ANNUAL REPORT

2011/12

Western Health

OUR VISION

Together, caring for the West,
our patients, staff, community and environment.

OUR PURPOSE

Working collaboratively to provide quality health and well-being services for the people of the West.

OUR APPROACH

Sharing responsibility for setting our strategic direction.
Steering Western Health, guided by our blueprint.
Together, caring for the West - our patients, staff, community and environment.

OUR VALUES

Compassion - consistently acting with empathy and integrity.
Accountability - taking responsibility for our decisions and actions.
Respect - for the rights, beliefs and choice of every individual.
Excellence - inspiring and motivating innovation and achievement.
Safety - prioritising safety as an essential part of everyday practice.

Acknowledgement of Traditional Owners
Western Health respectfully acknowledges the traditional owners of the land on which its sites stand as the Boon Wurrung and the Wurundjeri people of the greater Kulin Nation.

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MESSAGE FROM THE CHAIR OF THE BOARD & THE CHIEF EXECUTIVE 2011/12

Providing timely access to safe and effective patient care for a rapidly growing population, while overcoming infrastructure limitations, continued to present significant challenges for Western Health during 2011/12. We serve the fastest growing population in Australia with not only booming numbers of births but, at the other end of the spectrum, large numbers of older residents.

There were a number of highlights in the 2011/12 period, including the Victorian Government announcement of funding for an ICU at Sunshine Hospital – marking a turning point in the gradual transition of Sunshine Hospital.

It was fitting that the announcement of the ICU funding for Sunshine came just as the construction of the $90.5 million Acute Services Building on the site neared completion. It will be wonderful to see the commissioning of that building during this 2012/13 year, providing vastly improved settings for the provision of a wide range of services, from paediatric and adult outpatient clinics to day oncology services and a new Special Care Nursery.

With the Western Centre for Health Research and Education and the Sunshine Hospital Radiation Therapy Centre completing more than a year of operation since opening in 2011, Sunshine Hospital is a very different campus compared with three years ago.

Strategic Masterplans for Western and Williamstown Hospitals were also completed during the year, along with a review of the options for the next stages of development at Sunshine Hospital.

We were proud to have played a key role in 2011/12 in the successful finalisation of the collaborative Better Health Plan for the West. The Plan sets out strategies for sharing the task of responding to high levels of chronic disease and complex medical conditions, against a backdrop of socio-economic disadvantage and cultural and linguistic diversity.

Improving access to emergency care and elective surgery continue to be two of the toughest challenges facing any major health services – both in Australia and internationally – and this was once again the case for Western Health. A number of strategies were implemented to support improvement projects across the areas of emergency care and elective surgery access and we believe the results of these will become evident over the next 12 months.

Nursing and midwifery strategic planning was undertaken during the year, including a major focus on boosting the professional profile of nurses, engaging them in many initiatives which enhance their skills and enable nurses and midwives to share their knowledge and experiences.

Volunteers remain a vital force within Western Health, with more than 400 staff providing services across the spectrum of services. The newly developed Volunteer Meal Assistance Program went on to win a coveted Outstanding Achievement Award at the 2012 Minister for Health Volunteer Awards.

Western Health passed the Australian Council on Healthcare Standards (ACHS) accreditation process with a strong report card during the year, meeting or exceeding the targets for each domain. The ACHS surveyors noted that Western Health has a mature understanding of its communities and awarded an Outstanding Achievement Award for the criterion covering cultural diversity.

With hundreds of thousands of patients requiring healthcare through Western Health during 2012/13, it is imperative that we continue to build on our strengths and achievements.

Regards,

The Hon Ralph Willis
Chair of the Board
Western Health

Ms Kathryn Cook
Chief Executive
Western Health

YEAR IN REVIEW

During 2011/12, our communities accessed our services in great numbers once again:

- 120,013 Emergency Department attendances
- 162,940 outpatient visits
- 119,467 inpatient admissions
- 121,160 Community and Care Co-ordination Services appointments

In each case, the numbers represented an increase on the previous year and in total, represent more than half a million occasions of patient service just in these four areas of service alone. In order to assist Western Health in meeting these challenges, a range of developments occurred.

A COMPLEX REGION

The Western edge of Melbourne continues to be one of Australia's fastest growing regions and this trend will continue over the next decade, with the population predicted to exceed 1.1 million in 2021.

The communities served by Western Health are among the most diverse in Australia with a high proportion of the population from culturally and linguistically diverse backgrounds, significant areas of socio-economic disadvantage along with high rates of chronic disease and co-morbidities.

A number of Western Health's communities have the highest levels of diabetes in the metropolitan area. An ageing population and a high level of industry across the region also contribute to conditions such as osteoporosis and arthritis. Our communities also have significant levels of cancer, particularly bowel cancer.

It is in the context of these many health issues that Western Health continued to provide high quality care over the past year.

BETTER HEALTH PLAN FOR THE WEST

During 2011/2012, 20 partner agencies from across the West and North West of Melbourne, collaborated to complete the development of the Better Health Plan for the West.

Health providers in the West have a track record of collaborating together to develop and deliver new and innovative services. The Better Health Plan for the West presents the opportunity to build upon this culture of dialogue and collaboration, and for the West to be a leader among regional health partnerships in Victoria.

The Plan identifies an agreed set of key health issues and broad directions for future service delivery in the western metropolitan region for the next decade. All partners will be accountable for contributing to the implementation of this plan.

ACUTE SERVICES BUILDING CONSTRUCTION

The construction of the Acute Services Building was completed ahead of schedule soon after the end of the 2011/12 financial year. The $90.5 million four level building commenced construction in late 2010. It includes space for 128 acute overnight beds, a 26 cot special care nursery and new ambulatory care facilities including day oncology and chemotherapy, as well as new adult and paediatric outpatients areas and a new reception space for Sunshine Hospital.

FUNDING COMMITMENT FOR ICU AT SUNSHINE HOSPITAL

The Victorian Government budget announcement of $15.1 million to fund critical care services at Sunshine Hospital, including an Intensive Care Unit, was welcomed by Western Health. Sunshine Hospital is one of the largest hospitals in Australia without an ICU. Western Hospital has the only ICU in the western suburbs of Melbourne, servicing the fastest growing

YEAR IN REVIEW

population in Australia and a current population of 777,000 people.

Western Health is working to enable critical care services to be operational at Sunshine Hospital as soon as possible.

