appointed 18 May 2016. Current term 18 May 2017 to 17 May 2021.

Judy Searle started her career as a medical specialist before moving primarily into leadership and management positions in academia, health professional advocacy and health policy. She continues to contribute to the health and education sectors as a Non-Executive Director and as an academic consultant, with particular focus on clinical service provision, health policy development, regulation and accreditation, and medico-politics.

Dr Andrew Weissenberger MBBS (Hons), FRACGP, GAICD

Appointed 7 September 2012. Current term 18 May 2018 to 17 May 2021.

Andrew Weissenberger began his career in hospitals, working at the Mater Hospital in Brisbane, before moving into community general practice in Brisbane and on the Gold Coast. Andrew has a keen interest in the training and education of both medical students and registrars and is a Senior Lecturer with Griffith University. He is also actively involved as a surveyor for accreditation in general practice.

Prof Cindy Shannon AM, BA (Economics and History), Grad Dip Ed, MBA, DrSocSc (Pol Sci), GAICD, FQAAS (FQA)

Appointed 17 May 2020. Current term 18 May 2020 to 17 May 2024.

Professor Cindy Shannon is a Ngugi woman and descendant of the Quandamooka people. She is an Emeritus Professor with the University of Queensland, among many other roles. Cindy was the Pro-Vice-Chancellor (Indigenous Engagement) at the University of Queensland from 2011-2017, and inaugural Director of its Poche Centre for Indigenous Health. Cindy led the development and implementation of Australia's first degree-level program for Aboriginal and Torres Strait Islander health workers and played a key role is supporting the establishment of

the Institute for Urban Indigenous Health in South-East Queensland. Cindy has contributed to Indigenous health policy in Queensland and nationally.

Board remuneration

The Governor-in-Council approves the remuneration arrangements for Board Chairs and members. The annual fees paid by Gold Coast Health are consistent with the *Remuneration Procedures for Part-time Chairs and Members of Queensland Government Bodies*. The approved fees are $85,714 for the Board Chair and $44,503 for members. Committee fees are $4000 per Committee Chair role and $3000 for Committee membership per annum.

Board members were reimbursed for out-of-pocket expenses during 2019–2020. The total value reimbursed was $1820.64.

Board Professional Development

Gold Coast Hospital and Health Service is committed to the continual learning and development of Board members to be able to contribute to high standards of governance and leadership of the GCHHS.

The Board Professional Development Policy (POL1550) is intended to ensure that Board members are equipped with the knowledge and skills to discharge their roles and responsibilities. Board members endeavour to share their learning from a range of professional development opportunities across their diverse career portfolios.

Board committees

Gold Coast Health is committed to achieving the highest standards of corporate governance and seeks to adopt best practice. All committees of the Board abide by their approved terms of reference and assist the Board in the execution of its duties by enabling more detailed consideration of key issues.

Executive

Chair: Ian Langdon

Members: Dr Cherrell Hirst, Colette McCool, Prof Judy Searle, Prof Cindy Shannon and Dr Andrew Weissenberger

As set out in section 32B of the *Hospital and Health Boards Act 2011*, the Executive Committee supports the Board in progressing the delivery of strategic objectives for Gold Coast Health and by strengthening the relationship between the Board and the Chief Executive to ensure accountability in the delivery of services.

Safety, Quality and Clinician Engagement

Chair: Prof Judy Searle

Members: Prof Helen Chenery, Michael Kinnane, Colette McCool, Dr Andrew Weissenberger and additional contributors

The Safety Quality and Clinician Engagement Committee is prescribed by the *Hospital and Health Boards Act 2011* and advises the Board on matters relating to the safety and quality of healthcare provided, including the health service's strategies for the following:

- minimising preventable patient harm
- reducing unjustified variation in clinical care
- improving the experience of patients and carers in receiving health services
- complying with national and state strategies, policies, agreements and standards relevant to promoting consultation about the provision of health services.

The Safety, Quality and Clinician Engagement Committee also monitors governance arrangements, policies and plans regarding safety and quality and promotes improvements in safety and quality.

Audit and Risk

Chair: Robert Buker
Members: Ms Teresa Dyson, Dr Cherrell Hirst, Michael Kinnane and external members
The Audit and Risk Committee is required under the *Hospital and Health Boards Act 2011* and under the Financial and Performance Management Standard 2019. The committee operates in accordance with Queensland Treasury's Audit Committee Guidelines and oversees governance, risk and assurance processes. It is responsible for assessing the integrity of the service's financial statements, internal and external audit activities, effectiveness of risk management, and compliance with legal and regulatory requirements. The Audit and Risk Committee also monitors the management of legal and compliance risks and internal compliance systems, including compliance with relevant laws and government policies.

Finance and Performance

Chair: Dr Cherrell Hirst
Members: Robert Buker, Teresa Dyson, Michael Kinnane, Ian Langdon and Prof Cindy Shannon
The Finance and Performance Committee meets monthly to assist the Board in fulfilling its responsibilities to oversee Gold Coast Health's assets and resources. It has a range of functions required under Section 33 of the *Hospital and Health Boards Regulation 2012*, including reviewing and monitoring the financial performance of the health service in accordance with approved strategies, initiatives and goals.

Research

Chair: Prof Helen Chenery
Members: Ian Langdon, Colette McCool, Prof Cindy Shannon and external members
The Research Committee advises the Board in relation to developing a future-focused Research Strategy and Roadmap that emphasises the enhancement of clinical and health service delivery based on patient-centered care and evidence-based practice. Fundamental to these aims is the building of long-term collaborations in research that are founded on sustainable and trusting partnerships. These research programs are facilitated by a shared collective vision that includes discovery, translation and adoption of research outcomes into practice resulting in the Gold Coast region being recognised as a world-class health precinct of national and international significance. Representatives of university partners regularly attend the Research Committee and provide valuable insight into research practice and collaborative opportunities.

Digital Innovation Advisory Committee

Chair: Prof Helen Chenery
Members: Dr Cherrell Hirst and external members
In 2019, the Board established the Digital Innovation Advisory Committee. Its primary purpose is to provide continuous, forward-thinking input and guidance to the Board, ensuring the health service stays continuously relevant and connected to the broader digital and technology industry trends that are transforming healthcare. The committee consists of two Board members, in addition to four external members, appointed for their skills, experience or knowledge relevant to the scope and function of the committee.

Table: Board Director meeting attendance

Board Member	Ian Langdon	Judy Searle	Helen Chenery	Teresa Dyson	Andrew Weissenberger	Colette McCool	Cherrell Hirst	Robert Buker	Michael Kinnane	Cindy Shannon
Board	13/13	13/13	13/13	11/13	10/13	13/13	11/13	12/13	12/13	8/13
Executive	5/5	5/5	1/5*	x	5/5	5/5	5/5	x	5/5*	3/5
Finance and Performance	7/11	4/11*	2/11*	7/11	2/11*	3/11*	10/11	10/11	10/11	7/11
Audit and Risk	1/4*	x	x	3/4	x	1/4*	4/4	4/4	3/4	x

Safety, Quality and Clinician Engagement	4/6*	6/6	6/6	x	5/6	6/6	x	x	5/6	x
Research	2/4	x	4/4	x	x	4/4	x	x	x	2/4

* Denotes attendance at committee meetings for which the Board Director is not a specified member.
The Digital Innovation Advisory Committee is not listed in the above table as it is not a remunerated sub-committee.

Executive management

The Gold Coast Health Executive Management Team consists of the Chief Executive and a suite of Executive Directors responsible for a range of portfolios including Operations, Finance, Strategy and Service Planning, People and Corporate Services, Strategic Communication and Corporate Governance, Digital Transformation, Robina Hospital, and Clinical Governance, Education and Research.

Chief Executive – Ron Calvert BSc (Hons), MBA

Ron commenced as Chief Executive of Gold Coast Health in 2012, bringing with him more than 20 years of health management skills and experience. He has held Chief Executive roles at England's Doncaster and Bassetlaw National Health Service (NHS) Foundation Trust and Trafford Healthcare NHS Trust, where he introduced a quality regime that resulted in a significant reduction in mortality rates. Prior to this, he held Board-level roles at University College London Hospitals and University Hospitals Leicester.

Chief Operations Officer – Kimberley Pierce BSc, ENB (Cardiology), CCRN, CertIV (ProjMgmt), GAICD

Kimberley joined Gold Coast Health in 2014 as Divisional Executive Director, Diagnostic, Emergency and Medical Services, and was appointed Chief Operations Officer in 2017. She has worked in South Africa as a clinical director of 22 private hospitals and was Chief Executive of private hospitals in London and Manchester.

Chief Finance Officer – Ian Moody BA (Hons), FCA, MAICD

Ian joined Gold Coast Health in December 2013 following an international career of 15 years in assurance and consulting in various commercial industries and government sectors. He is a Board Director of the Healthcare Financial Management Association.

Executive Director, Clinical Governance, Education and Research – Dr Jeremy Wellwood MBBS (Hons), FRACP, FRCPA

Jeremy returned to Gold Coast Health in 2005 as a Clinical and Laboratory Haematologist after having been a registrar in the service in the mid-1990s. He led the development of tertiary cancer services on the Gold Coast and draws on his 25 years of clinical experience to provide values-based leadership with a focus on improving staff and patient experience.

Acting Executive Director, Digital Transformation and Chief Information Officer – Mark Luchs BSc, MA (Administration), MA (National Resource Strategy)

Mark joined Gold Coast Health in 2015 following a military career where he worked across a variety of specialties including information communication and technology, information assurance, operational support and contingency planning. He has been acting in the executive role overseeing the digital and information portfolios since 2019.

Executive Director, Strategic Communication and Engagement, Acting Executive Director, Governance, Risk and Commercial Services – Sarah Dixon B Bus (Comms), JP(Qual), GAICD, MPRIA

Sarah joined Gold Coast Health's executive team in 2018, following a 15-year consulting career in corporate affairs, communication and marketing. She has worked across a wide variety of sectors, including health, and has advised Boards and executive management teams on a range of complex issues and situations in the national spotlight. She is also the Chair of an independent school board, a Trustee Director of a public offer superannuation fund, and Deputy Chair of a charitable trust.

Executive Director, People and Corporate Services – Hannah Bloch BBus (HRM), LLB

Hannah joined the executive team in September 2016 following more than 10 years working across Queensland Health. Hannah's role is critical to ensuring the Health Service has the right workforce with the right skills to meet future service delivery needs. She is focused on supporting the broader executive team to engage with staff and drive strategies to build a culture of success.

Executive Director, Strategy and Service Planning – Toni Peggrem BPThy, BSc, MSc (Ed), GAICD

Toni started at Gold Coast Health in 2006 and brought with her more than 15 years' experience in health service delivery and health administration. Toni played an integral role in the development, planning and delivery of the Robina Hospital expansion, Robina Health Precinct and Gold Coast University Hospital building projects.

Strategic Committees

Executive Management Committees

Executive Management Team

The Executive Management Team is comprised of the Executive Directors, Clinical Directors, Directors of Nursing and the Professor of Nursing and Midwifery. Meetings are held monthly to consider matters of strategic importance and cross-divisional impact. In this forum, members of the executive provide information and advice to the Chief Executive and their colleagues to enable planning, review and analysis. Each member holds responsibility for their divisional, financial, operational and clinical performance.

Finance and Performance Executive Committee

The Finance and Performance Executive Committee (FPEC) provides leadership, direction and governance oversight for the financial and operational performance of Gold Coast Health and supports the Chief Executive to ensure the financial and operating performance of the Health Service is efficiently reviewed and monitored, and that will provide assurance to support the monthly report to the Board.

Clinical Governance Committee

The Clinical Governance Committee provides strategic direction and oversight of patient safety and quality systems to maintain and improve the reliability and quality of patient care, as well as improve patient outcomes. The committee is responsible for overseeing and setting standards of clinical governance within Gold Coast Health.

The committee monitors, evaluates and improves performance in clinical practice to ensure optimal patient safety and high care quality. This committee reports to the Board's Safety, Quality and Clinician Engagement Committee and has membership comprised of senior clinicians and managers across a number of disciplines, including allied health, medicine, nursing and clinical governance.

Digital Portfolio Committee

The Digital Portfolio Committee adopts a strategic view of planning, performance and benefits realisation of information management processes and Information Communication Technology (ICT) systems across Gold Coast Health. This committee has oversight of key strategic ICT risks and is responsible for ensuring that capacity, capability and solutions are planned, procured, designed, implemented and evaluated. The committee makes recommendations to the Health Service Chief Executive about investment decisions, including current systems and those planned as part of future expansion.

Work Health and Safety Management Committee

The Work Health and Safety Management Committee meets quarterly and provides a forum for multi-divisional consultation and dissemination of all safety and wellness-related information. The committee monitors performance and make recommendations based on identified work health and safety risks to staff, patients and visitors.

Transformation Oversight Committee

Our service is facing pressures and we need to transform as part of a broader Health Sustainability challenge. We are evolving our approach to delivering change and addressing 12

recommendations agreed with the Queensland Treasury Corporation (QTC) and have consequently introduced a new form of governance to improve the way we coordinate change. The Transformation Oversight Committee sets the priorities of the organisation and the overall targets for the Transformation Program, decides on program trade-offs and avoids conflicting priorities, and allows supportive reporting and clear responsibilities to drive change.

Clinician Engagement

Clinical Council

Clinical Council is the peak clinical leadership forum within Gold Coast Health, empowered by the Board and Chief Executive. The objective of Clinical Council is to facilitate authentic engagement of clinicians in health service planning, strategy development and other issues of clinical importance. The Council provides advice to the Chief Executive and an opportunity to embed clinician feedback in governance, strategy and cultural development activities.

Research Council

The Research Council is the peak communication body for aligning and supporting long-term collaborations in research across all clinical directorates and research active services. The Research Council ensures the delivery of strategic research priorities to help shape and guide the direction of research at Gold Coast Health, in line with the overall health service strategy, state and national health strategies. To achieve this purpose, the Council is responsible for identifying and enacting practical strategies that overcome cognitive, resource, motivation and political hurdles to engage Gold Coast Health staff in research and foster collegial relationships with academic partners, public and private organisations.

The Research Council also advises on effective communication strategies to ensure Gold Coast Health cultivates a strong team culture to uphold its reputation for delivering excellence in research-infused and evidence-based health care.