FUNDING FOR ADDITIONAL BIRTHING FACILITIES

Funding was also received in the State Budget for additional birthing suite capacity at Sunshine Hospital, to assist Western Health in responding to the extraordinary number of births occurring.

FIRST YEAR OF SUNSHINE HOSPITAL RADIATION THERAPY CENTRE

Around 1000 patients have received their radiation therapy at the Centre, which is operated in partnership with Peter MacCallum Cancer Centre, since it opened in early 2011. A high proportion of these patients are from non-English speaking backgrounds. This is the first time that public radiation therapy services have been available in the western suburbs of Melbourne.

A second Linear Accelerator came on line at the Centre towards the end of 2011, in response to demand for treatment.

FIRST YEAR OF WESTERN CENTRE FOR HEALTH RESEARCH AND EDUCATION

The first year of operation for the Western Centre for Health Research and Education saw a high volume of usage by internal and external stakeholders. The Centre has enabled a number of new opportunities to emerge including the launch of the Australian Institute for Musculoskeletal Science (AIMSS) – an important research partnership between Western Health, the University of Melbourne and Victoria University.

EMERGENCY OBSERVATION UNITS

The work on both the Sunshine and Western Hospital Emergency Department Short Stay Units was completed on time.

Now known as the Emergency Observation Units, the number of beds has increased from eight to 12 at Western Hospital, and from six to 12 at Sunshine Hospital. The beds are available for patients requiring a stay of up to 24 hours for observation prior to discharge or - where their condition has not improved - admission.

Work commenced on both sites in late January 2012 and the aim was to have all major works complete to coincide with the implementation of the Winter Plan on 1 June – with this target being achieved.

Planning Ahead

GRADUAL TRANSITION TO A TERTIARY HOSPITAL

The process of gradual transition of Sunshine Hospital to the level of a tertiary referral hospital will continue over the 2012/13 year with the transfer of targeted service provision from Western Hospital to Sunshine Hospital.

The 2012/13 financial year will see substantial work done towards the development of the ICU at Sunshine Hospital. Extensive work will be required to remodel a number of existing areas as well as upgrading and fitting out other spaces. Service planning and workforce development will also occur to ensure that the necessary associated services and staffing will be available at the time of opening the ICU.

The Acute Services Building at Sunshine Hospital will be a key part of the strategy to transition tertiary services to Sunshine over time. A large amount of planning is taking place with the wards and specialty units which will be occupying the new building, to ensure as smooth a transition as possible when the building is commissioned in 2013.

NURSING AND MIDWIFERY STRATEGIC PLAN 2012 – 2015

The Nursing and Midwifery Strategic Plan 2012 – 2015 supports Western Health and the achievement of positive patient experiences. Nurses and midwives will be engaged in making a difference through the following professional agendas:

- Supporting professional training, skills and experience
- Provision of opportunities for patients, nurses and midwives to discuss patient care experiences

- Reviewing clinical practice and improvement by applying research- based change
- Participation in nursing and midwifery-led research
- Attracting, supporting and retaining the best qualified workforce possible.

IMPROVING ACCESS TO EMERGENCY CARE

Further work will continue under the National Emergency Access Targets (NEAT) Strategy Project.

A range of interventions are taking place across the patient system to improve emergency care and access performance. Six key priorities have been identified for improvement strategies for 2012/13 and improvements in systems and patient flow will continue to become evident with further advances expected throughout the year.

A range of systems will continue to be redesigned and reviewed over the 2012/13 period, to support improved timeliness of emergency care.

IMPROVING ACCESS TO ELECTIVE SURGERY

By June 2013, Western Health will have progressed a range of measures to increase access to elective surgery, and comply with the targets set by Government. Measures to be taken will involve addressing theatre capacity; day surgery arrangements; the management of long wait patients; pathways for emergency surgery; and the separation of elective and emergency surgery.

NATIONAL SAFETY AND QUALITY HEALTH SERVICE (NSQHS) STANDARDS

The National Safety and Quality Health Service (NSQHS) Standards support the Australian Health Services Safety and Quality Accreditation (AHSSQA) Scheme – endorsed by Australian Health Ministers in 2010.

The ten NSQHS Standards provide nationally consistent measures of safety and quality and propose evidence-based improvement strategies to deal with gaps between current and best practice.

The Standards will gradually become integral to the accreditation process for health services as they will determine how an organisation's performance will be assessed.

The Standards address the following areas:

1. Governance for safety and quality in health service organisations
2. Partnering with consumers
3. Preventing and controlling healthcare associated infections
4. Medication safety
5. Patient identification and procedure matching
6. Clinical handover
7. Blood and blood products
8. Preventing and managing pressure injuries
9. Recognising and responding to clinical deterioration in acute health care
10. Preventing falls and harm from falls

PROGRESSING BEST CARE FOR OLDER PEOPLE INITIATIVES

For 2012/13 a range of additional measures will be implemented at Western Health through the Best Care for Older People (BCOP) program, with Victorian Government funding support. This will include developing an organisational policy on Minimising Functional Decline of Older Hospitalised Patients and a patient/carer consumer advisory group; establishing two Advisory Committees – one on Continence and on Cognition; and increasing staff education on function decline in hospitalised patients.

Sunshine Hospital Emergency Department – a hub of activity

There is rarely a quiet moment in Sunshine Hospital's Emergency Department. A steady stream of paramedics bring in patients on stretchers through one entry and the queues continue to grow at the triage counter at the other.

The Nurses' and Doctors' Station - affectionately referred to as 'the Fishbowl' - is a hub of activity, with medical and administrative staff working side by side to ensure that patients coming through the Emergency Department are seen in a timely manner, treated and then transitioned to the appropriate destination, whether that be a ward, an alternative hospital such as Western Hospital or home.

Sunshine Hospital's Emergency Department (ED) has 40 emergency care beds, including nine general adult beds, six cardiac monitoring beds, nine paediatric beds, a Resuscitation Unit with three adult beds and one paediatric bed, and a 12 bed Emergency Observation Unit for those patients requiring observation for a period of up to 24 hours. Patients requiring treatment in certain specialist areas or those in need of Intensive or Coronary Care are transferred to another hospital with such facilities, either to Western Hospital or elsewhere.

The very nature of the ED workload means that no two days are the same. One morning could see staff deal with a range of cases: an overdose; a pedestrian injured in a collision with a car; an angina sufferer with severe chest pains; a mother recovering from a recent caesarean, who is suffering stomach and back pains.

Some patients who have more minor injuries such as a broken arm, will be triaged to go to the Fast Track area of the Emergency Department, where they are treated swiftly, often requiring a follow up appointment in Outpatients or Physiotherapy. For many of Sunshine Hospital ED's patients however, their time in the unit marks the start of an individual journey through the hospital system, as many patients have complex and chronic conditions and a large number are elderly.

Sunshine Hospital has the third busiest paediatric emergency department in Victoria and each day dozens of children come through the ED.

The diversity of Sunshine Hospital ED's patient groups means that interpreters are often among the large number of staff involved in ensuring the Emergency Department runs smoothly and patients receive safe and effective care.

OUR FACILITIES

WESTERN HOSPITAL

Western Hospital is an acute teaching hospital with approximately 360 beds. It provides the majority of acute elective and acute emergency services for Western Health. Patients are provided with a range of inpatient and outpatient services including acute general medical and surgical, intensive and coronary care, sub-specialty medicine, surgical services, and related clinical support. Research covering a range of medical, surgical and specialty areas is also conducted at the hospital.

Western Health maintains strong partnerships with a number of lead universities including the University of Melbourne, La Trobe, Monash, RMIT and Victoria University for medical, nursing and midwifery and allied health training.

SUNSHINE HOSPITAL

Sunshine Hospital is a teaching hospital in Melbourne's outer-West with approximately 426 beds. Sunshine Hospital has a comprehensive range of services including women's and children's services, surgical, medical, mental health, aged care and rehabilitation services. Sunshine Hospital's emergency department, incorporating a paediatric service, is one of the busiest general emergency departments in the state.

The Maternity services at Sunshine Hospital continue to grow to meet the increasing demand within the community and it now has the third highest number of births of any hospital site in the state.

SUNSHINE HOSPITAL RADIATION THERAPY CENTRE

The Sunshine Hospital Radiation Therapy Centre has been open for more than a year now. In that time, the Centre has seen more than 1000 patients from Melbourne's western suburbs receive their cancer treatment closer to home.

The Centre, a partnership between Western Health and the Peter MacCallum Cancer Centre, provides a state-of-the-art radiation planning system and two linear accelerators to deliver treatment to patients with a range of cancers. Two additional bunker spaces have been included to provide for projected future growth.

WILLIAMSTOWN HOSPITAL

Williamstown Hospital is a 90 bed facility providing emergency services, surgical services, a range of rehabilitation services including geriatric evaluation and management, transitional and restorative care, renal dialysis services and community rehabilitation.

SUNBURY DAY HOSPITAL

The Sunbury Day Hospital has been treating local patients for more than a year. The Day Hospital provides day medical, day surgical, dialysis treatment and a number of specialist clinics.

DRUG AND ALCOHOL SERVICES

Drug and Alcohol Services provide a diverse range of services for individuals and their families affected by drug and alcohol related problems. Drug and Alcohol Services is a community based program of Western Health and offers innovative and client centred recovery programs that include specialist programs for Adult, Women and Children's Services, Youth and Family and Residential Withdrawal Services.

WESTERN CENTRE FOR HEALTH RESEARCH AND EDUCATION

Located at Sunshine Hospital, the Western Centre for Health Research and Education has had a busy 12 months since opening its doors in mid 2011. The Centre provides a range of purpose built, state-of-the-art teaching and research facilities. Available within the Centre is a 200 seat auditorium, a 100 seat lecture theatre, library facilities, simulation centres and a number of seminar and tutorial rooms. The Centre is home to the Western Clinical School for Medicine and Allied Health in partnership with the University of Melbourne and also houses researchers, academics and educators from Western Health, Victoria University and the University of Melbourne.

The Centre has already started to play a pivotal role in researching diseases that affect our local communities and has placed Western Health as a centre of excellence in academic and research fields.

REG GEARY HOUSE

Established in 1994, Reg Geary House is one of the key providers of residential aged care within the Melton community, providing 30 high care beds.

HAZELDEAN TRANSITION CARE

Hazeldean Transition Care is located close to the Williamstown Hospital and now provides Transition Care Program services to the people of the West. The Transition Care Program provides goal oriented, time limited and therapy focused care to help older people at the conclusion of their hospital stay.

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ABOUT WESTERN HEALTH

Western Health manages three acute public hospitals: Western Hospital at Footscray; Sunshine Hospital at St Albans; and Williamstown Hospital. It also operates the Sunbury Day Hospital, a Transition Care Program at Hazeldean in Williamstown and a residential aged care facility at Reg Geary House at Melton. A wide range of community based services are also managed by Western Health, along with a large Drug and Alcohol Service.

The Radiation Therapy Centre at Sunshine Hospital, operated in partnership with Peter MacCallum Cancer Centre, has seen more than 1000 patients since it opened in early 2011.

The Western Centre for Health Research and Education at Sunshine Hospital, has been well utilised since opneing in June 2011 in partnership with the University of Melbourne and Victoria University.

Services are provided to a population of more than 777,000 people across the western region of Melbourne.

Western Health provides a comprehensive, integrated range of services from its various sites; ranging from acute tertiary services in areas of emergency medicine, intensive care, medical and surgical services, through to subacute care and specialist ambulatory clinics. Western Health provides a combination of hospital and community-based services to aged, adult and paediatric patients and newborn babies.

Employing approximately 5,000 staff, Western Health has a strong philosophy of working with its local community to deliver excellence in patient care. Western Health has long-standing relationships with health providers in the western region of Melbourne and strong affiliations with numerous Colleges and academic institutions.

Our community:

- is growing at an unprecedented rate
- is among the fastest growth corridors in Australia
- covers a total catchment area of 1,569 square kilometres
- has a population of more than 777,000 people
- has high levels of cancer, heart disease, stroke and mental illness, with diabetes and depression also significant population health issues
- has a diverse social and economic status
- is one of the most culturally diverse communities in the State
- speaks more than 100 different languages/dialects
- provides a significant number of our staff
- has a strong history of working collaboratively with Western Health to deliver excellence in patient care.