Organisational structure and workforce profile

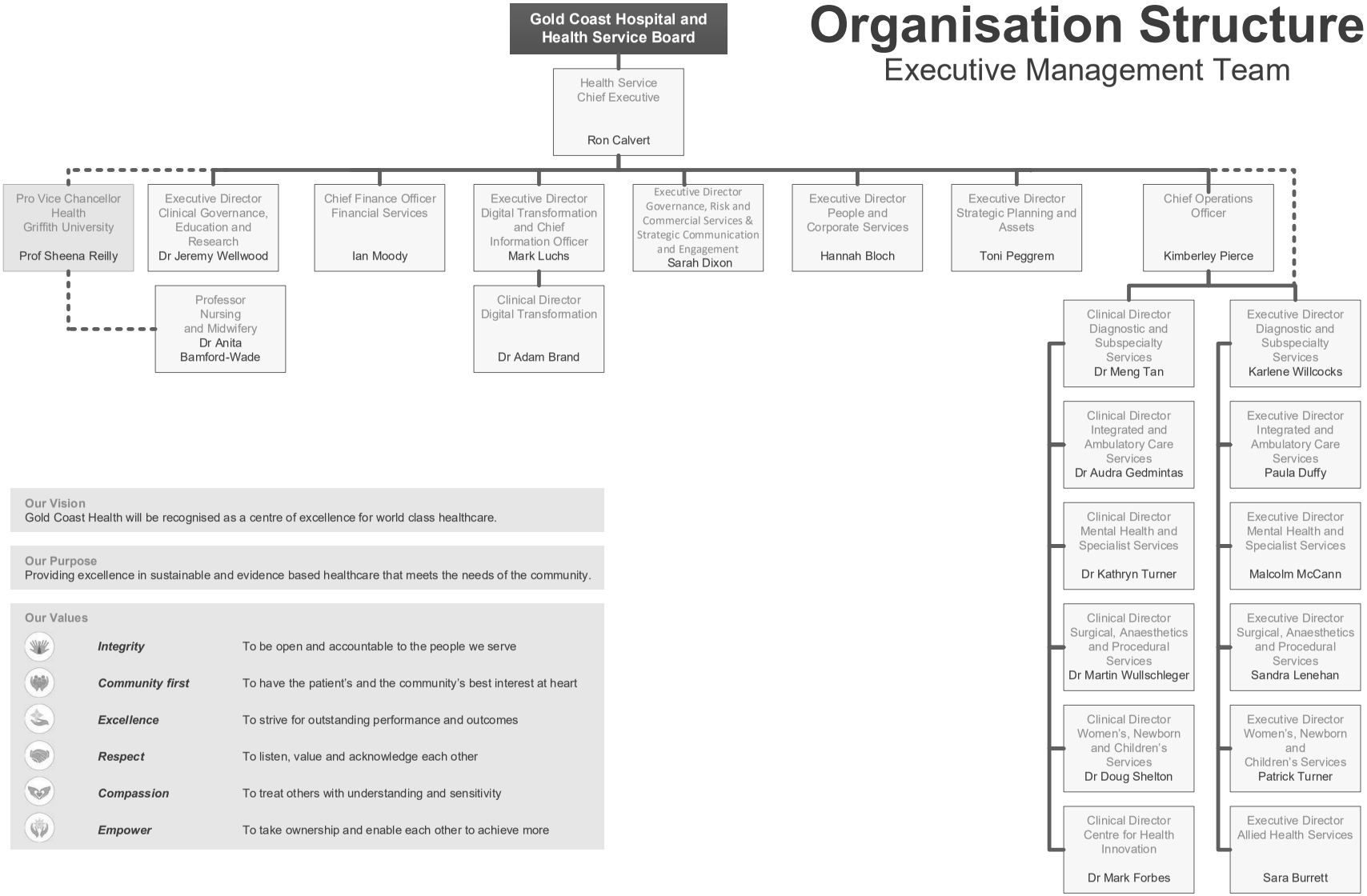
Organisational structure

Gold Coast Health has a two-tier management structure consisting of the Gold Coast Health Board and Executive Management. The Board supervises the performance of the health service, its management and organisation. It also participates in determining the strategy of Gold Coast Health. Executive Management, in turn, is responsible for the overall conduct of the business and all operational matters, organisation of the health service as well as allocation of resources, determination and implementation of strategies and policies, direction-setting and ensuring timely reporting and provision of information to the Board.

Changes to employer arrangements came into effect from 15 June 2020. These changes mean all non-executive health service employees in Gold Coast Health are now employed by the Director-General, as system manager of Queensland Health. The changes ensure there are clear and consistent employer arrangements for non-executive health service employees in all Hospital and Health Services, and reflects the fact that staff work for the health of all Queenslanders, regardless of which hospital or service they are based in.

Organisation Structure

Executive Management Team



Our Vision
Gold Coast Health will be recognised as a centre of excellence for world class healthcare.

Our Purpose
Providing excellence in sustainable and evidence based healthcare that meets the needs of the community.

Our Values

Integrity	To be open and accountable to the people we serve
Community first	To have the patient's and the community's best interest at heart
Excellence	To strive for outstanding performance and outcomes
Respect	To listen, value and acknowledge each other
Compassion	To treat others with understanding and sensitivity
Empower	To take ownership and enable each other to achieve more

Strategic workforce planning and performance

An equal opportunity employer

Workforce figures show 1.43 per cent of Gold Coast Health employees identify as a First Nations person.

*Table 1: More doctors and nurses**

	2015-16	2016-17	2017-18	2018-19	2019-20
Medical staff [a]	990	1,033	1,088	1,118	1,203
Nursing staff [a]	3,196	3,275	3,480	3,668	3,989
Allied Health staff [a]	909	932	993	1,035	1,061

*Table 2: Greater diversity in our workforce**

	2015-16	2016-17	2017-18	2018-19	2019-20
Persons identifying as being First Nations [b]	68	73	96	107	128

Note: * Workforce is measured in MOHRI – Full-Time Equivalent (FTE). Data presented reflects the most recent pay cycle at year's end. Data presented is to May-20.

Source: [a] DSS Employee Analysis, [b] Queensland Health MOHRI, DSS Employee Analysis

Gold Coast Health's workforce consists of 8,784 full-time equivalent (FTE) staff. Gold Coast Health appointed a total of 981 new employees during the 2019–2020 financial year.

During the COVID-19 pandemic, Gold Coast Health ensured employees had reasonable access to flexible working arrangements where access does not disrupt business continuity and is of benefit to employee health and wellbeing. More than 780 employees applied for access to flexible working arrangements.

Permanent separation

During 2019–2020, 305 staff separated permanently from the service, a rate of 3.97 per cent.

Going for Gold Staff Survey

The 2020 Going for Gold Staff Survey census period opened on 6 March 2020.

The 2020 survey saw an improvement in overall response rate, up to 69 per cent from 67 per cent in 2018. In total, 6956 staff submitted a response.

Alongside an increased response rate, the overall level of employee engagement also increased, rising to 49 per cent from 46 per cent in 2018. This is a significant improvement for an organisation of our size, and confirms we are well underway on our journey towards a culture of success.

Workforce planning approach

Following the launch of the *Gold Coast Health Workforce Strategy* (the strategy) in 2019, a strong focus was placed on developing the strategy's underlying frameworks. A two-year implementation road map was developed to realise strategies for induction, staff development, performance management, mobility and recognition. This body of work was deferred in February 2020 to enable staff to focus on the COVID-19 response. The strategy's implementation recommenced in June 2020, with priorities on strategic workforce planning, succession planning and culture.

Key highlights included:

- a post-implementation review of the *Reward and Recognition Framework*, and its supporting initiatives, resulted in a series of recommendations which supported increased leadership engagement and further broadened the reach of the program to community-based and frontline staff
- a refresh of the *Performance and Development Planning Framework* to offer a more inclusive, best-practice approach to empower our leaders to support staff in reaching their full potential
- consultation towards the development of a new onboarding and engaging framework, with the aim to provide a more consistent approach to onboarding, while allowing flexibility across various service lines
- commencement towards designing our exit and transitioning framework, empowering staff to offboard with respect and pride in their accomplishments.

Attracting our workforce

The Workforce Strategy and Engagement team, in collaboration with the Strategic Communication and Engagement team, developed the *Attraction and Recruitment Framework* (the framework) in consultation with key stakeholders across the business. The framework was launched in August 2019 and drives our strategy to build a culture of success that translates to recruiting and maintaining a high-performing, motivated workforce.

The framework will undergo a post-implementation review in late 2020, to ensure that Gold Coast Health is able to continuously improve and adopt best-practice recruitment strategies. Our approach to the development of the enabling framework for the Workforce Strategy involves both collaboration and consultation with key partners including the Consumer Advisory Group, education partners, statewide advisory groups, internal professional experts and key leadership roles.

Developing our workforce

Workforce capability development and learning activities that directly support our strategic plan are a focal point of Gold Coast Health's Learning and Capability Planning Framework; in particular, the Core Capability Framework (CCF).

The CCF provides staff with a pathway that connects their capability development by aligning skills, abilities and behaviours that are valued and recognised as critical to successfully deliver our services to the community.

Underpinned by our values, the CCF guides the translation of our values into action and provides a consistent measure of the skills and behaviours we are looking for when attracting, recruiting, developing and retaining our people.

Our Core Capability Framework includes 20 capabilities that are categorised into five key capability groups. Each capability is demonstrated at four different levels of leadership. The framework is integrated into our entire employee lifecycle and works in conjunction with Professional Capability Frameworks.

Gold Coast Health's *Learning and Capability Planning Framework* ensures Gold Coast Health has:

- Supported leaders through CCF-aligned leadership development pathways that provide our leaders with the capabilities to lead.
- Improved communication through the development of skills and knowledge in communication that provide a robust framework for shared understanding and direction.
- Improved patient outcomes as staff are equipped with the skills and knowledge to provide improved patient-centred care.

To further support the framework, 10 new courses were launched, on topics such as change management and emotional intelligence. These programs were delivered to more than 1300 participants across more than 120 sessions.

Developing our leaders

Building on the success of the Higher-Level Apprenticeship program, a multi-tier leadership program was launched within the service. The overall program includes the:

- Emerging Leaders Program, designed to bridge the gap between leadership levels. Delivered in partnership with TAFE Gold Coast, a blended training approach was taken to deliver online content, combined with a monthly face-to-face session.
- Evolving Leaders Program, designed to provide continued support to existing leaders. The program was designed in alignment with the CCF and provided 250 of our leaders with access to online, empowering them to drive their own leadership journey.
- Strategic Leaders Program, designed for Executive Leaders and delivered in partnership with Queensland University of Technology. The program included Gold Coast Health's Executive Leaders, as well as leaders from a variety of private and public institutions, and saw the provision breakthrough sessions, facilitated by world-class thought leaders.
- Manager Induction Program, designed to focus on the operational aspects of management. The program was targeted at new managed, and involved presenters from across the organisation including Finance, Project Services and Human Resources. The program ensures new managers have the suitable information provided to successfully fulfil their roles and responsibilities within the health service.
- Targeted Leadership Programs, designed to improve the culture and leadership landscape throughout the organisation. These sessions were tailored to individual areas and aimed to address unit-specific requirements.

Early retirement, redundancy and retrenchment

During the period, one employee received a redundancy package at a cost of $124,076.75*. Employees who did not accept an offer of a redundancy were offered case management, and reasonable attempts were made to find alternative employment placements.

*This figure excludes accrued leave (redundancy payout only).

Our risk management

Risk management is integral to effective strategic planning and decision-making. Gold Coast Health seeks to:

- Continually improve the risk management culture and maturity of the health service, ensuring best practice is maintained
- Take a consistent approach to managing risks across Gold Coast Health
- Clearly define roles, responsibilities and training to ensure effective risk management
- Assign necessary resourcing to support the risk management function.

Gold Coast Health is committed to managing risk in a proactive and integrated manner. Risk is an inherent part of the health service's operating environment. Risk management activities are incorporated into strategic planning, governance reporting and operational processes.
Gold Coast Health's risk management framework aligns to *Australian/New Zealand International Standards; ISO 31000:2018; Risk Management Guidelines; and National Safety and Quality Health Service Standard 1, Clinical Governance Standard*. The risk management framework defines the process for identifying, recording, analysing, controlling, monitoring and reporting risks.

Accountable bodies within our risk framework are:

- Gold Coast Health Board: The Board retains responsibility for ensuring systems and processes are in place to mitigate and manage risks appropriately. The Board has delegated responsibility for overseeing the risk management framework to the Audit and Risk Committee.
- The Audit and Risk Committee: The Committee oversees the assurance of the risk management framework and the internal control structure, to ensure it is efficient, effective and in line with the desired Board culture in relation to risk management.
- The Executive Management Team: The Executive Management Team has active risk management responsibilities, both collectively, and individually as Executive Directors in charge of separate service streams. Significant risks are reported to the Executive Management team, Audit and Risk Committee and Board on a regular basis.

Internal audit

Gold Coast Health has established an internal audit function in accordance with section 29 of *the Financial and Performance Management Standard 2019*.

The Gold Coast Health internal audit unit, led by the Director of Assurance and Advisory Services, co-sources its internal audit activity with numerous professional services firms and subject-matter experts.

The internal audit function provides the Audit and Risk Committee and the Board with independent and objective assurance on the adequacy and effectiveness of the systems of risk management, internal control and governance in key risk areas by:

- reviewing and appraising the adequacy and effectiveness of financial and operational controls
- ascertaining compliance with established policies, procedures and statutory requirements
- ascertaining that assets are accounted for and safeguarded from loss
- identifying opportunities to improve business processes and internal control systems
- conducting investigations and special reviews as requested by management or the Audit and Risk Committee.

The internal audit function operates within the Institute of Internal Auditors Professional Practice Framework and, as such, is independent of management under a charter endorsed by the Gold Coast Hospital and Health Board's Audit and Risk Committee. The Internal Audit Plan is approved by the Board. The execution of the of the plan and the performance of the Internal Audit function is monitored by the Audit and Risk Committee in accordance with the *Audit Committee Guidelines*.

The focus areas for the 2019–2020 year for the internal audit function were patient safety, electrical safety controls, business continuity and key financial controls.

In 2019–2020, the internal audit function:

- enhanced the linkages to other governance, risk and compliance (GRC) functions to improve the overall assurance provided to the Board
- finalised four audits in key risk and control areas and provided recommendations for improvement to address risks identified impacting the health service's ability to meet its obligations and achieve its objectives. COVID restrictions limited the number of audits able to be executed
- enhanced the assurance map previously developed by linking to industry governance, risk and control frameworks.

External scrutiny, Information systems and recordkeeping

In 2019–20, Parliamentary reports tables by the Auditor-General which broadly considered the performance of the Gold Coast Health included:

Report to Parliament 7: Health: 2018–19 results of financial audits

The objective of this audit report was to summarise the results of the financial audits of the 16 Hospital and Health Services, which included timeliness and quality of financial reporting, as well as financial performance and sustainability.

Crime and Corruption Commission – Operation Impala

Gold Coast Health contributed to the Crime and Corruption's Operation Impala. The scope of this review was to examine the misuse of confidential information within the Public Sector. The recommendations are currently with Parliament for consideration

Office of Workplace Health and Safety Queensland

Workplace Health and Safety Queensland and the Electrical Safety Office investigated a matter to determine if there were any breaches of law. While there were no significant findings or breaches, Gold Coast Health reviewed its systems and is currently implementing identified improvements.