Western Health's catchment includes the following local government municipalities:

- Brimbank
- Hobsons Bay
- Maribyrnong
- Melton
- Moonee Valley
- Moorabool
- Hume
- Wyndham

ON A TYPICAL DAY AT WESTERN HEALTH

933
Patients are cared for overnight
(acute, subacute and residential care)

100
Patients require the services of an interpreter

446
Patients see a doctor in an outpatient clinic

40
Patients are visited at home by
our Hospital In the Home program

329
Patients attend one of our three
Emergency Departments

112
Volunteers provide a range of services

57
Surgical operations take place

13
Babies are welcomed into the world
at Sunshine Hospital

327
Patients are discharged

3,006
Meals are served

343
Patients are seen by our Community
and Care Co-ordination Services

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STATEMENT OF PRIORITIES

VICTORIAN HEALTH PRIORITIES FRAMEWORK – PRIORITY AREAS	PLANNED DELIVERABLES	OUTCOMES
Developing a system that is responsive to people's needs	Clinical service plans developed for Emergency, Subacute and Drug & Alcohol Services	Service Plans have been developed in line with the endorsed WH Service Plan 2011. A Clinical Service Plan has been developed for Drug and Alcohol Services, with preliminary work commenced on reprioritised clinical areas including paediatrics, cardiac care and subacute care.
	Access implementation Plan progressed and supporting performance against access targets.	Elective Surgery Targets for Activity and Waiting Times were achieved for 2011/12. Due to continuing poor performance against Emergency Care targets, a range of access improvement initiatives were designed and implemented between February - June 2012.
	Better Health Plan for the West finalised; Governance arrangements for Plan implementation agreed and 2011/12 milestones met.	The Better Health Plan for the West was finalised in late 2011, with governance of the implementation phase agreed. This includes Western Health taking the role of Auspice Agency throughout 2012/13.
People & Culture	Work progressed with St Vincent's and Northern Health on Closing the Gap Strategy for the North West Region.	Work has progressed against the Closing the Gap Strategy for the North West Region. Western Health has expanded its Aboriginal Health Unit and integrated Aboriginal health projects in maternity services, people services and education and training. Participation in the Improving the Pathways to Hospital Care (IPHC) Project has enabled Western Health to implement a culturally appropriate quality improvement process in Aboriginal Health.
	'Together, Transforming Care @ WH' initiative launched, with transformational care initiatives rolled out to improve the patient experience.	Transformational care initiatives, including Patient Rounding have been implemented. In-house indicators demonstrate an improved patient experience, with a decrease in patient complaints and the use of patient call bells.
Expanding service, workforce and system capacity	Strategic Master Plan Review completed.	The Strategic Master Plan Review has been completed.
	Acute Services Building construction milestones achieved for 2011/12.	Acute Service Building construction milestones were achieved for 2011/12, with building completion forecasted to be ahead of schedule.
	Stage 2 of the 'Clinicians at the Helm' Program delivered and engagement & development program for leaders identified on the WH Succession Plan completed.	Stage 2 of the 'Clinicians at the Helm Program' has been completed, . The Executive and Senior Leadership Development Program commenced in February 2012, with fifty senior leaders having undertaken the program.
Increasing the system's financial sustainability and productivity	Business Improvement Initiatives (BIPs) implemented in line with agreed 2011/12 milestones and deliverables.	Business Improvement Initiatives were implemented, with the majority of BIPs achieving targeted savings.
	Clinical Costing Framework developed	After re-scoping, the Project will now progress from August 2012, with the completion date for refresh of the clinical costing system expected to be end March 2013.
Implementing continuous improvements and innovation	Research Strategy implementation milestones achieved for 2011/12.	Research Strategy implementation milestones achieved for 2011/12 include the strengthening of links with local and overseas institutions, the establishment of an annual Research Week and WH Research Advisory Committee.
Increasing accountability and transparency	WH MaP Central Data Warehouse progressed.	Clinical indicator suites have been developed for the areas of clinical quality and finance. Western Health has undertaken requested work to support the development of the VINAH Minimum Dataset.
Using e-health and communications technology	Digital Medical Record and GP Messaging Gateway introduced.	The WH Digital Medical Record (DMR) has been introduced and continues to be embedded across WH. The WH E-Messaging Gateway outbound messaging solution (Hospital to GP) has been successfully deployed.

SAFE & EFFECTIVE PATIENT CARE

ACCREDITATION OUTCOMES

Western Health received a strong report card following the survey in late 2011 by the Australian Council on Healthcare Standards' (ACHS) Accreditation team, based on the ACHS EQuIP5 Standards. The nine surveyors conducted a thorough review of Western Health's activities during the five day visit.

The surveyors noted that all previous recommendations had been signed off. Staff involved in responding to cultural diversity across Western Health can be justifiably proud of their achievements – this was the one criteria to receive an Outstanding Achievement assessment.

The feedback was very positive, with recommendation for continuation of full ACHS Accreditation status for Western Health.

All 47 ACHS criteria were noted to meet minimum compliance requirements, with 17 attracting the more substantive rating of Extensive Achievement.

Surveyors noted that Western Health has a mature understanding of its community and felt that the commitment to supporting the health care needs of its culturally diverse community was outstanding. As a result, the surveyors awarded an Outstanding Achievement rating to the ACHS criterion covering cultural diversity. This is the highest commendation ACHS can bestow on a single criterion and is a great achievement for Western Health.

Approximately 12 recommendations will be made to enhance our systems for the provision of care and services. Several of these align with current strategic and operational plans, for example, critical care services at Sunshine; upgrade of security equipment; and enhancement of processes supporting auditing of clinical documentation.

CLINICAL GOVERNANCE COMMITTEE

The Clinical Governance Committee of Western Health is made up of the Clinical Services Directors and a number of Western Health's most senior medical, surgical, nursing, clinical support and allied health clinicians, providing a leadership role to Western Health on matters relating to clinical quality, policy and strategy. It does this by:

- Setting strategic and operational priorities for the improvement of safe care
- Promoting the use of consistent clinical audit and critical incident reporting
- Guiding the development of appropriate clinical policies and procedures
- Advising on action plans to address clinical system improvement opportunities identified by external review
- Reviewing the findings and recommendations of serious adverse patient events and agreeing on sponsorship and support for clinical practice improvement
- Endorsing and monitoring mitigation strategies against operational clinical risks
- Monitoring and providing feedback/advice to clinical divisions on performance against identified critical clinical risks
- Providing support and direction to the Clinical Governance Direct Report Committees.
- Providing advice on clinical practice improvement opportunities

ACCESS PLAN FOR ELECTIVE SURGERY

Western Health has once again met all elective surgery key performance indicators. This has been achieved through ongoing opportunity assessments to identify theatre efficiencies and effective management of elective surgery waiting lists.

During 2011/12 these initiatives included improved theatre efficiency, undertaking emergency surgery in standard hours where possible and realignment of the elective surgery nurse liaison model. Additionally, a new consultant led model of care for patients requiring emergency surgery at Sunshine Hospital was trialled and measured in terms of both cost efficiency and patient outcomes.

Improvement in on-time starts and turnaround times in the operating rooms increased the availability of standard hours theatre time, providing an additional 900 hours where emergency surgery was able to be undertaken. This further reduced the number of elective surgery hospital-initiated postponements relating to patients requiring emergency surgery.

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SAFE & EFFECTIVE PATIENT CARE

Realignment of the Elective Surgery Nurse Liaison Model to provide cover for each clinical speciality utilising the operating theatres, has achieved a greater level of patient focus where individual patients are treated equitably using the principle of the longest waiting patient receiving treatment first. Individual patients waiting longer than the clinical threshold for their category of elective surgery are individually managed, as such Western Health believes it is well placed to meet the National Elective Surgery Targets. In the realigned model, the liaison nurse attends their clinical specialty outpatient sessions to ensure patients requiring Category 1 urgent elective surgery are provided with a theatre date at the earliest possible time. As patients have a single point of contact and theatre dates are able to be negotiated, the rate of patients failing to attend for their surgery has dramatically decreased, which in turn leads to more efficient theatre utilisation.

Development of the Acute General Surgery Receiving Model at Sunshine Hospital has enabled the management of rapid growth in emergency surgery whilst maintaining elective surgery throughput. The model includes a 70:30 split in all theatre sessions with 30 per cent of each list being left available for emergency cases. International benchmarking through the Advisory Board Theatre Compass program demonstrates that this model provides for a far more cost efficient service than running dedicated emergency operating lists. The model has been complemented by the development of clinical guidelines for the most common emergency diagnosis presentations to reduce variation between treating surgeons and provide guidance for the Junior Medical Staff.

ACCESS PLANS FOR EMERGENCY CARE

The National Health Reform Agreement (National Partnership Agreement on Improving Public Hospital Services), endorsed the National Emergency Access Targets (NEAT) becoming mandatory for all public hospitals as of 1 January 2012. This requires 70 per cent of all patients presenting to the Emergency Departments (ED), across all triage categories to be admitted to an inpatient bed, transferred to another hospital or discharged from Emergency Departments within 4 hours. The target will continue to increase over the next three years until 2015 where 90 per cent of all patients are required to be admitted or discharged from emergency within 4 hours. It has previously been shown that overcrowding in ED has been associated with an increase in inpatient adverse events, mortality and length of stay.

A systems approach and project framework has been adopted under the Western Health NEAT Strategy Project to identify and implement system and process improvements across the whole organisation. This project framework has been built on the previous work undertaken through the BlowTorch strategy. The systems approach identifies organisational wide interventions to improve patient access and flow through all care components and episodes.

The following strategies have been implemented since the commencement of the project in January 2012 with the following improvements and outcomes:

- **Admission Practices**

  Broad organisational wide consultation occurred to have agreed framework to promote earlier decision making in a patients admission to hospital. The formal launch in the change to admission practices occurred in June 2012 and initial review indicates that more patients are transferring to ward beds earlier in their admission.

- **Review and redesign of Fast Track and Short Stay Units**

  The model and admission pathways for both Fast Track and Short Stay Units have been developed. These two core functions within the Emergency Department provide alternatives to admission to ward/hospital care and will influence Western Health's ability to manage emergency presentations and patient admissions in a more time efficient and effective manner. The Short Stay units have been expanded and are now called Emergency Observation Units (EOUs). With the new pathway/admission practices and increased capacity both units (Footscray and Sunshine) are seeing an improvement activity level with an increase in daily admissions from 10 per day to an average of 20 admissions per day.

NEW MATERNITY SERVICES MODEL OF CARE

Western Health developed a Model of Care for its Maternity Services which presents the vision for the delivery of these services over the next 10-15 years. The vision is to provide a service that is based on a wellness model organised around the needs of the woman, the baby and the family.

Some of the features of the planned new model are the development of tertiary maternity and some paediatric services at Sunshine Hospital, new local maternity care centres, and integrated community pre and postnatal services linked to GP and maternal and child health services.

As far as possible, there will be continuity in the providers of care from prenatal care to birthing and on to postnatal care, with access to social and psychological as well as physical care. The service will be committed to quality, safety and positive outcomes. There will be an expanded range of settings from which maternity care is delivered which provide more local access and which are family-focused in design.

This Maternity Model of Care will offer some birthing options in local areas, enabling women to choose the service that fits their needs and a capability to receive maternity care locally.

Western Health is now in the process of implementing the preliminary steps needed to implement this Maternity Model of Care through the development of the Western Collaborative to work with other health providers in the west and community services to care for women and children in the West. This links the Model of Care work to a collaborative framework and strategic direction for the western region.

PATIENT ROUNDING

Hourly patient rounding is a nurse-initiated project which was piloted in June 2011 on two wards in Sunshine Hospital and has now been rolled out across the organisation due to its positive impact on patient care.

The process involves the nursing team visiting each patient every hour (or every two hours at night) and addressing five key questions regarding each patient:

- pain
- toilet needs
- positioning
- personal needs
- plan of care

The new process has focused on improving communication between patients and nursing staff and has resulted in a raft of additional benefits including increased patient satisfaction, reduced call bells and fewer falls and pressure ulcers in some wards.

The primary objective of rounding is to improve communication, but it has also had beneficial effects in reducing adverse outcomes.

BEST CARE FOR OLDER PEOPLE

Best Care for Older People (BCOP) is Western Health's approach to implementing the Victorian Government Department of Health Improving Care for Older People: A Policy (IC4OP).

Improving Care for Older People (IC4OP) is the Victorian Government's response to the Council of Australian Government's Long Stay of Older Patients initiative. The main aim of the policy is "minimising functional decline and improving care of older people who require hospitalisation".

The Department of Health has provided funding to all major Victorian Health Services to implement the policy through environmental and service delivery improvements. Western Health has received $920,000 for 2011 - 13 to implement this work.

On a typical day at Western Health, 70 per cent of admitted patients are aged 65 years and over (Census data, 2011). These patients transition across the continuum of care so Western Health has focused on having an organisational wide approach.