Queensland Public Service ethics

Ethical decision-making in the Queensland Public Sector affects everyone, across a wide range of positions and roles. Gold Coast Health employees, administrative procedures and management practices must comply with 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 1994.* These consist of:

- Integrity and impartiality
- Promoting the public good
- Commitment to the system of government
- Accountability and transparency.

Our values are included for new staff at induction and embedded within employee role descriptions and performance reviews for current staff. The *Code of Conduct* is available to all existing staff through the Gold Coast Health intranet site. An online learning system allows staff to independently access mandatory training, including training on ethics, integrity, accountability, fraud control awareness and public interest disclosure.

Human Rights

Since 1 January 2020, Statutory Compliance and Conduct has assessed 38 complaints where *Human Rights Act 2019* provisions were considered. The complaint matters and outcomes are summarised in the below table.

Section	Total number of complaints	Requires further action (matter ongoing)	No further action (not substantiated)	Disciplinary Action	Management Action
Section 19 – Freedom of movement	1	1	0	0	0
Section 24 – Property rights	1	1	0	0	0
Section 25 – Privacy and reputation:	13	11	2	0	0
Section 29 – Liberty and security of person	4	4	0	0	0
Section 31 – Fair hearing	36	27	3	4	2
Section 37 – Health services	1	1	0	0	0

Legal Services undertook a review of governance documents to identify and update as required to ensure compliance. Governance documents that did not require or substantively benefit from revision will be considered during the document's ordinary review cycle. A mandatory training package is being finalised with a view to being deployed in September 2020.

The *Human Rights Act 2019* has been promoted by:

- in-person and virtual training sessions and workshops hosted by Legal Services
- posters and information sheets placed around GCHHS facilities, particularly staff lunchrooms
- screen savers, notices in e-mail newsletters, and a dedicated intranet resource page.

Confidential information

The *Hospital and Health Boards Act 2011* requires annual reports to state the nature and purpose of any confidential information disclosed in the public interest during the financial year. The chief executive did not authorise the disclosure of confidential information during the reporting period.

Performance

Service standards

Table 3: Service Standards – Performance 2019–2020

Service Standards	Target	Actual
Effectiveness measures		
Percentage of patients attending emergency departments seen within recommended timeframes: [a]		
Category 1 (within 2 minutes)	100%	100.0%
Category 2 (within 10 minutes)	80%	60.4%
Category 3 (within 30 minutes)	75%	66.4%
Category 4 (within 60 minutes)	70%	85.4%
Category 5 (within 120 minutes)	70%	93.8%
Percentage of emergency department attendances who depart within four hours of their arrival in the department [a]	>80%	73.5%
Percentage of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	>98%	98.9% [1]
Category 2 (90 days)	>95%	92.8%
Category 3 (365 days)	>95%	88.9%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days [c]	<2	0.7 [2]
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit [d]	>65%	63.4%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge [d]	<12%	13.4% [3]
Percentage of specialist outpatients waiting within clinically recommended times: [e]		
Category 1 (30 days)	66%	84.0% [1]
Category 2 (90 days)	56%	33.4%
Category 3 (365 days)	94%	57.9%

Percentage of specialist outpatients seen within clinically recommended times: [e]		
Category 1 (30 days)	84%	70.3% [1]
Category 2 (90 days)	62%	46.6%
Category 3 (365 days)	67%	72.7%
Median wait time for treatment in emergency departments (minutes) [a]	..	14
Median wait time for elective surgery (days) [b]	..	43
Efficiency Measure		
Average cost per weighted activity unit for Activity Based Funding facilities [f,g]	$ 5,005	$5,291 [4]
Other Measures		
Number of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	6,805	6,012 [1]
Category 2 (90 days)	7,278	6,294
Category 3 (365 days)	3,966	2,731
Number of Telehealth outpatient occasions of service events [h]	2,176	5,939

Page Break*Table 3: Service Standards – Performance 2019-20 (continued)*

Service Standards	**Target**	**Actual**
Other Measures (continued)		
Total weighted activity units (WAU's) [g]		
Acute Inpatient	145,787	139,771 [5]
Outpatients	36,575	35,772
Sub-acute	11,537	11,041
Emergency Department	28,632	26,596
Mental Health	16,786	15,983
Prevention and Primary Care	3,263	3,672
Ambulatory mental health service contact duration (hours) [d]	>90,125	86,298
Staffing [i]	8,385	8,784

Table *3: Service Standards – Performance 2019-2020 (continued)*

Service Standards	Target	Actual
Other Measures (continued)		
Total weighted activity units (WAU's) [g]		
Acute Inpatient	145,787	139,771 [5]
Outpatients	36,575	35,772
Sub-acute	11,537	11,041
Emergency Department	28,632	26,596
Mental Health	16,786	15,983
Prevention and Primary Care	3,263	3,672
Ambulatory mental health service contact duration (hours) [d]	>90,125	86,298
Staffing [i]	8,385	8,784

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

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

[3] Readmission to acute Mental Health inpatient unit data presented as May-20 FYTD.

[4] Cost per WAU data presented as Mar-20 FYTD.

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

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

Emergency treatment

The continued growth in presentations, along with the increasing acuity and complexity of the patients, has presented challenges for the organisation. Despite these challenges, Gold Coast Health EDs have performed well across Categories 4 and 5, exceeding targets respectively. The overall percentage of patients attending emergency departments seen within recommended timeframes was 70.22 per cent in 2019–2020, against a target of 80 per cent for all patients to be discharged home, admitted or transferred to another facility within four hours of arrival.

Elective surgery waiting times

Providing timely access to surgery positively contributes to a patient's quality of life. During the 2019–2020 reporting period, elective surgery as affected by the COVID-19 elective surgery ramp down period.

Category 1 patients exceeded target (98 per cent) at 98.9 per cent while patients in Categories 2 and 3 were below the NEST target (95 percent) at 92.8 per cent and 89 per cent respectively.

The COVID-19 elective surgery ramp down had a significant effect on elective case numbers in March to May 2020, but returned to full capacity in June 2020 with ramped-up internal capacity to address the resulting long-wait patients.

As part of the *Gold Coast Health Service Plan 2016–2026,* and in response to predicted procedural and surgical elective activity over this period, the Varsity Lakes Day Hospital provided staged, flexible service delivery options that were responsive to specific demand. Increased use of clinic space and ongoing review of services continued to provide improved outcomes across patient flow, waitlist reduction and theatre capacity.

Outpatient waiting times

The health service moved from 15.5 per cent of outpatient appointments being delivered by telephone and video conference pre-COVID to 44.1 per cent.

This change allowed for service provision to continue, protected both patients and staff from unnecessary direct contact and supported patients accessing clinical care during this challenging period.

Through the work undertaken with the Queensland Treasury Corporation (QTC), the health service has introduced outpatient future focus projects of Rigorous Referral Management and

Scheduling Optimisation, targeting the reduction of waiting times and introduction of sustainable system-wide solutions.

Financial summary

Summary of financial performance

Gold Coast Health reported a deficit of $11.759 million for the year. A large portion of the 2019–20 operating deficit related to the increasing demand for healthcare services.

Where our funds came from

The Queensland Department of Health commissions services from Gold Coast Health on behalf of the State and the Commonwealth. The relationship is managed and monitored using a Service Agreement underpinned by a performance management framework. The total income for Gold Coast Health for 2019–20 was $1.660 billion (compared to $1.567 billion in 2018–19). The primary source of funds is the Queensland Department of Health.

Activity-based funding

In the service agreement between Gold Coast Health and the Queensland Department of Health, the measure used to quantify activity delivered is a Queensland Weighted Activity Units (QWAU). A QWAU is a measure of the level of resources consumed during the patient's journey through our health service. The value is recalculated each year based on the national average, which is determined by the Independent Hospital Pricing Authority (IHPA).

How our funds were used

The significant increase in demand for healthcare-related services has been the primary driver behind the 6.2 percent increase in expenditure from $1.573 billion to $1.671 billion, evidenced by an 8.5 percent increase in employee expenses to $1.166 billion. For further information regarding these variances, please refer to the notes in the financial statements.

Where our funds came from

Revenue	2018	2019	2020
Commonwealth Contributions	$409,862,677	$532,859,355	$534,376,438
Queensland Government Contributions	$928,837,767	$907,368,532	$983,920,564
User Charges	$97,348,514	$105,052,859	$115,820,442
Other Revenue and Grants and Contributions	$19,067,431	$21,796,159	$25,496,149
Total Revenue	**$1,455,116,389**	**$1,567,076,905**	**$1,659,613,593**

Expenses by category (over three years)

Expenses	2018	2019	2020
Employee Expenses	$971,855,515	$1,074,491,854	$1,165,781,951
Supplies and Services Expense	$387,446,073	$393,611,407	$407,087,449
Depreciation and Amortisation Expense	$78,648,976	$80,061,785	$77,942,751
Other Expenses	$9,209,427	$24,983,153	$20,560,445
Expenses	**$1,447,159,991**	**$1,573,148,199**	**$1,671,372,596**

Anticipated maintenance

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

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

As of 3 June 2020, GCHHS had reported total anticipated maintenance of $25.2 million. Gold Coast Health is currently completing a condition assessment program for its major facilities, and the value of anticipated maintenance may vary as a result.

Gold Coast Health has the following strategies in place to mitigate any risks:

- Ongoing audit and prioritisation of maintenance activities
- Identification and discussion with Department of Health for prioritisation for emerging funding
- Seek assistance from the Priority Capital Program where this applies

For the financial year the GCHHS expended $40,509,452 on asset maintenance and associated building and infrastructure activities.

Financial statements

Gold Coast Hospital and Health Service
Financial Statements - 30 June 2020

General information

Gold Coast Hospital and Health Service ("Gold Coast Health") is a Government statutory body established under the *Hospital and Health Boards Act 2011* and its registered trading name is Gold Coast Hospital and Health Service.

The head office and principal place of business of Gold Coast Health is

Gold Coast University Hospital
1 Hospital Boulevard
Southport QLD 4215

A description of the nature of Gold Coast Health's operations and its principal activities is included in the annual report.

For information in relation to Gold Coast Health, please visit the website www.goldcoast.health.qld.gov.au

Contents

Section 1: Basis of financial statement preparation

These policies have been consistently applied to all the years presented, unless otherwise stated.

1.1 The reporting entity

Gold Coast Health is established under the *Hospital and Health Boards Act 2011*. Gold Coast Health is an independent statutory body and a reporting entity, which is domiciled in Australia. Accountable to the Minister for Health and to the Queensland Parliament, it is primarily responsible for providing quality and safe public hospital and health services and for the direct management of the facilities within the Gold Coast region. The ultimate parent entity is the State of Queensland.

The financial statements are authorised for issue by the Board Chair and Chief Executive at the date of signing the management certificate.

1.2 Statement of compliance

Gold Coast Health has prepared these financial statements in compliance with the relevant sections of the *Financial and Performance Management Standard 2019 (QLD)* and other prescribed requirements. In addition, the financial statements comply with Queensland Treasury's Minimum Reporting Requirements for the year ended 30 June 2020, and other authoritative pronouncements.

Gold Coast Health is a not-for-profit entity and these general purpose financial statements are prepared on an accrual basis (except for the statement of cash flows which is prepared on a cash basis) in accordance with Australian Accounting Standards and Interpretations applicable to not-for-profit entities.

Except where stated, the historical cost convention is used.

1.3 Presentation

Amounts in this report are in Australian dollars and have been rounded off to the nearest thousand dollars, or in certain cases, the nearest dollar.

There were no material restatements of the comparative information. Immaterial reclassifications have occurred to ensure consistency with current period disclosures.

Assets and liabilities are classified as either 'current' or 'non-current' in the statement of financial position and associated notes. Assets are classified as 'current' where their carrying amount is expected to be realised within 12 months after the reporting date. Liabilities are classified as 'current' when they are due to be settled within 12 months after the reporting date, or there is no unconditional right to defer settlement to beyond 12 months after the reporting date.

1.4 Basis of preparation

Gold Coast Health has prepared these financial statements on a going concern basis, which assumes that Gold Coast Health will be able to meet the payment terms of its financial obligations as and when they fall due. Gold Coast Health is economically dependent on funding received from its Service Agreement with the Department of Health ("the Department").

A Service Agreement Framework is in place to provide Gold Coast Health with a level of guidance regarding funding commitments and purchase activity for 2019-2020 to 2021-2022. The Board and management believe that the terms and conditions of its funding arrangements under the Service Agreement Framework will provide Gold Coast Health with sufficient cash resources to meet its financial obligations for at least the next year.

In addition to Gold Coast Health's funding arrangements under the Service Agreement Framework, Gold Coast Health has no intention to liquidate or to cease operations; and under section 18 of the *Hospital and Health Boards Act 2011*, Gold Coast Health represents the State of Queensland and has all the privileges and immunities of the State.

1.5 Critical accounting estimates

The preparation of the 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 with the most significant effect on the financial statements are:

- Useful lives assessment – refer Note 2.7
- Land and building valuation assessment – Note 2.13

1.6 Taxation

Gold Coast Health is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation except for Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). All Queensland Hospital and Health Services and the Department are grouped for the purposes of Section 149-25 *A New Tax System (Goods and Services Tax) Act 1999*.

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.

Section 2: Financial Statements and Related Notes

Gold Coast Hospital and Health Service
Statement of comprehensive income
For the year ended 30 June 2020

	Note	2020 $'000	2019 $'000
Income			
Funding for public health services	2.1	1,518,297	1,427,785
User charges and fees	2.2	115,820	110,448
Grants and other contributions	2.3	18,958	16,875
Other revenue	2.4	6,469	11,638
Total revenue		1,659,544	1,566,746
Gain on disposal/revaluation of assets		69	85
Total income		1,659,613	1,566,831
Expenses			
Employee expenses	2.5	(1,123,582)	(1,074,234)
Health service employee expenses	2.5	(42,200)	-
Supplies and services	2.6	(407,087)	(393,791)
Grants and subsidies		-	(652)
Depreciation and amortisation	2.7	(77,943)	(80,062)
Impairment loss		(2,579)	(3,003)
Other expenses	2.8	(17,981)	(21,160)
Total expenses		(1,671,374)	(1,572,902)
Operating result for the year		(11,759)	(6,071)
Other comprehensive income			
Items that will not be reclassified to operating result:			
- Increase in revaluation surplus	2.13b	30,532	36,656
Total other comprehensive income		30,532	36,656
Total comprehensive income		18,773	30,585

The above statement of comprehensive income should be read in conjunction with the accompanying notes.

Gold Coast Hospital and Health Service
Statement of financial position
As at 30 June 2020

	Note	2020 $'000	2019 $'000
Current assets			
Cash and cash equivalents	2.9	119,343	92,026
Receivables	2.10	9,897	9,968
Inventories	2.11	11,758	10,324
Other assets	2.12	15,319	16,502
Total current assets		156,317	128,820
Non-current assets			
Property, plant and equipment	2.13	1,677,854	1,705,741
Intangible assets		152	204
Total non-current assets		1,678,006	1,705,945
Total assets		1,834,323	1,834,765
Current liabilities			
Payables	2.15	65,211	45,050
Accrued employee/health service employee benefits	2.16	50,459	44,235
Other liabilities	2.17	28,684	11,306
Total current liabilities		144,354	100,591
Total liabilities		144,354	100,591
Net assets		1,689,969	1,734,174
Equity			
Contributed equity		1,500,417	1,563,395
Accumulated surplus		6,145	17,904
Revaluation surplus	2.13b	183,407	152,875
Total equity		1,689,969	1,734,174

The above statement of financial position should be read in conjunction with the accompanying notes.