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SAFE & EFFECTIVE PATIENT CARE

For 2011-12 the BCOP program and funding has enabled a range of measures to be taken:

- New weighing equipment for use across the three inpatient campuses as identified by a Nutrition Department audit.
- The provision of 320 new patient chairs, 220 visitor chairs and 130 footrests across the three inpatient campuses. The new seating will allow patients to be seated out of bed during the day to assist with minimising functional decline.
- The commencement of the BCOP Nursing Projects Program with 18 nursing champions engaged in leading related quality projects on their wards.
- Implementation of a standardised functional maintenance screening tool and care plan across the acute and subacute wards of Western Health.
- Review of the Secure Geriatric Evaluation and Management (GEM) environment, implementing the use of artwork to assist with orientation and behaviour management.
- A BCOP monthly staff newsletter - an interdisciplinary publication that promotes best practice in regards to the care of older hospitalised patients.

ADVANCED PRACTICE PHYSIOTHERAPY

Over the past two years Western Health has developed six Advanced Practice Physiotherapy roles and clinics. Two years ago, three Advanced Practice Physiotherapy roles were introduced and involved physiotherapists assessing and managing patients traditionally reviewed initially by orthopaedic consultants. The clinics developed from these roles are the Orthopaedic Physiotherapist-Led Clinic, Osteoarthritis Hip & Knee Service and the Paediatric Orthopaedic Physiotherapist-Led Clinic. A further three roles were developed over the last year: the Neurosurgery Physiotherapist-Led Clinic, Primary Care Physiotherapy in the Sunshine Emergency Department and the multi-disciplinary Developmental Dysplasia of the Hip Clinic. These clinics also involved specially trained physiotherapists assessing and managing patients traditionally reviewed by medical staff including neurosurgeons, ED medical staff and orthopaedic consultants.

A review of service statistics confirmed that each of the six roles and clinics achieved the aims of improving patient access to healthcare, optimising efficiency of the current workforce, increasing availability of medical staff for time-critical presentations/referrals, improving consistency of care, improving satisfaction and enhancing staff knowledge on assessment and management of musculoskeletal conditions.

Caption: Physiotherapist Sam Wills at the Developmental Dysplasia of the Hip Clinic at Sunshine Hospital.

CANCER SERVICES

Western Health now manages one of the largest cancer services in Melbourne. The organisation is the largest provider of treatment for colorectal cancer and one of the leaders in the treatment of upper gastro-intestinal cancers. We are also seeing further growth in our lead tumour streams for breast and lung cancer. The Western region of Melbourne is an area of extreme cultural diversity, with rapidly growing numbers of young adults and a rapidly increasing aged population. Responding to this complexity will continue to be integral to overcoming future cancer challenges and driving the next generation of progress in the prevention, detection and treatment of cancer. Over the 2011/12 year, Western Health continued to develop and strengthen its cancer services and also worked with its joint venture partners to establish the Victorian Comprehensive Cancer Centre.

HOSPITAL IN THE HOME

On 16 May 2012, the Hospital In The Home (HITH) program commenced direct operation by Western Health, providing direct nursing care to Western Health patients in the community.

Fifteen additional nurses were employed by Western Health to assist in providing high quality nursing care in the patients' homes. This was an extension of the existing program, which had already employed liaison nurses under Western Health in December 2011, to assist in coordination and facilitation of patient referrals and assessments and to ensure effective treatment plans are in place for the nurses to provide acute care to Western Health patients in the community

NEW DIRECTION FOR DRUG AND ALCOHOL SERVICE

During the year, the Western Health Board endorsed an innovative Service Plan for the organisation's drug and alcohol services.

As part of this Service Plan, Western Health's community based drug and alcohol service adopted a new direction, which commits the service to:

- Consider patients as partners
- Ensure clinical practice is multidisciplinary in focus
- Coordinate the continuity of management of patients with drug and alcohol issues from the acute to community based settings
- Strengthen community linkages, including collocation opportunities with mental health and other relevant agencies in the major population centres of Western Melbourne
- Extend research, education and innovation portfolios

A drug and alcohol Consultation Liaison Service is currently being planned for Western Health campuses.

In addition, a chronic disease management framework for drug and alcohol will be implemented at the drug and alcohol services. The disease management program will be established with the same structure and philosophy as programs for other chronic diseases. This focus will move away from an episodic care model to engaging with clients and families on an ongoing basis to reduce harm from alcohol and other drug use.

Caption: Drug and alcohol services staff Justine Ruolle (r) together with colleagues Helen Gliwa (left) and Rebecca Tooley (centre)

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SAFE & EFFECTIVE PATIENT CARE

DIGITAL MEDICAL RECORD IMPLEMENTATION

Over the past 12 months, Western Health has moved from a manual medical record system to a Digital Medical Record (DMR).

The implementation of the BOSSnet Digital Medical Record system was required in order to enable the digital storage and delivery of patient medical records across Western Health campuses.

In order to provide seamless care to all Western Health patients, it is vital that patient information is available when required, at any site. Patient records are now accessible from any site on the health service network.

The security of private patient information has also been enhanced through the digital system.

By eliminating the need for a physical record, the DMR system has limited access to only those people who need to have access to the system and provides the ability to maintain a log of user access of records, which would enable the detection of unauthorised record access. The new system has also overcome gaps in a medical record such as missing pages and misplaced records.

GP MESSAGING GATEWAY

The Western Health e-Messaging Gateway outbound messaging solution (hospital to GP) was successfully deployed in June 2012. GPs can now select their preferred method to receive information on patients regarding admission, discharge, transfer or mortality. The new system is expected to be a valuable tool in supporting the provision of appropriate and effective patient care and services.

CLINICIANS AT THE HELM

Building on the success of the inaugural Clinicians at the Helm program, this highly regarded development opportunity was provided to a further 70 senior clinicians and health professionals in 2011 - 2012. Providing the benefit of a globally recognised management and leadership development program which is tailored to meet local requirements, the 6 day program has been delivered by The Advisory Board, with strong support from the Western Health Executive.

Participants from across the service and from a wide range of medical, nursing, and health professional roles engaged with evidence- based approaches and utilised best practice tools to explore and address critical challenges facing leaders in health care systems. As well as developing management and leadership skills and engagement amongst clinical leaders, the program supported the development of strong working relationships and supportive networks and promoted effective interdisciplinary working relationships, in line with Western Health's educational strategy.

VICTORIAN PUBLIC HEALTHCARE AWARDS

Western Health was awarded three prestigious awards as part of the Victorian Public Healthcare Awards 2011.

Two Silver Awards and one Highly Commended Award in the 'Better Health Awards' category were presented to Western Health by Minister for Health, David Davis.

One of the Silver Award winners was Western Health's Cultural Key Phrases tool: 'Swallow please!', which was developed by Speech Pathology and Languages Services staff to assist with the challenges of conducting efficient and effective swallowing assessments for culturally and linguistically diverse patients with limited interpreter access.

Also in receipt of a Silver Award was Western Health's Neurosurgery Physiotherapist-led Clinic, which was developed in response to the increasing demand for neurosurgery at Western Health.

The 'Clinman – transformation of surgical patient management Information Communications and Technology development program' received a Highly Commended Award.

PEOPLE & CULTURE

ORGANISATIONAL DEVELOPMENT PLAN

Organisational development (OD) is the planned process of developing an organisation to be more effective in achieving its goals. Key pillars of the OD plan 2011 have been: Organisational Strategy and Plans, Human Resources and People, The Executive Team, Senior Management Group, Partnering, Leadership and Communication. "One Western Health" has continued to be an integrating principle for the OD plan.

The biennial People Matters staff survey (PMS) has enabled benchmarked monitoring of progress against elements of the OD plan. PMS collects data on employee perceptions of values and principles applied in the workplace together with information on people management issues such as employee commitment and satisfaction. Comparison of PMS results between 2007 and 2011 shows WH has moved from being one of the lower performing health services in 2007 to being above average for all indicators (and in the top quartile for 75% of indicators) in 2011.

Workforce planning in 2011/12 has included a high level quantification of the impacts of the WH service plan on staffing levels for nursing, medical, allied health and other staff groups and the operational planning for workforce for new facilities as they become available as part of the funded capital development of the service.

Health and Safety innovation Recognised

Caption: Patient Services staff at Western Health

Maintaining a safe and healthy workplace is an essential part of valuing staff at Western Health. Each year, the Occupational Health and Safety Awards recognise the important contributions made by staff, to ensure a safe and healthy workplace is maintained.

This year's winner of the OH&S Team Award was the Environmental/Patient Services team for their Western Environmental Services OHS Working Party. The team reviewed a range of issues and implemented seven health and safety initiatives, resulting in a real reduction of risks to Environmental/Patient Services Assistant and other staff.

The winner of the Individual Award for Occupation Health and Safety was presented to Leanne Basset from the Emergency Department of Western Hospital for her ingenuity in designing a new lighter oxygen cylinder holder for patient trolleys.

"The new oxygen cylinder holders are easier to use and present less risk of injury from lifting than the heavier conventional holders," Chief Executive, Ms Kathryn Cook explained.

PEOPLE & CULTURE

EXCELLENCE IN INNOVATION AWARDS

The extraordinary service delivered by Western Health staff over the past 12 months was acknowledged at the Annual General Meeting, through the Excellence in Innovation Awards.

Now in their 10th year, the Awards were established to provide a forum for staff to showcase innovative projects and gain recognition from their peers.

Board Chair, the Hon. Ralph Willis presented the winners with their Awards, along with representatives from SGE Credit Union and Highpoint, the Award sponsors.

The overall Winner of the 2011 Excellence in Innovation Awards was the Co-Head of the Orthopaedic Unit in Surgical Services at Western Health, Phong Tran, for the 'Orthofracs' project.

The orthopaedic unit designed and implemented an interactive multi-faceted e-learning website which, through integrating registrar training, has positioned Western Health as a leading teaching facility. Western Health is now the reference e-learning web resource site for the Royal Australian College of Surgeons (RACS) and Australian Orthopaedic Association (AOA).

The first of two Highly Commended Awards went to Sam Wills (Paediatric Orthopaedic Physiotherapy), Kathy MacDonald (Radiology) and Francis Sweeney (Paediatric Outpatients) for the 'Advanced Practice Developmental Dysplasia of the Hip (DDH) Ultrasound Clinic'.

The second Highly Commended Award went to Consultant Geriatrician, Dr Claire McKie and her team for the introduction of the Ortho-Geriatric Unit at Sunshine Hospital.