Gold Coast Hospital and Health Service
Statement of changes in equity
For the year ended 30 June 2020

	Note	Contributed Equity	Accumulated Surplus	Asset Revaluation Surplus	Total equity
		$'000	$'000	$'000	$'000
Balance at 1 July 2018		1,616,134	23,975	116,219	1,756,328
Deficit for the year		-	(6,071)	-	(6,071)
Other comprehensive income for the year					
- Increase in asset revaluation surplus	2.13	-	-	36,656	36,656
Total comprehensive income for the year		-	(6,071)	36,656	30,585
Transactions with owners as owners:					
Equity injections		21,370	-	-	21,370
Net non-current asset transfers		5,953	-	-	5,953
Equity withdrawals (depreciation funding)	2.1	(80,062)	-	-	(80,062)
Balance at 30 June 2019		1,563,395	17,904	152,875	1,734,174

		Contributed Equity	Accumulated Surplus	Asset Revaluation Surplus	Total equity
		$'000	$'000	$'000	$'000
Balance at 1 July 2019		1,563,395	17,904	152,875	1,734,174
Deficit for the year		-	(11,759)	-	(11,759)
Other comprehensive income for the year					
- Increase in asset revaluation surplus	2.13	-	-	30,532	30,532
Total comprehensive income for the year		-	(11,759)	30,532	18,773
Transactions with owners as owners:					
Equity injections		11,798	-	-	11,798
Net non-current asset transfers		3,167	-	-	3,167
Equity withdrawals (depreciation funding)	2.1	(77,943)	-	-	(77,943)
Balance at 30 June 2020		1,500,417	6,145	183,407	1,689,969

The above statement of changes in equity should be read in conjunction with the accompanying notes.

Gold Coast Hospital and Health Service
Statement of cash flows
For the year ended 30 June 2020

	Note	2020 $'000	2019 $'000
Cash flows from operating activities			
Inflows			
Funding for public health services		1,457,358	1,364,137
User charges and fees		114,132	109,877
Grants and other contributions		17,079	16,763
GST collected from customers		1,825	1,766
GST input tax credits from Australian Taxation Office		19,262	20,234
Other operating cash inflows		8,555	11,638
Outflows			
Employee expenses		(1,141,488)	(1,069,792)
Supplies and services		(407,390)	(400,004)
Grants and subsidies		-	(898)
GST paid to suppliers		(19,394)	(19,072)
GST remitted to Australian Taxation Office		(1,777)	(1,795)
Other operating cash outflows		(17,841)	(20,348)
Net cash from operating activities	2.9	30,321	12,506
Cash flows from investing activities			
Payments for property, plant and equipment		(14,419)	(18,991)
Sale of property, plant and equipment		73	137
Net cash used in investing activities		(14,346)	(18,854)
Cash flows from financing activities			
Equity injections		11,492	23,995
Lease payments	2.14	(150)	-
Net cash provided by financing activities		11,342	23,995
Net increase in cash and cash equivalents		27,317	17,647
Cash and cash equivalents – opening balance		92,026	74,379
Cash and cash equivalents – closing balance	2.9	119,343	92,026

The above statement of cash flows should be read in conjunction with the accompanying notes.

Note 2.1: Funding for public health services

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Activity based funding	1,218,788	1,129,352
Other public health service revenue		
Non-activity based funding	221,566	218,371
Depreciation and amortisation funding	77,943	80,062
Total funding for public health services	1,518,297	1,427,785

Funding for public health services relate to the Service Agreement between the Department and Gold Coast Health. The adoption of AASB 15 *Revenue from Contracts with Customers* and AASB 1058 *Income of Not for Profit Entities* in 2019-20 did not change the timing of revenue recognition.

Accounting policy – revenue from contracts with customers

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
Activity based funding (ABF)	ABF funding is provided according to the type and number of services purchased by the Department, based on a Queensland price for each type of service. ABF funding is received for inpatients, critical care, sub and non acute, emergency department, mental health and outpatients. The funding from the Department is received in cash fortnightly in advance.	Revenue is recognised based on purchased activity once delivered or as otherwise agreed. Where actual activity exceeds purchased activity, additional funding is negotiated with the Department and accrued as a contract asset on the Statement of Financial Position where funding has been agreed based on performance obligations being met, but not yet received. Where targets are not met, funding is renegotiated with the Department and may result in a deferral or return of revenue recognised as a contract liability on the Statement of Financial Position.

Accounting policy – other public health service revenue

Non-activity based funding is received for other services Gold Coast Health has agreed to provide per the Service Agreement with the Department. This funding has specific conditions attached that are not related to activity covered by ABF. The funding from the Department is received in cash fortnightly in advance. Funding is recognised as received.

The service agreement between the Department and Gold Coast Health specifies that the Department funds Gold Coast Health's depreciation and amortisation charges via non-cash revenue drawn from equity. The Department retains the cash to fund future major capital replacements. This transaction is shown in the Statement of Changes in Equity as a non-appropriated equity withdrawal. The revenue is matched to depreciation expense.

Note 2.2: User charges and fees

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Hospital fees and related services/goods	33,036	36,002
Pharmaceutical benefits scheme	63,387	54,060
Private practice revenue	9,714	8,221
Other user charges and fees		
Property rental	2,086	2,079
Other goods and services	7,597	10,086
Total user charges and fees	115,820	110,448

Accounting policy – revenue from contracts with customers

Revenue from contracts with customers is recognised when Gold Coast Health transfers control over a good or service to the customer. The following table provides information about the nature and timing of the satisfaction of performance obligations, significant payment terms, and revenue recognition of Gold Coast Health's user charges that are contracts with customers.

The adoption of AASB 15 *Revenue from Contracts with Customers* in 2019-20 did not change the timing of revenue recognition.

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
Hospital fees and related services/goods	Hospital fees arise primarily from private patients and patients' ineligible for Medicare. Cash is collected on presentation where possible or invoiced on discharge.	Hospital fees are recognised as revenue when the services/goods have been provided to the customer. Where inpatients have not been discharged and therefore not invoiced, revenue is accrued on the Statement of Financial Position to the extent of services/goods provided. Revenue is recognised net of discounts provided in accordance with approved policies.
Pharmaceutical Benefits Scheme	Reflects recoveries under the Federal government's Pharmaceutical Benefits Scheme. Cash is received in arrears when a claim is lodged electronically of PBS eligible drugs dispensed from hospital pharmacies.	Revenue is recognised when received or accrued where a reliable estimate can be made for drugs dispensed under the scheme, but the cash has not yet been received.
Private practice revenue	Fees generated by billing private patient services performed by doctors with an assignment private practice arrangement, and service fees charged to doctors with a retention private practice arrangement.	These fees are recognised as revenue when service has been completed and the portion of revenue owing to Gold Coast Health can be calculated. See Note 5.5.

Accounting policy – Other user charges and fees

Property Rental revenue is recognised as income on a periodic straight-line basis over the lease term.

Other goods and services are provided such as hospital run canteens. Revenue from the sale of these goods and services are recognised on receipt or generation of an invoice.

Note 2.3: Grants and contributions

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Commonwealth grants and contributions	13,481	13,470
Other grants and contributions	2,508	2,371
Other grants and contributions		
Donations other	1,089	922
Donations non-current physical assets	1,880	358
Total grants and contributions	18,958	17,121

Grants, contributions and donations are non-reciprocal transactions where Gold Coast Health does not directly give approximately equal value to the grantor.

Where the grant agreement is enforceable and contains sufficiently specific performance obligations, the transaction is accounted for under AASB 15 *Revenue from Contracts with Customers*. In this case, revenue is initially deferred and recognised as or when the performance obligations are satisfied.

Otherwise, the grants and contributions are accounted for under AASB 1058 *Income of Not-for-Profit Entities*, whereby revenue is recognised upon receipt.

Accounting policy – revenue from contracts with customers

Various grants are received from state and commonwealth departments. Grant agreements specify the agreed performance obligations and price for the services to be provided. The funding is recognised progressively as the services are provided. A contract asset is recognised in the Statement of Financial Position where there is a delay in receipt, but the service has been performed.

Accounting policy – Other grants and contributions

Donations are recognised on receipt of the donated asset or when entitlement to receive the donated asset arises. Cash donations are banked into a trust fund. Further information on trust monies are disclosed in Note 5.4

Accounting policy – Services received below fair value

Contributions of 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. Gold Coast Health receives corporate services support from the Department for no cost. Corporate services received include payroll services and accounts payable services. An approximate value provided by the Department has been disclosed in Note 4.2.

Note 2.4: Other revenue

	2020 $'000	2019 $'000
Interest	142	244
Minor capital recoveries	3,070	8,878
Contractor recoveries	724	-
Other	2,533	2,516
Total other revenue	6,469	11,638

Refer note 2.5 for explanation of contractor recoveries.

Note 2.5: Employee Expenses and Health service employee expenses

Employee Expenses

	2020 $'000	2019 $'000
Employee benefits		
Wages and salaries	877,519	847,705
Annual leave levy/expense	109,054	103,105
Employer superannuation contributions	95,788	88,428
Long service leave levy/expense	21,736	18,020
Termination benefits	682	667
Employee related expenses		
Other employee-related expenses	8,434	8,395
Workers compensation premium	10,368	7,912
Payroll tax	1	2
Total employee expenses	1,123,582	1,074,234

Wages and salaries include $5.9m of $1,250 one-off, pro-rata payments for 4,443 full-time equivalent employees (announced in September 2019).

Health service employee expenses

	2020 $'000	2019 $'000
Health service employee expenses	42,200	-

Full-time equivalent (reflecting Minimum Obligatory Human Resource Information)

	As at 30 June 2020	As at 30 June 2019
Numbers of employees	422	8,262
Number of health service employees	8,360	-
Total full time equivalent	8,782	8,262

Legislative change

The *Hospital and Health Boards Act 2011* (HHB Act) was amended through the *Hospital and Health Boards (Changes to Prescribed Services) Amendment Regulation 2019.* This change removes a Hospital and Health Services (HHS) power to directly employ non-executive staff. The removal of this power revokes a HHS from being a prescribed employer under section 20(4). With the change in legislation a prescribed HHS effectively becomes a non-prescribed employer where employees are employed directly by the Director-General in the Department of Health and contracted to the HHS. This change took effect from the 15 June 2020. Payments made under the non-prescribed arrangement are classified as Health service employee expenses. Board, Executive, Senior Medical Officers (SMOs) and Visiting Medical Officers (VMOs) are disclosed as Employee Expenses.

Note 2.5: Employee Expenses and Health service employee expenses continued

Accounting policy – employee expenses

The Director-General, Department of Health, is responsible for setting terms and conditions for employment, including remuneration and classification structures, and for negotiating enterprise agreements.

Recoveries of salaries and wages costs for Gold Coast Health employees working for other agencies are offset against employee expenses.

Due to the legislative change explained above, the following accounting policies apply to all employees from 1 July 2019 to 14 June 2020 and to Board, Executive, SMOs and VMOs only from 15 June to 30 June 2020.

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

Sick Leave

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

Annual Leave, Long Service Leave and Other Leave
Gold Coast Health participates in the Queensland Government's Annual Leave Central Scheme and Long Service Leave Scheme. Under the Annual Leave Central Scheme and Long Service Leave Central Scheme, a levy is made on Gold Coast Health to cover the cost of employees' annual leave (including leave loading and on-costs) and long service leave. The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave and long service leave are claimed from the Schemes quarterly in arrears.

Superannuation
Employer superannuation contributions are paid to the employees' superannuation fund at rates prescribed by the government. Contributions are expensed in the period in which they are paid or payable. Gold Coast Health's obligation is limited to its contributions. The superannuation schemes have defined benefit and 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*.

Accounting policy – health service employee expenses

From the 15 June, all employees other than Board, Executive, SMOs an VMOs are deemed to be employees of the Department of Health. A payment is made to the Department to offset the costs of these expenses. Due to the timing of the adoption of this change, health service employee expenses at 30 June reflects an accrual for the period from 15 to 30 June 2020.

The Director-General, Department of Health, is responsible for setting terms and conditions for employment, including remuneration and classification structures, and for negotiating enterprise agreements.

Recoveries of salaries and wages costs for health service employees working for other agencies are recorded as revenue. Refer note 2.4 Other Revenue.

Note 2.6: Supplies and services

	2020 $'000	2019 $'000
Building services	1,884	1,845
Catering and domestic supplies	11,778	10,282
Clinical supplies and services	122,436	115,594
Communications	17,891	15,504
Computer services	17,333	19,864
Consultants	374	1,043
Contractors and external labour	18,405	22,122
Drugs	81,257	70,054
Expenses relating to capital works	3,478	6,144
Interstate patient expenses	49,240	49,246
Lease expenses	55	-
Motor vehicles	1,148	1,138
Outsourced service delivery	27,177	19,703
Property and fleet rental	5,085	5,205
Repairs and maintenance	29,412	28,245
Travel - patients	1,130	4,559
Travel - staff	1,050	1,202
Utilities	12,520	12,160
Other	5,434	9,881
Total supplies and services	407,087	393,791

Accounting policy – distinction between grants and procurement

For a transaction to be classified as supplies and services, the value of goods and services received by Gold Coast Health must be of approximately equal value to the value of the consideration exchanged for those goods or services. Where this is not the substance of the arrangement, the transaction is classified as a grant.

Lease expenses

Lease expenses disclosure for 2019-2020 has been amended to comply with the classification requirements of AASB 16 *Leases*. Refer to Note 2.14 for further details.

Note 2.7: Depreciation and amortisation

	2020 $'000	2019 $'000
Depreciation	77,741	79,328
Amortisation	202	734
Total depreciation and amortisation	77,943	80,062

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 any estimated residual value, progressively over its estimated useful life. Intangibles are also amortised on a straight-line basis.

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

Assets under construction (work-in-progress) are not depreciated until they are ready for use as intended by management.

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.

Where assets have separately identifiable components that are subject to regular replacement and these components have useful lives distinct from the asset to which they relate, they are separated into components and depreciated accordingly to the extent the impact on depreciation is material.

Note 2.7: Depreciation and amortisation continued

The estimated useful lives of assets are reviewed annually and where necessary, are adjusted to better reflect the pattern of future economic benefits. The useful lives could change significantly because of events such as the asset is technically obsolete, or non-strategic assets have been abandoned or sold.

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

Buildings	2.5% - 4.5%
Plant and equipment	
Computer hardware	10.0% - 20%
Engineering	8.3% - 10%
Medical equipment	6.70% - 20%
Office, furniture and fittings	6.70% - 16.7%
Vehicle	7.7% - 20%
Intangible assets	9.1% - 20%

Note 2.8: Other expenses

	2020 $'000	2019 $'000
Advertising	394	252
Ex-gratia payments	36	258
External audit fees	246	240
Insurance premiums (Queensland Government Insurance Fund)	14,460	13,227
Insurance - other	190	289
Internal audit fees	219	330
Interpreter fees	988	1,083
Inventory written off/(on)	(137)	495
Legal fees	850	1,297
Losses from the disposal of non-current assets	140	812
Other expenses	595	2,877
Total other expenses	17,981	21,160

Special payments

Ex-gratia payments are special payments that Gold Coast Health is not contractually or legally obligated to make to other parties and include payments to patients and staff for damaged or lost property. In compliance with the *Financial and Performance Management Standard 2019*, Gold Coast Health maintains a register setting out details of all special payments greater than $5,000. One patient related matter and one employee related matter exceeded the $5,000 threshold in 2019-2020.

External audit fees

Total audit fees quoted by the Queensland Audit Office relating to the 2019-2020 financial statements are $281,000 (2018-2019: $240,000). There are no non-audit services included in this amount.

Insurance (QGIF)

Gold Coast Health is covered by the Department's insurance policy with the Queensland Government Insurance Fund (QGIF). Gold Coast Health pays a fee to the Department as part of a fee-for-service arrangement.

Note 2.9: Cash and cash equivalents

	2020 $'000	2019 $'000
Cash on hand	25	24
Cash at bank	111,525	84,330
QTC Cash Fund	7,793	7,672
Total cash	119,343	92,026

For the purposes of the statement of financial position and the statement of cash flows, cash assets include all cash and cheques receipted but not banked at 30 June as well as deposits at call with financial institutions.

a) Restricted Cash

Gold Coast Health receives cash contributions from private practice arrangements (refer to Note 5.5) for education, study and research in clinical areas, and from external parties in the form of gifts, donations and bequests for stipulated purposes. This money is retained separately, and payments are only made from the General Trust Fund for the specific purposes upon which contributions were received. The value as at 30 June 2020 was $9.6m (2018-2019: $9.9m).

b) Effective Interest Rate

Cash deposited with the Queensland Treasury Corporation earns interest at a rate of 1.44% per annum (2018-2019: 2.55%). No interest is earned on Gold Coast Health bank accounts.

c) Reconciliation of surplus to net cash from operating activities

	2020 $'000	2019 $'000
(Deficit) for the year	(11,759)	(6,071)
Non-cash items included in operating result:		
Depreciation and amortisation expense	77,943	80,062
Depreciation and amortisation funding	(77,943)	(80,062)
Donated/Contributed assets received	(1,880)	(358)
Net losses on disposal of property, plant and equipment	140	814
Net gains on disposal of property plant and equipment	(69)	(85)
Change in operating assets and liabilities:		
Decrease in receivables	71	30,154
(Increase) in inventories	(1,434)	(1,236)
Decrease/(Increase) in other assets	1,489	(13,796)
Increase/(decrease) in payables	20,161	(10,123)
Increase in other employee benefits	6,224	4,442
Increase in other liabilities	17,378	8,765
Net cash from operating activities	30,321	12,506

Note 2.9: Cash and cash equivalents continued

d) Changes in liabilities arising from financing activities

There were no lease liabilities recorded on the balance sheet as at 30 June 2019. One lease met the definition of the accounting standard in 2019-20 but it was disposed of by 30 June 2020. Payments related to this lease totalled $0.15m.

e) Non-cash investing and financing activities

Assets and liabilities received or donated/transferred are recognised as revenues or expenses as applicable.

Note 2.10: Receivables

	2020 $'000	2019 $'000
Trade debtors	12,000	11,337
Less: Loss allowance	(3,913)	(3,084)
	8,087	8,253
GST receivable	1,982	1,850
GST payable	(182)	(135)
	1,800	1,715
Other receivables	10	-
Total receivables	9,897	9,968

Receivables comprise trade debtors and GST net receivables.

Accounting policy – trade debtors

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.

Loss Allowance
The loss allowance for trade debtors reflects lifetime expected credit losses. Economic changes impacting debtors and relevant industry data form part of the impairment assessment.

Where there is no reasonable expectation of recovering an amount owed by a debtor, the debt is written-off by directly reducing the receivable against the loss allowance. If the amount of debt written off exceeds the loss allowance, the excess is recognised as an impairment loss.

a) Impaired trade receivables

The maximum exposure to credit risk at balance date for receivables is the gross carrying amount of those assets. No collateral is held as security and there are no other credit enhancements relating to the receivables. Based on the materiality of the debtor balance, Gold Coast Health has considered the trade debtor balance in total when measuring expected credit losses.

Note 2.10: Receivables continued

The calculations reflect historical observed default rates calculated using credit losses experienced on past sales transactions. The historical default rates have not been adjusted for forward-looking information that may affect the future recovery of those receivables as there are no material adjustments expected based on reasonable judgement.

Set out below is the credit risk exposure on Gold Coast Health's trade debtors.

	2020			2019		
	Gross receivables	Loss Rate	Expected credit losses	Gross receivables	Loss Rate	Expected credit losses
	$'000	%	$'000	$'000	%	$'000
1-30 days	3,311	3%	(113)	3,115	4%	(112)
31-60 days	2,032	9%	(181)	2,438	13%	(317)
61-90 days	1,523	19%	(289)	1,533	19%	(293)
More than 90 days	5,134	65%	(3,330)	4,251	56%	(2,362)
Total	12,000		(3,913)	11,337		(3,084)

Movements in loss allowance for trade receivables:

	2020 $'000	2019 $'000
Loss allowance as at 1 July	3,084	3,036
Increase in allowance recognised in operating result	2,106	2,768
Amounts written off during the year	(1,277)	(2,720)
Loss allowance as at 30 June	3,913	3,084

Note 2.11: Inventories

	2020 $'000	2019 $'000
Pharmaceutical supplies	4,618	4,139
Less: Provision for impairment	(81)	(282)
Clinical and other supplies	7,221	6,467
Total inventories	11,758	10,324

Inventories consist mainly of pharmaceutical supplies and clinical supplies held in wards for use throughout the hospitals. Inventories are measured at cost adjusted for periodic assessments for obsolescence. Where damaged or expired items have been identified, provisions are made for impairment.

Consignment stock is held but is not recognised as inventory as it remains the property of the supplier until consumption. Upon consumption, it is expensed as clinical supplies.

Note 2.12: Other assets

	2020 $'000	2019 $'000
Contract assets		
Funding for public health services	5,863	4,499
User charges and fees	5,691	9,374
Other assets		
Prepayments	3,765	2,629
Total other assets	15,319	16,502

Accounting Policy – contract asset

Contract assets arise from contracts with customers and are transferred to receivables when Gold Coast Health's right to payment becomes unconditional. In the case of public health service funding, this usually occurs when the service agreement is signed by both parties to the agreement. In the case of user charges and fees this usually occurs when an invoice is issued to a customer.

Comparatives have been moved for disclosure purposes and were previously recognised in the receivables note.

Note 2.13: Property, plant and equipment

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

Category	Threshold
Buildings	$10,000
Land	$1
Plant and equipment	$5,000

Property, plant and equipment are initially recorded at consideration plus any other costs directly incurred in ensuring the asset is ready for use.

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*.

Note 2.13: Property, plant and equipment continued

a) Closing Balances and reconciliation of carrying amount

30 June 2020

	Land (fair value)	Buildings (fair value)	Plant and Equipment (cost)	Work-in-Progress (cost)	**Total**
	$'000	$'000	$'000	$'000	**$'000**
Gross	95,644	2,010,157	195,087	2,803	**2,303,691**
Less accumulated depreciation	-	(501,463)	(124,374)	-	**(625,837)**
Carrying amount as at 30 June 2020	95,644	1,508,694	70,713	2,803	1,677,854
Represented by movements in carrying amount:					
Carrying amount at 1 July 2019	94,423	1,526,183	75,289	9,846	**1,705,741**
Acquisitions	-	-	10,342	4,077	**14,419**
Disposals	-	-	(144)	-	**(144)**
Net revaluation increments/(decrements)	1,221	29,311	-	-	**30,532**
Donations/Contributed assets received	-	-	1,880	-	**1,880**
Net transfers from the Department/Other HHS	-	3,246	(79)	-	**3,167**
Transfers from Work-in-Progress	-	10,950	170	(11,120)	**-**
Depreciation expense	-	(60,996)	(16,745)	-	**(77,741)**
Carrying amount at 30 June 2020	95,644	1,508,694	70,713	2,803	**1,677,854**

30 June 2019

	Land (fair value)	Buildings (fair value)	Plant and Equipment (cost)	Work-in-Progress (cost)	**Total**
	$'000	$'000	$'000	$'000	**$'000**
Gross	94,423	1,956,826	189,519	9,846	**2,186,163**
Less accumulated depreciation	-	(430,643)	(114,230)	-	**(544,873)**
Carrying amount as at 30 June 2019	94,423	1,526,183	75,289	9,846	**1,705,741**
Represented by movements in carrying amount:					
Carrying amount at 30 June 2018	89,416	1,546,546	85,046	2,968	**1,723,976**
Acquisitions	-	-	9,553	9,438	**18,991**
Disposals	-	-	(865)	-	**(865)**
Net revaluation increments/(decrements)	(900)	37,556	-	-	**36,656**
Donations received/made	-	-	358	-	**358**
Net transfers from the Department/Other HHS	5,907	-	46	-	**5,953**
Transfers between asset classes	-	313	(313)	-	**-**
Transfers from Work-in-Progress	-	1,360	1,200	(2,560)	**-**
Depreciation expense	-	(59,592)	(19,736)	-	**(79,328)**
Carrying amount at 30 June 2019	94,423	1,526,183	75,289	9,846	**1,705,741**

Note 2.13: Property, plant and equipment continued

b) Valuations of land and buildings

Land and buildings are measured at fair value in accordance with AASB 116 *Property, Plant and Equipment*, AASB 13 *Fair Value Measurement* as well as Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector.

The cost of items acquired during the financial year has been judged by management to materially represent their fair value at the end of the reporting period.

Property, plant and equipment classes measured at fair value are revalued on an annual basis either by appraisals undertaken by an independent professional valuer, or by the use of appropriate and relevant indices.

Gold Coast Health engage external valuers to determine fair value through either comprehensive revaluations and/or the indexation of the assets not subject to comprehensive revaluations. Comprehensive revaluations are undertaken at least once every five years. However, if a particular asset class experiences significant volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practicable, regardless of the timing of the last specific appraisal.

The fair values reported by the department are based on appropriate valuation techniques that maximise the use of available and relevant observable inputs and minimise the use of unobservable inputs. Materiality is considered in determining whether the difference between the carrying amount and the fair value of an asset is material (in which case revaluation is warranted).

Where indices are used, these are either publicly available, or are derived from market information available to the valuer. The valuer provides assurance of their robustness, validity and appropriateness for application to the relevant assets. Indices used are also tested for reasonableness by applying the indices to a sample of assets, comparing the results to similar assets that have been comprehensively valued by the valuer, and analysing the trend of changes in values over time.

At 30 June 2020 the COVID-19 pandemic has not materially altered valuations of land and buildings.

Land

The State Valuation Service provided an index for land in 2019-2020. The indexation for land is 1 except for three properties at Robina due to market movements in that region. The land indexation is based on market conditions for commercial property on the Gold Coast.

Previously, the State Valuation Service performed a comprehensive valuation of all land holdings, with an effective valuation date of 30 June 2017. The valuation was based on a market approach. Key inputs into the valuation include publicly available data on sales of similar land in nearby localities in the 12 months prior to the date of revaluation. Adjustments were made to the sales data to take into account the location, size, street/road frontage and access, and any significant restrictions for each individual parcel of land.

Buildings

AECOM Australia Pty Ltd provided an index for buildings in 2019-2020. The indexation for buildings was 2% based on cost escalations evidenced in the market.

Previously, AECOM Australia Pty Ltd performed a comprehensive valuation of all buildings measured on a current replacement cost basis (effective valuation date of 30 June 2017), except one building held at market value which was not revalued due to immateriality in 2016-2017. Key inputs into the valuation on replacement cost basis included internal records of the original cost of the specialised fit out and more contemporary design/construction costs published for various standard components of buildings. Significant judgement was also used to assess the remaining service potential of the buildings given local environmental conditions and the records of the current condition of the building.

The asset revaluation surplus in the statement of financial position as at 30 June 2020 ($183.4m) relates to land ($2.9m) and building ($180.5m) revaluation increments. (2018-2019: $152.8m including $1.6m land and $151m building revaluation increments).

Note 2.13: Property, plant and equipment continued

Revaluation increment reconciliation:

	2020 $'000	2019 $'000
Recognised in operating result:		
Land revaluation increment	-	-
Building revaluation increment	-	-
Total net revaluation increment in operating result	-	-
Recognised in other comprehensive income:		
Net land revaluation increment/(decrement)	1,221	(900)
Net building revaluation increment	29,311	37,556
Net revaluation increment in other comprehensive income	30,532	36,656
Total net revaluation increment	30,532	36,656

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, for assets valued using a cost valuation approach, 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. On revaluation, for assets valued using a market approach, accumulated depreciation is eliminated against the gross amount of the asset prior to restating for valuation.

c) Fair value hierarchy classification

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

Observable inputs are publicly available data that are relevant to the characteristics of the assets/liabilities being valued. Examples for Gold Coast Health include, but are not limited to, published sales data for land and general buildings.

Unobservable inputs are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Significant unobservable inputs used include, but are not limited to, subjective adjustments made to observable data to take account of the characteristics of the assets/liabilities, internal records of recent construction costs (and/or estimates of such costs), assets' characteristics/functionality, and assessments of physical condition and remaining useful life. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

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

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the following fair value hierarchy, based on the data and assumptions used in the most recent specific appraisals:

- Level 1: represents fair value measurements that reflect unadjusted quoted market prices in active markets for identical assets and liabilities;
- Level 2: represents fair value measurements that are substantially derived from inputs (other than quoted prices included within level 1) that are observable, either directly or indirectly; and
- Level 3: represents fair value measurements that are substantially derived from unobservable inputs.

Note 2.13: Property, plant and equipment continued

Land and buildings valued with reference to an active market is classified as Level 2. Purpose-built hospital and health service buildings valued without reference to an active market are valued using the replacement cost methodology and classified as Level 3.

2020	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Assets				
Land		95,644		95,644
Buildings		4,788	1,503,906	1,508,694
Total assets		100,432	1,503,906	1,604,338

2019	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Assets				
Land	-	94,423	-	94,423
Buildings	-	5,005	1,521,178	1,526,183
Total assets	-	99,428	1,521,178	1,620,606

The movements associated with Level 3 assets are shown below:

	2020 $'000	**2019 $'000**
Balance at 1 July	1,521,178	1,544,684
Transfers out of Level 3 into Level 2	-	(3,201)
Disposals	-	-
Revaluation increments	29,217	36,888
Transfers from Work-in-Progress	10,950	1,360
Transfers in	3,246	313
Depreciation	(60,685)	(58,866)
Balance at 30 June	1,503,906	1,521,178

Note 2.14: Leases

A new accounting standing AASB 16 *Leases* came into effect in 2019-20 Gold Coast Health has assessed all rental agreements and determined that none meet the classification requirements under AASB 16 *Leases* as at 30 June 2020.

Gold Coast Health measures right-of-use assets at cost subsequent to initial recognition. Gold Coast Health has elected not to recognise right-of-use assets and lease liabilities arising from short-term leases and leases of low value assets. The lease payments are recognised as expenses on a straight-line basis over the lease term. An asset is considered low value where it is expected to cost less than $10,000 when new.

One asset met the classification requirements during the year, but the lease was disposed of prior to 30 June 2020.

(i) Property and fleet rentals

The Department of Housing and Public Works (DHPW) provides Gold Coast Health with access to accommodation and fleet vehicles under government-wide frameworks. This includes the Varsity Lakes Day Hospital. These arrangements are categorised as procurement of services rather than as leases because DHPW has substantive substitution rights over the assets. They are called property and fleet rental and are disclosed in the supplies and services note 2.6.

(ii) Amounts recognised in profit or loss

Lease expenses in 2019-20 amounted to $0.05m and related to one lease that was disposed of in the financial year.

(iii) Total cash outflow for leases

Lease payments in 2019-20 amounted to $0.15m and related to one lease that was disposed of in the financial year.

2018-19 disclosures under AASB 117

Non-cancellable operating leases

	2019 $'000
Operating lease commitments at 30 June 2019	
Within one year	4,906
One to five years	5,239
Total commitment	10,145

$9.3m of the commitment related to property and fleet rentals that are not leases under the new accounting standard. Refer to section (i) above. The remaining lease was disposed of in the financial year.

Note 2.14: Leases continued

Leases as lessor

Gold Coast Health recognises lease payments from operating leases as income on a straight-line basis over the lease term.

Gold Coast Health sub-leases space for clinical and retail purposes. Lease income from operating leases is reported as 'Property Rental' in Note 2.2. No amounts were recognised in respect of variable lease payments other than CPI-based or market rent reviews.

The following table sets out a maturity analysis of future undiscounted lease payments receivable under operating leases.

Lessor commitments

	2020 $'000
Less than one year	1,744
One to two years	1,728
Two to three years	1,596
Three to four years	30
Four to five years	-
More than five years	-
Total	5,098

2018-19 disclosures under AASB 117

	2019 $'000
Within one year	1,867
One to five years	5,937
Total commitment	7,804

Note 2.15: Payables

	2020 $'000	2019 $'000
Trade and other payables	16,546	15,235
Payables to the Department	18,101	2,570
Accrued expenses	30,564	27,245
Total payables	65,211	45,050

Trade creditors are recognised on 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.

Payables to the Department represent amounts owing for supplies and services provided by the Department but not yet settled. Funding related payables are disclosed under other liabilities at note 2.17.

Note 2.16: Accrued employee and health service employee benefits

	2020 $'000	2019 $'000
Accrued employee benefits		
Wages and salaries payable	7,560	33,022
Superannuation payable	699	4,137
Other leave	-	7,076
Total accrued employee benefits	8,259	44,235
Health service employee benefits	42,200	-
Total accrued employee and health service employee benefits	50,459	44,235

Accounting policy – accrued employee benefits

No provision for annual leave or long service leave is recognised 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*.

Other leave relates to Rostered Days Off, Nurses Professional Development and Purchased leave entitlements. These liabilities are expected to be settled wholly within 12 months after the end of the period in which the employees render the related service. They are measured at the amounts expected to be paid when the liabilities are settled and recognised at undiscounted values.

Accounting policy – accrued health service employee benefits

With the change to the prescribed employer arrangements as detailed in Note 2.5, this balance represents the accrual for the period from the date of the legislative change to 30 June 2020.

Other leave relating to accrued health service employees has been transferred back to the Department of Health as employer.

Note 2.17: Other liabilities

	2020 $'000	2019 $'000
Contract liabilities		
Funding for public health services deferred	15,800	7,028
User charges and fees	194	876
Non-contract liabilities		
Funding for public health services to be returned	12,690	3,402
Total other liabilities	28,684	11,306

Funding for public health services deferred is an amount of funding received under the Service Agreement with the Department where the agreed activity or service could not be completed by the end of the financial year and agreement has been reached to defer the revenue to the next financial year when the services will be delivered.

Funding for public health services to be returned reflects the portion of the funding received under the service agreement to be repaid to the Department of Health in the next financial year.

Section 3: Budgetary Reporting Disclosures

Budget vs Actual Comparison

This section provides an explanation for major variances between the original budget and actual performance for 2019-2020.

The original budget is the budget in the Queensland Health Service Delivery Statement which was published prior to the completion of negotiations on the service agreement with the Department of Health.

Statement of comprehensive income

	Note	Original Budget $'000	Actual $'000	Variance $'000
Revenue				
Funding for public health services		1,460,291	1,518,297	58,006
User charges and fees	3.1	96,941	115,820	18,879
Grants and other contributions		15,258	18,958	3,700
Other revenue		2,183	6,469	4,286
Total revenue		1,574,673	1,659,544	84,871
Gain on disposal/revaluation of assets		-	69	69
Total income		1,574,673	1,659,613	84,940
Expenses				
Employee expenses		(1,107,677)	(1,123,582)	(15,905)
Health service employee expenses		-	(42,200)	(42,200)
Supplies and services	3.2	(367,699)	(407,087)	(39,388)
Grants and subsidies		(1,323)	-	1,323
Depreciation and amortisation		(80,739)	(77,943)	2,796
Impairment loss		(1,185)	(2,579)	(1,394)
Other expenses		(16,050)	(17,981)	(1,931)
Total expenses		(1,574,673)	(1,671,372)	(96,699)
Operating result for the financial year		-	(11,759)	(11,759)
Other comprehensive income for the year				
Items that will not be reclassified subsequently to operating result:				
- Increase in asset revaluation surplus		-	30,532	30,532
Total other comprehensive income		-	30,532	30,532
Total comprehensive income for the year		-	18,773	18,773

Budget vs Actual Comparison (continued)

Statement of financial position

	Note	Original Budget $'000	Actual $'000	Variance $'000
Assets				
Current assets				
Cash and cash equivalents	3.3	77,686	119,343	41,657
Receivables	3.4	43,623	9,897	(33,726)
Inventories	3.5	9,266	11,758	2,492
Other assets	3.6	3,240	15,319	12,079
Total current assets		133,815	156,317	22,502
Non-current assets				
Property, plant and equipment		1,680,014	1,677,854	(2,160)
Intangibles		34	152	118
Total non-current assets		1,680,048	1,678,006	(2,042)
Total assets		1,813,863	1,834,323	20,460
Liabilities				
Current liabilities				
Payables		60,402	65,211	4,809
Accrued employee and health service employee benefits		46,633	50,459	3,826
Other liabilities	3.7	2,541	28,684	26,143
Total current liabilities		109,576	144,354	34,778
Total liabilities		109,576	144,354	34,778
Net assets		1,704,287	1,689,969	(14,318)
Equity				
Contributed equity		1,499,447	1,500,417	970
Accumulated surplus		17,975	6,145	(11,830)
Asset revaluation surplus		186,865	183,407	(3,458)
Total equity		1,704,287	1,689,969	(14,318)

Budget vs Actual Comparison (continued)

Statement of cash flows

	Note	Original Budget $'000	Actual $'000	Variance $'000
Cash flows from operating activities				
Funding for public health services		1,379,552	1,457,358	77,806
User charges and fees	3.1	95,640	114,132	18,492
Grants and contributions		15,258	17,079	1,821
GST collected from customers	3.9	-	1,825	1,825
GST input tax credits from Australian Taxation Office	3.9	8,050	19,262	11,212
Other operating cash inflows		2,183	8,555	6,372
Employee expenses		(1,100,853)	(1,141,488)	(40,635)
Supplies and services	3.2	(365,667)	(407,390)	(41,723)
Grants and subsidies		(1,323)	-	1,323
GST paid to suppliers	3.9	(8,055)	(19,394)	(11,339)
GST remitted to Australian Taxation Office	3.9	-	(1,777)	(1,777)
Other operating cash outflows		(16,050)	(17,841)	(1,791)
Net cash from operating activities		8,735	30,321	21,641
Cash flows from investing activities				
Payments for property, plant and equipment	3.8	(11,515)	(14,419)	(2,904)
Proceeds from sale of property, plant and equipment		(85)	73	158
Net cash used in investing activities		(11,600)	(14,346)	(2,746)
Cash flows from financing activities				
Equity injections		11,515	11,492	(23)
Lease payments		-	(150)	(150)
Net cash from financing activities		11,515	11,342	(173)
Net increase in cash and cash equivalents		8,650	27,317	18,667
Cash and cash equivalents at the beginning of the financial year		69,036	92,026	22,990
Cash and cash equivalents at the end of the financial year		77,686	119,343	41,657

Budget vs Actual Comparison (continued)

Explanations of major variances

3.1. User charges and fees variance

User charges revenue is higher than budget by $18.9m. This is due to additional revenue from chargeable services of which $4.1m related to higher volume of patient fees and $12.1m related to higher volume of PBS charges due to increased patient activity levels. These factors caused the corresponding increase in the statement of cash flows of $18.5m.

3.2. Supplies and services variance

Supplies and services is $39.4m higher than original budget. Contributing to the variance is additional funding received during the year that was not reflected in the original budget to fund outsourced service delivery ($6.9m) and PBS drugs ($10.3m). Other factors contributing to the variance are increased use of external contractors (mainly nursing staff) ($15.9m) and increased repairs and maintenance costs ($6.9m) to meet service demand. This also caused the corresponding increase in statement of cash flows of $41.3m.

3.3. Cash and cash equivalents variance

The cash balance fluctuates due to the timing of receivables and payables. Refer to cash flow notes for more information.

3.4 Receivables variance

Receivables is lower than budget by $33.7m. $11.5m is due to the reclassification of contract asset accruals from receivables to other assets. The remaining balance of $22.2m is due to differences in the assumed impact of timing of payments from customers at the time of preparing the budget.

3.5 Inventories variance

Inventories is higher than budget by $2.5m. This is predominantly due to increased holdings arising from COVID-19 protective equipment requirements.

3.6 Other assets variance

The other assets balance is higher than budget by $12.1m. This is predominantly due to the reclassification of contract asset accruals from receivables to other assets.

3.7. Other liabilities variance

The other liabilities balance is higher than budget by $26.1m. This is due to the reclassification of final amendments to funding in the Service Agreement with the Department from payables to other liabilities.

3.8. Payments for property plant and equipment variance

Payments for property, plant and equipment ($14.4m) predominantly reflects the expenditure of the equity injection funding of $11.5m. The equity injection includes funding to purchase equipment under the Health Technology Equipment Replacement program ($6.2m). Payments can vary from budget due to the timing of reimbursements from the Department.

3.9. GST variance

Per Queensland Treasury Financial Reporting Requirements, GST inflows and outflows are reported separately in the financial statements. The net impact of the GST in the cash flow is only $0.08m and reflects the GST value on actual transactions.

Section 4: Key Management Personnel and Related Parties

4.1 Key Management Personnel

The following details for key management personnel include those positions that had the authority and responsibility for planning, directing and controlling the major activities of the Gold Coast Health.

Minister

The responsible minister is identified as part of Gold Coast Health Key Management Personnel. The Honourable Dr Steven Miles was appointed the Minister for Health and the Minister for Ambulance Services on 12 December 2017 and the Deputy Premier on 10 May 2020. No associated remuneration figures will be disclosed for the Minister, as Gold Coast Health does not provide the Minister's remuneration.

Board

The Board members of Gold Coast Health as at 30 June 2020 and their positions are outlined below.

Name and position of current incumbents	Appointment authority	Appointment date
Board Chair – Mr Ian Langdon	Section 25(1)(a), HHB Act	01/07/2012 (Reappointed 18/05/2020)
Board Member – Professor Judy Searle	Section 23, HHB Act	18/05/2016 (Reappointed 17/05/2017)
Board Member – Mr Robert Buker	Section 23, HHB Act	18/05/2016 (Reappointed 17/05/2017)
Board Member – Professor Helen Chenery	Section 23, HHB Act	18/05/2016 (Reappointed 17/05/2017)
Board Member – Dr Cherrell Hirst	Section 23, HHB Act	17/05/2014 (Reappointed 18/05/2018)
Board Member – Ms Colette McCool	Section 23, HHB Act	01/07/2012 (Reappointed 18/05/2018)
Board Member – Dr Andrew Weissenberger	Section 23, HHB Act	01/09/2012 (Reappointed 18/05/2018)
Board Member – Ms Teresa Dyson	Section 23, HHB Act	18/05/2016 (Reappointed 18/05/2019)
Board Member – Michael Kinnane	Section 23, HHB Act	18/05/2018 (Reappointed 18/05/2019)
Board Member – Professor Cindy Shannon	Section 23, HHB Act	18/05/2020

Further information about these positions can be found in the body of the Annual Report under the section relating to Executive Management.

4.1 Key Management Personnel continued

Executives

The Key Management Personnel – Executive level includes those positions that have responsibility for planning, directing and controlling the agency as a whole. Each member holds responsibility for their division's financial, operational and clinical (if applicable) performance as reflected in the position title in table below

Name and position of current incumbents	Contract classification and appointment authority	Appointment date
Chief Executive – Mr Ron Calvert	SESL Contract - Section 33, HHB Act.	01/10/2012 (reappointed 16/09/2019)
Chief Operations Officer – Ms Kimberley Pierce	HES3 Contract - Section 67, HHB Act.	15/08/2016
Chief Finance Officer – Mr Ian Moody	HES3 Contract - Section 67, HHB Act.	04/12/2013 (reappointed 04/12/2016)
Executive Director, Clinical Governance, Education and Research – Dr Jeremy Wellwood	Medical Officer (Queensland Health) Certified Agreement (No. 5) 2019	06/08/2018
Executive Director, Digital Transformation and Chief Information Officer – Mr Mark Luchs	HES2 Contract - Section 67, HHB Act.	23/09/2019
Executive Director, People and Corporate Services – Ms Hannah Bloch	HES3 Contract - Section 67, HHB Act.	19/09/2016 (reappointed 20/12/2019)
Executive Director, Strategic Planning and Assets – Ms Toni Peggrem	HES3 Contract - Section 67, HHB Act.	29/09/2014
Executive Director, Strategic Communication and Engagement – Ms Sarah Dixon	HES2 Contract – Section 67, HHB Act	06/08/2018
Executive Director, Governance, Risk and Commercial Services – Not currently filled	HES2 Contract - Section 67, HHB Act.	vacant

Remuneration

Remuneration policy for the Gold Coast Health Board are approved by the Governor in Council and the Chair, Deputy Chair and members are paid an annual fee consistent with the government procedures titled 'Remuneration procedures for part-time chairs and members of Queensland Government bodies.

Remuneration policy for Gold Coast Health Executive is set by the Director-General of the Department as provided for under the HHB Act. The remuneration and other terms of employment are specified in employment contracts. Remuneration expenses for key management personnel comprise the following components:

- Short term employee expenses including salaries, allowances and leave entitlements earned and expensed for the entire year or for that part of the year during which the employee occupied the specified position. Non-monetary benefits consist 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 entitlements earned.
- Post-employment benefits include amounts expensed in respect of employer superannuation obligations.
- Termination benefits 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.

4.1 Key Management Personnel continued

2020

	Short-term employee expenses		Post-employment expenses	Long-term employee expenses	Termination benefits	Total Expenses
	Monetary	Non-monetary				
	$'000	$'000	$'000	$'000	$'000	$'000
Board						
Board Chair – Mr Ian Langdon	102	-	8	-	-	110
Board Member – Professor Judy Searle	52	-	5	-	-	57
Board Member – Mr Robert Buker	52	-	5	-	-	57
Board Member – Professor Helen Chenery	47	-	4	-	-	51
Board Member – Dr Cherrell Hirst	55	-	5	-	-	60
Board Member – Ms Colette McCool	51	-	5	-	-	56
Board Member – Dr Andrew Weissenberger	51	-	5	-	-	56
Board Member – Ms Teresa Dyson	51	-	5	-	-	56
Board Member – Michael Kinnane	54	-	5	-	-	59
Board Member – Professor Cindy Shannon	5	-	1	-	-	6
Executive						
Chief Executive – Mr Ron Calvert	408	23	34	9	-	474
Chief Operations Officer – Kimberley Pierce	235	-	24	5	-	264
Chief Finance Officer – Mr Ian Moody	258	-	26	5	-	289
Executive Director, Clinical Governance, Education and Research – Dr Jeremy Wellwood	480	-	36	10	-	526
Executive Director, Robina Hospital, Digital Transformation Service and Chief Information Officer – Mr Damian Green (end date 22/09/2019)	49	-	4	1	-	54
Executive Director, Digital Transformation and Chief Information Officer – Mark Luchs (start date 23/09/2019)	159	-	15	3	-	177
Executive Director, People and Corporate Services – Ms Hannah Bloch	228	-	23	5	-	256
Executive Director, Strategic Planning and Assets – Ms Toni Peggrem	222	-	22	5	-	249
Executive Director, Strategic Communication and Engagement – Ms Sarah Dixon	208	-	21	4	-	233

4.1 Key Management Personnel continued

2019

	Short-term employee expenses		Post-employment expenses	Long-term employee expenses	Termination benefits	Total Expenses
	Monetary	Non-monetary				
	$'000	$'000	$'000	$'000	$'000	$'000
Board						
Board Chair – Mr Ian Langdon	103	-	9	-	-	112
Deputy Board Chair – Ms Teresa Dyson	51	-	5	-	-	56
Board Member – Ms Colette McCool	50	-	5	-	-	55
Board Member – Dr Andrew Weissenberger	50	-	5	-	-	55
Board Member – Dr Cherrell Hirst	51	-	5	-	-	56
Board Member – Mr Robert Buker	51	-	5	-	-	56
Board Member – Professor Helen Chenery	50	-	5	-	-	55
Board Member – Professor Judy Searle	51	-	5	-	-	56
Board Member – Michael Kinnane	50	-	5	-	-	55
Executive						
Chief Executive – Mr Ron Calvert	406	17	33	8	-	464
Chief Operations Officer – Kimberley Pierce	235	-	24	5	-	264
Chief Finance Officer – Mr Ian Moody	245	-	25	5	-	275
Executive Director, Clinical Governance, Education and Research – Dr Jeremy Wellwood (from 06/08/2018)	425	-	32	8	-	465
Executive Director, Clinical Governance, Education and Research – Professor Marianne Vonau (end date 05/08/2018)	36	-	2	1	-	39
Executive Director, Robina Hospital, Digital Transformation Service and Chief Information Officer – Mr Damian Green	231	-	17	4	-	252
Executive Director, People and Corporate Services – Ms Hannah Bloch	206	-	21	4	-	231
Executive Director, Strategic Planning and Assets – Ms Toni Peggrem	201	-	20	4	-	225
Executive Director, Strategic Communication and Engagement – Ms Sarah Dixon	183	-	19	4	-	206
Executive Director, Governance Risk and Commercial Services – Ms Rebecca Freath (end date 10/05/2019)	182	-	17	3	-	202

4.2 Related Parties

Transactions with other Queensland Government-controlled entities

Gold Coast Health is controlled by its ultimate parent entity, the State of Queensland. All State of Queensland controlled entities meet the definition of a related party in AASB 124 *Related Party Disclosures.*

The following table summarises significant transactions with Queensland Government controlled entities:

Entity	Note	For the year ending 30 June 2020		At 30 June 2020	
		Revenue $'000	Expenditure $'000	Asset $'000	Liability $'000
Department of Health	(a)	1,531,110	84,652	5,738	101,644
Queensland Treasury Corporation	(b)	121	12	7.793	-
Department of Housing and Public Works	(c)	-	5,085	-	235
Other Hospital and Health Services	(d)	2,653	2,029	2	193
Gold Coast Hospital Foundation	(e)	161	-	161	-

Entity	Note	For the year ending 30 June 2019		At 30 June 2019	
		Revenue $'000	Expenditure $'000	Asset $'000	Liability $'000
Department of Health	(a)	1,427,784	82,475	5,491	20,766
Queensland Treasury Corporation	(b)	204	11	7,672	-
Department of Housing and Public Works	(c)	-	5,205	-	107
Other Hospital and Health Services	(d)	2,547	1,740	347	140
Gold Coast Hospital Foundation	(e)	285	-	285	-

(a) Department of Health
Gold Coast Health receives funding in accordance with a service agreement with the Department. The Department receives its revenue from the Queensland Government (majority of funding) and the Commonwealth. The signed service agreements are published on the Queensland Government website and publicly available.

The Department of Health provides support services on a fee basis such as ambulance, pathology, linen, medical equipment maintenance, information technology, communications, procurement and insurance.

In addition to the expenditure disclosed above, the Department provides several services free of charge including accounts payable, payroll and other support services. The Department has estimated the value of these services to be $12.5m (2019: $11.6m).

The increase in the liability from the prior year is due to the end of month payroll accrual of $42.2m and funding deferrals and payables of $28.5m.

(b) Queensland Treasury Corporation
Gold Coast Health has accounts with the Queensland Treasury Corporation (QTC) for general trust monies and receive interest and incur bank fees on these bank accounts.

(c) Department of Housing and Public Works
Gold Coast Health pays rent to the Department of Housing and Public Works (DHPW) for a number of clinical and non-clinical properties. In addition, the Department of Housing and Public Works provides fleet management services (Qfleet) to Gold Coast Health.

(d) Other Hospital and Health Service entities
Payments to and receipts from other Hospital and Health service entities in Queensland occur to facilitate the transfer of patients, drugs, staff and other services shared.

4.2 Related Parties continued

(e) Gold Coast Hospital Foundation
Gold Coast Hospital Foundation provides free equipment, resources and services to Gold Coast Health in accordance with their objectives identified in the *Hospitals Foundations Act 2018 (Qld)*. Where quantifiable, the value of these resources is disclosed above. The Foundation leases space in the foyer of Gold Coast University Hospital for a nominal value.

Transactions with people/entities related to Key Management Personnel

All transactions between Gold Coast Health and key management personnel, including their related parties were on normal commercial terms and conditions and were immaterial in nature.

Section 5: Other Financial Information

5.1 Financial Instruments

a) Recognition

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

b) Classification

Financial instruments are classified and measured as follows:

- Cash and cash equivalents - held at amortised cost
- Receivables - held at amortised cost
- Payables - held at amortised cost

Gold Coast Health does not enter into derivative and other financial instrument transactions for speculative purposes nor for hedging. Apart from cash and cash equivalents, Gold Coast Health holds no financial assets classified at fair value through profit and loss.

c) Risks

Gold Coast Health's activities expose it to a variety of financial risks – interest risk, credit risk and liquidity risk.

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

The carrying amounts of cash, trade and other receivables and trade and other payables are assumed to approximate their fair values as disclosed on the Statement of Financial Position due to their short-term nature.

Interest Risk
Gold Coast Health is exposed to interest rate risk through its cash deposited in interest bearing accounts. Changes in interest rates have had a minimal impact on the operating result.

Credit risk
Credit risk exposure refers to the situation where Gold Coast Health may incur financial loss because of another party to a financial instrument failing to discharge their obligation.

The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowances for impairment. As such, the gross carrying amount of cash and cash equivalents as well as receivables represents the maximum exposure to credit risk.

See Note 2.10 for further information on impairment of receivables.

Liquidity risk
Liquidity risk refers to the situation where Gold Coast Health may encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

Gold Coast Health is exposed to liquidity risk in respect of its payables. Exposure to liquidity risk is reduced by ensuring that sufficient funds are available to meet employee and supplier obligations as they fall due. This is achieved by ensuring that minimum levels of cash are held within the various bank accounts to match the expected incidence and duration of the various employee and supplier liabilities.

Gold Coast Health has an approved overdraft facility of $21m under whole-of-Government banking arrangements to manage any unexpected short-term cash shortfalls. This facility has not been drawn down as at 30 June 2020.

Gold Coast Health's trade and other payables are expected to be settled within 30-60 days.

5.2 Contingent liabilities

The following cases were filed in the courts naming the State of Queensland acting through Gold Coast Health as the defendant:

	2020 $'000	2019 $'000
Supreme Court	6	7
District Court	4	3
Magistrates Court	-	1
Tribunals, commissions and boards	-	-
Total cases	10	11

It is not possible to make a reliable estimate of the final amount payable, if any, in respect of litigations before the courts at this time. Any amount payable would be covered by the Queensland Government Insurance Fund (QGIF). Gold Coast Health's maximum exposure under the QGIF policy is an excess of $20,000 for each insurable event. Tribunals, commissions and boards include matters that may never be litigated or result in payments to claims.

5.3 Commitments

There were no non-cancellable capital commitments as at 30 June 2020. Lease related commitments are disclosed in note 2.14.

5.4 Trust transactions and balances

Gold Coast Health manages patient trust accounts transactions (fiduciary funds) as trustee. As Gold Coast Health acts only in a custodial role in respect of these transactions and balances, they are not recognised in the financial statements. Trust activities are included in the annual audit performed by the Auditor-General of Queensland.

Patient trust receipts and payments

	2020 $'000	2019 $'000
Receipts		
Amounts receipted on behalf of patients	248	174
Payments		
Amounts paid to or on behalf of patients	240	176
Assets		
Cash held and bank deposits on behalf of patients	24	16

5.5 Granted private practice arrangements

Gold Coast Health administers the Private Practice arrangements. As Gold Coast Health 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 scheme must be deposited initially into the private practice bank accounts and later distributed in accordance with the policy governing the private practice scheme. Private Practice funds are not controlled but the activities are included in the annual audit performed by the Auditor-General.

Payments to Gold Coast Health indicated below relate to revenue that has been recognised by Gold Coast Health.

	2020 $'000	2019 $'000
Receipts		
Private practice revenue	17,098	14,029
Private practice interest revenue	17	35
Total receipts	17,115	14,064
Payments		
Payments to private practice doctors under retention arrangements	5,369	4,502
Payments to Gold Coast Health for service fees	8,295	7,028
Payments to Gold Coast Health for assignment arrangements	1,784	2,512
Payments to Gold Coast Health Private Practice Trust Fund*	1,193	1,056
Total payments	16,641	15,098
Assets		
Cash held and bank deposits for private practice	1,269	795

The cash balance above represents timing differences between cash receipts and payments in relation to the private practice arrangements.

* Private Practice Trust funds are generated by doctors reaching the ceiling allowable under the retention option arrangements. These funds are included in the General Trust Fund and the allocation of these funds is managed by an advisory committee.

5.6. Events after the reporting period

No events have occurred after the reporting period that have an impact on the financial statements.

5.7 Other matter

On 1 August 2019, Gold Coast HHS implemented S4/HANA, a new statewide enterprise resource planning (ERP) system, which replaced FAMMIS ERP. The system is used to prepare the general purpose financial statements, and it interfaces with other software that manages revenue, payroll and certain expenditure streams. Its modules are used for inventory and accounts payable management. IT and application level controls were required to be redesigned and new workflows implemented. Extensive reconciliations were completed on implementation to ensure the accuracy of the data migrated.

Section 6: New Accounting Standards

6.1 New, revised or amending Accounting Standards and Interpretations adopted

The below summarises the relevant Australian Accounting Standards amendments which have been adopted for the 2019-2020 year.

AASB 16 Leases

Gold Coast Health applied AASB 16 Leases for the first time in 2019-20. The department applied the modified retrospective transition method and has not restated comparative information for 2018-19, which continue to be reported under AASB 117 Leases and related interpretations.

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

In 2018-19, Gold Coast Health held operating leases under AASB 117 from the Department of Housing and Public Works (DHPW) for commercial accommodation through the Queensland Government Accommodation Office (QGAO). Effective 1 July 2019, the framework agreements that govern QGAO were amended with the result that these arrangements would not meet the definition of a lease under AASB 16 and therefore are exempt from lease accounting. From 2019-20 onward, the costs for these services are expensed as supplies and services expenses when incurred. The new accounting treatment is due to a change in the contractual arrangements rather than a change in accounting policy.

Lease liabilities

Lease liabilities are initially recognised at the present value of lease payments over the lease term that are not yet paid. The lease term includes any extension or renewal options that Gold Coast Health is reasonably certain to exercise.

The future lease payments included in the calculation of the lease liability comprise the following:
- fixed payments (including in-substance fixed payments), less any lease incentives receivable
- variable lease payments that depend on an index or rate, initially measured using the index or rate as at the commencement date
- amounts expected to be payable by the department under residual value guarantees
- the exercise price of a purchase option that the department is reasonably certain to exercise
- payments for termination penalties, if the lease term reflects the early termination

The discount rate used is the interest rate implicit in the lease, or Gold Coast Health's incremental borrowing rate if the implicit rate cannot be readily determined.

Subsequently, the lease liabilities are increased by the interest charge and reduced by the amount of lease payments. Lease liabilities are also remeasured in certain situations such as a change in variable lease payments that depend on an index or rate (e.g. a market rent review), or a change in the lease term.

Right-of-use assets

Right-of-use assets are initially recognised at cost comprising the following:
- the amount of the initial measurement of the lease liability
- lease payments made at or before the commencement date, less any lease incentives received
- initial direct costs incurred, and
- the initial estimate of restoration costs

Right-of-use assets will subsequently give rise to a depreciation expense and be subject to impairment.

Right-of-use assets differ in substance from leased assets previously recognised under finance leases in that the asset represents the intangible right to use the underlying asset rather than the underlying asset itself.

Short-term leases and leases of low value assets

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

Lessor accounting

Lessor accounting remains largely unchanged under AASB 16. Leases are still classified as either operating or finance leases. However, the classification of subleases now references the right-of-use asset arising from the head lease, instead of the underlying asset.

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

AASB 15 *Revenue from Contracts with Customers*

Gold Coast Health applied AASB 15 *Revenue from Contracts with Customers* for the first time in 2019-20. AASB 15 establishes a new five-step model for determining how much and when revenue from contracts with customers is recognised. The five-step model and significant judgments at each step are detailed below.

Step 1 – Identify the contract with the customer	Funding that Gold Coast Health receives may contain a contract with a customer and thus fall within the scope of AASB 15. This is the case where the funding agreement requires Gold Coast Health to transfer goods or services to third parties on behalf of the grantor, it is enforceable, and it contains sufficiently specific performance obligations.
Step 2 – Identify the performance obligations in the contract	This step involves firstly identifying all the activities Gold Coast Health is required to perform under the contract, and determining which activities transfer goods or services to the customer. Where there are multiple goods or services transferred, Gold Coast Health must assess whether each good or service is a distinct performance obligation or should be combined with other goods or services to form a single performance obligation. To be within the scope of AASB 15, the performance obligations must be 'sufficiently specific', such that Gold Coast Health is able to measure how far along it is in meeting the performance obligations.
Step 3 – Determine the transaction price	When the consideration in the contract includes a variable amount, Gold Coast Health needs to estimate the variable consideration to which it is entitled and only recognise revenue to the extent that it is highly probable a significant reversal of the revenue will not occur. This includes sales with a right of return, where the amount expected to be refunded is estimated and recognised as a refund liability instead of revenue.
Step 4 – Allocate the transaction price to the performance obligations	When there is more than one performance obligation in a contract, the transaction price must be allocated to each performance obligation, generally this needs to be done on a relative stand-alone selling price basis.
Step 5 – Recognise revenue when or as the department satisfies performance obligation	Revenue is recognised when Gold Coast Health transfers control of the goods or services to the customer. A key judgement is whether a performance obligation is satisfied over time or at a point in time. And where it is satisfied over time, Gold Coast Health must also develop a method for measuring progress towards satisfying the obligation.

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

The standard requires contract assets (accrued revenue) and contract liabilities (unearned revenue) to be shown separately and requires contract assets to be distinguished from receivables. For easier comparison, accrued revenue and deferred revenue have been reclassified to the other current asset/liabilities note.

AASB 1058 Income of Not-for-Profit Entities

AASB 1058 applies to transactions where Gold Coast Health acquires an asset for significantly less than fair value principally to enable Gold Coast Health to further its objective, and to the receipt of volunteer services.

Gold Coast Health's revenue line items recognised under this standard from 1 July 2019 include some grants and contributions and other revenue.

General revenue recognition framework
The revenue recognition framework for in scope transactions, other than specific-purpose capital grants, is as follows.
1. Recognise the asset – e.g. cash, receivables, PP&E, a right-of-use asset or an intangible asset
2. Recognise related amounts – e.g. contributed equity, a financial liability, a lease liability, a contract liability or a provision; (grants and donations in many cases can have nil related amounts)
3. Recognise the difference as income upfront

Volunteer services
Under AASB 1058, Gold Coast Health will continue to recognise volunteer services only when the services would have been purchased if they had not been donated, and the fair value of the services can be measured reliability. This treatment is the same as in prior years.

AASB 1058 optionally permits the recognition of a broader range of volunteer services, however Gold Coast Health has elected not to do so.

Transitional policies adopted are as follows:
- Gold Coast Health applied the modified retrospective transition method and has not restated comparative information for 2018-19. They continue to be reported under relevant standards applicable in 2018-19, such as AASB 1004.

Most of Gold Coast Health's revenue will fall within the scope of AASB 15 *Revenue from Contracts with Customers*, the transitional impacts are disclosed above.

Revenue recognition for grants and contributions that were recognised under AASB 1004, will not change under AASB 1058. Revenue will continue to be recognised when Gold Coast Health gains control of the asset (e.g. cash or receivable) in most instances.

6.2 New Accounting Standards and Interpretations not yet mandatory or early adopted

Australian Accounting Standards and Interpretations that have recently been issued or amended but are not yet mandatory, have not been early adopted by Gold Coast Health. Gold Coast Health's assessment of the impact of these new or amended Accounting Standards and Interpretations where applicable, are set out below.

AASB 1059 Service Concession Arrangements: Grantors

AASB 1059 will first apply to Gold Coast Health's financial statements in 2020-2021. This standard defines service concession arrangements and applies a new control concept to the recognition of service concession assets and related liabilities.

Gold Coast Health have arrangements with the operators of the GCUH secure carpark and co-located private hospital which were assessed in accordance with this new standard. The impact of this new standard is still being determined.

All other Australian accounting standards and interpretations with future effective dates are either not applicable to Gold Coast Health's activities or have no material impact on the health service.

Management Certificate

Section 7: Management Certificate

GOLD COAST HOSPITAL AND HEALTH SERVICE
Management Certificate
for the year ended 30 June 2020

These general purpose financial statements have been prepared pursuant to s.62(1) of the *Financial Accountability Act 2009 (the Act)*, section 39 of the *Financial and Performance Management Standard 2019* and other prescribed requirements. In accordance with s.62(1)(b) of the Act we certify that in our opinion:

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

(b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Gold Coast Hospital and Health Service for the financial year ended 30 June 2020 and of the financial position of the Gold Coast Hospital and Health Service at the end of that year; and

We acknowledge responsibility under s.7 and s.23 of the *Financial and Performance Management Standard 2019* for the establishment and maintenance, in all material respects, of an appropriate and effective system of internal controls and risk management processes with respect to financial reporting throughout the reporting period.

Ian Langdon
Board Chair

18 August 2020

Ron Calvert
Chief Executive

18 August 2020

Independent Auditor’s Report

Queensland Audit Office
Better public services

INDEPENDENT AUDITOR'S REPORT

To the Board of Gold Coast Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Gold Coast Hospital and Health Service.

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2020, and its financial performance and cash flows for the year then ended

b) complies with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2019 and Australian Accounting Standards.

The financial report comprises the statement of financial position as at 30 June 2020, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matters

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

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Fair value of buildings ($1,508.694 million)

Refer to Note 2.13 in the financial report.

Key audit matter	How my audit addressed the key audit matter

Buildings were material to Gold Coast HHS at balance date and were measured at fair value using the current replacement cost method.
 	
Gold Coast HHS performed an indexation of its buildings this year. The last comprehensive revaluation was in 2016–17.
 	
The current replacement cost method comprises:
• gross replacement cost, less
• accumulated depreciation.
 	
Using indexation required:
• significant judgement in determining changes in cost and design factors for each asset type since the previous comprehensive valuation
• reviewing previous assumptions and judgements used in the last comprehensive valuation to ensure ongoing validity of assumptions and judgements used.
 	
The measurement of accumulated depreciation involved significant judgements for determining condition and forecasting the remaining useful lives of building components.
 	
The significant judgements required for gross replacement cost and useful lives are also significant for calculating annual depreciation expense.
	My procedures included, but were not limited to:
	• assessing the adequacy of management's review of the valuation process and results.
	• reviewing the scope and instructions provided to the valuer.
	• assessing the appropriateness of the valuation methodology and the underlying assumptions with reference to common industry practices.
	• assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices
	• assessing the competence, capabilities and objectivity of the experts used to develop the models
	• for unit rates:
	  ○ on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the:
	  ○ modern substitute (including locality factors and oncosts)
	  ○ adjustment for excess quality or obsolescence.
	• evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices
	• evaluating useful life estimates for reasonableness by:
	  ○ reviewing management's annual assessment of useful lives
	  ○ at an aggregated level, reviewing asset management plans for consistency between renewal budgets and the gross replacement cost of assets
	  ○ ensuring that no building asset still in use has reached or exceeded its useful life
	  ○ enquiring of management about their plans for assets that are nearing the end of their useful life
	  ○ reviewing assets with an inconsistent relationship between condition and remaining useful life.
	• Where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expense were supported by appropriate evidence.

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Implementation of new finance system

Refer to Note 5.7 in the financial report.

Key audit matter	How my audit addressed the key audit matter

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

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Responsibilities of the entity for the financial report

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

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

Auditor's responsibilities for the audit of the financial report

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

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

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances. This is not done for the purpose of expressing an opinion on the effectiveness of the entity's internal control, but allows me to express an opinion on compliance with prescribed requirements.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the entity.
- Conclude on the appropriateness of the entity's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. I base my conclusions on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.

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

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

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

Report on other legal and regulatory requirements

Statement

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

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

b) I consider that, the prescribed requirements in relation to the establishment and keeping of accounts were complied with in all material respects.

Prescribed requirements scope

The prescribed requirements for the establishment and keeping of accounts are contained in the *Financial Accountability Act 2009*, any other Act, and the Financial and Performance Management Standard 2019. The applicable requirements include those for keeping financial records that correctly record and explain the entity's transactions and account balances to enable the preparation of a true and fair financial report.

C. G. Strickland

21 August 2020

C G Strickland
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

Glossary

Glossary of acronyms

ARR	Annual report requirements for Queensland Government agencies
CAG	Consumer Advisory Group
CEO	Chief Executive Officer
CPC	Clinical Prioritisation Criteria
ED	Emergency Department
EMR	Electronic Medical Record
EMT	Executive Management Team
FAA	Financial Accountability Act 2009
FBT	Fringe Benefits Tax
FPMS	Financial and Performance Management Standard 2009
FRR	Financial Reporting Requirements
FTE	Full-time Equivalent
FYTD	Financial year to date
GCHHS	Gold Coast Hospital and Health Service
GCUH	Gold Coast University Hospital
GP	General Practitioner
GRC	Governance, Risk and Compliance
GST	Goods and Services Tax
HHB	Hospital and Health Board
HHS	Hospital and Health Service
HLA	Higher Level Apprenticeship
HR	Human Resources
ICA	Integrated Care Alliance
ICT	Information Communication Technology
ICU	Intensive Care Unit
ieMR	Integrated Electronic Medical Record
IHPA	Independent Hospital Pricing Authority
KPI	Key Performance Indicators
MOHRI	Minimum Obligatory Human Resource Information
MP	Member of Parliament

NEST	National Elective Surgery Target
NHS	National Health Service
NPA	National Partnership Agreement
NSQHS	National Safety and Quality Health Service
PID	Public Interest Disclosure
PLS	Patient Liaison Service
PPA	Promoting Professional Accountability
QAO	Queensland Audit Office
QTC	Queensland Treasury Corporation
QUT	Queensland University of Technology
QWAU	Queensland Weighted Activity Units
SCC	Statutory Compliance and Conduct
SDS	Service Delivery Statement
SNAP	Sub and Non-Acute Patient
TAFE	Training and Further Education
WAU	Weighted Activity Units

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, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients).

Allied health

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.

Best practice

The 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.

FirstNet

A program that replaced the existing Emergency Department Information System, to allow integration with ieMR.

Full-time equivalent (FTE)

Refers to full-time equivalent staff currently working in a position.

Department of Health

Refers to Queensland Health.

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 Service (HHS) is a separate legal entity established by Queensland Government to deliver public hospital services.

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.

Indigenous health worker

An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Indigenous Australians.

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.

Nurse Navigator Highly experienced nurses who have an in-depth understanding of the health system and who will assist patients with complex healthcare needs to navigate to and from their referring general practitioner and/or other primary care providers, through hospital, the community and back home again.

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.

Occasions of service

Occasions of service include any examination, consultation, treatment or other service provided to a non-admitted patient in each functional unit of a health service facility, on each occasion such service is provided.

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.

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 and 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.

Weighted Activity Unit

A standard unit used to measure all patient care activity consistently. The more resource intensive an activity is, the higher the weighted activity unit. This is multiplied by the standard unit cost to create the ‘price’ for the episode of care.

Compliance checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	• **A letter of compliance from the accountable officer or statutory body to the relevant Minister/s**	ARRs – section 7	4
Accessibility	• **Table of contents** • **Glossary**	ARRs – section 9.1	5 110–116
	• **Public availability**	ARRs – section 9.2	2
	• **Interpreter service statement**	*Queensland Government Language Services Policy* ARRs – section 9.3	2
	• **Copyright notice**	*Copyright Act 1968* ARRs – section 9.4	2
	• **Information Licensing**	*QGEA – Information Licensing* ARRs – section 9.5	2
General information	• **Introductory Information**	ARRs – section 10.1	9
	• **Machinery of Government changes**	ARRs – section 10.2, 31 and 32	NA
	• **Agency role and main functions**	ARRs – section 10.2	9, 19
	• **Operating environment**	ARRs – section 10.3	9, 19
Non-financial performance	• **Government's objectives for the community**	ARRs – section 11.1	6
	• **Other whole-of-government plans / specific initiatives**	ARRs – section 11.2	17
	• **Agency objectives and performance indicators**	ARRs – section 11.3	12-16
	• **Agency service areas and service standards**	ARRs – section 11.4	46
Financial performance	• **Summary of financial performance**	ARRs – section 12.1	49
Governance – management and structure	• **Organisational structure**	ARRs – section 13.1	34-35
	• **Executive management**	ARRs – section 13.2	30
	• **Government bodies (statutory bodies and other entities)**	ARRs – section 13.3	9
	• **Public Sector Ethics**	*Public Sector Ethics Act 1994* ARRs – section 13.4	43
	• **Human Rights**	*Human Rights Act 2019* ARRs – section 13.5	43
	• **Queensland public service values**	ARRs – section 13.6	11, 37, 42
	• **Risk management**	ARRs – section 14.1	40

Summary of requirement		Basis for requirement	Annual report reference
Governance – risk management and accountability	• **Audit committee**	ARRs – section 14.2	28
	• **Internal audit**	ARRs – section 14.3	41
	• **External scrutiny**	ARRs – section 14.4	42
	• **Information systems and recordkeeping**	ARRs – section 14.5	42
Governance – human resources	• **Strategic workforce planning and performance**	ARRs – section 15.1	36-39
	• **Early retirement, redundancy and retrenchment**	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	39
Open Data	• **Statement advising publication of information**	ARRs – section 16	2
	• **Consultancies**	ARRs – section 33.1	https://data.qld.gov.au
	• **Overseas travel**	ARRs – section 33.2	https://data.qld.gov.au
	• **Queensland Language Services Policy**	ARRs – section 33.3	https://data.qld.gov.au
Financial statements	• **Certification of financial statements**	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	103-105
	• **Independent Auditor's Report**	FAA – section 62 FPMS – section 46 ARRs – section 17.2	106-111

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