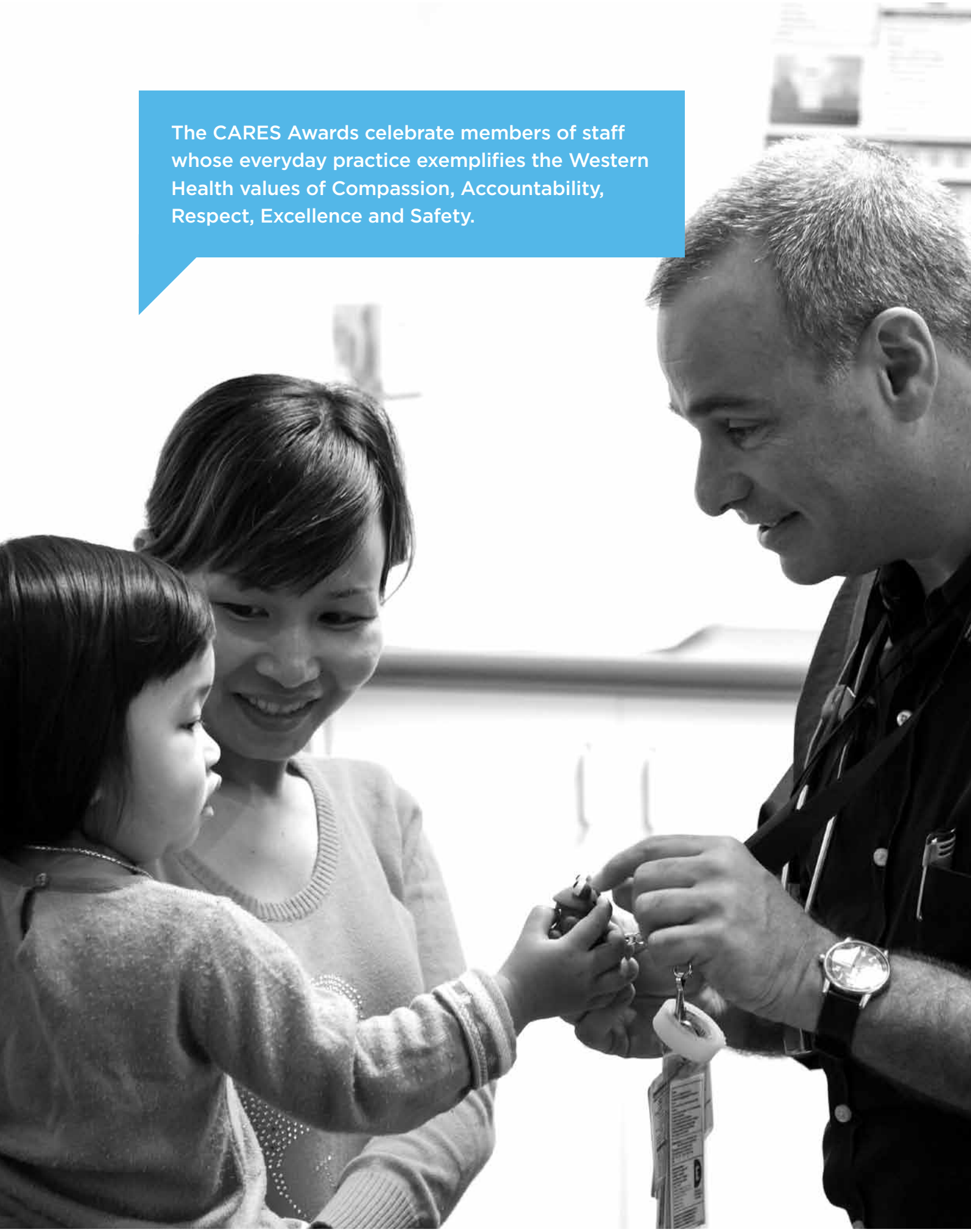
CARES Awards

The CARES Awards celebrate members of staff whose everyday practice exemplifies the Western Health values of Compassion, Accountability, Respect, Excellence and Safety. A typical example is Kylie Chalmers, clinical nurse specialist in ICU, whose nomination included the following summary:

Kylie is a humble person who does not seek acknowledgement for the work she does. Her clinical expertise has already been recognised via an International Nurses Day award. However, she is also someone who constantly goes above and beyond to enable the best care for patients. She focuses on patients and families as individuals and is very present with them throughout the frightening and stressful experience of being in ICU. She is recognised and admired by her colleagues for excellence in clinical practice, strong leadership skills and her unwavering commitment to supporting patients and families.

This year, 19 staff received awards and thanks from the Chief Executive and staff. They represented every operational division in many different types of roles, including enrolled and registered nurses, nurse managers, senior medical staff, technicians, administrative and professional staff, occupational therapists and physiotherapists.

The CARES Awards celebrate members of staff whose everyday practice exemplifies the Western Health values of Compassion, Accountability, Respect, Excellence and Safety.



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COMMUNITY & PARTNERSHIPS

SETTING UP THE WESTERN HEALTH FOUNDATION

Western Health established the Western Health Foundation in the last financial year.

The Foundation has been set up as a separate legal entity in order to seek funding from wider sources, specifically those organisations that are restricted to providing funding to charities. In the current economic climate, there is intense competition for philanthropic funding.

The Foundation is committed to inspiring support, creating partnerships and presenting Western Health as a leader in the community's health care.

The Foundation commenced officially on 1 July 2012 and is seeking funding for numerous projects. A user friendly website for accepting on-line donations has also been established.

To ensure strong partnerships are formed between the Foundation and philanthropic organisations, up-to-date fundraising software has been adopted. It will provide an accurate data-base and perform the necessary processes such as receipt generation, personalised correspondence and report generation.

Mr Robert Scarborough was appointed as the Foundation's first Chairman, while Mr Ian Higgins was appointed to the role of Director and Executive Officer of the Western Health Foundation The Foundation is "dedicated to raising funds to assist Western Health and the people of Melbourne's West."

BETTER HEALTH PLAN FOR THE WEST

The Better Health Plan for the West is a key partnership between 21 partner organisations across the western region of Melbourne. Western Health has played an important role in helping to develop the Plan over the past year. It is aimed at shaping the way local health services respond to the complex needs of one of Australia's fastest growing and most diverse regions.

The Plan identifies an agreed set of key health issues and broad directions for future service delivery in the western metropolitan region for 2011-2021.

The Plan has identified seven key objectives to work towards:

1. Improve health literacy
2. Deliver services that are inclusive and culturally appropriate
3. Provide services that are well coordinated, easy to access and navigate
4. Attract, grow and share outstanding staff in the West
5. Optimise current resources and attract new resources to meet the current and future needs of communities
6. Develop a research program focused around health priority areas
7. Utilise e-health and communications technology

The Plan includes the partnership of a broad spectrum of health providers from the West, who have a strong track record of collaborating together to develop and deliver new and improved services. The Plan was developed was endorsed by all partner organisations in September 2011.

CULTURAL DIVERSITY

A Western Health Cultural Responsiveness Plan was developed against the Victorian Department of Health Cultural Responsiveness Framework. This Framework addresses six standards for cultural responsiveness which cover:

- an organisation- wide approach to cultural responsiveness
- a leadership approach to cultural responsiveness
- using accredited interpreters
- developing culturally appropriate practical care
- involving diverse consumers, carers and community members in health service planning
- providing professional development for staff at all levels

The Cultural Responsiveness Plan has provided a focus and platform for improvement activity. Whilst still in its initial stages of implementation, the Plan has informed, for example, the development of on-line education modules. These modules cover: Delivering Culturally Appropriate Care; The Vietnamese Community in Australia; The Sudanese Community in Australia; and Improving Care for Aboriginal and Torres Strait Islander Patients.

During 2011, 67 participants viewed the online training modules and 52 participants completed one or more modules.

More than 38 per cent of Western Health's catchment population speak a language other than English at home, which reinforces the need for a high priority to be placed on the provision and continual improvement of Language Support Services. Western Health now has a complete staff base of in-house interpreters for the most requested languages: Vietnamese, Arabic, Greek, Italian, Spanish, Dinka, Mandarin, Cantonese, Macedonian, Serbian, Croatian. This has had a positive impact on patient care by having interpreters available at short notice and on demand. In-house interpreters also enable the organisation to monitor the quality of interpreting and provide patients with a quality service. Face to face interpreting also improves patient satisfaction and outcomes.

Supporting Cultural Diversity at the Point of Care - development of a Cultural Key Phrases Toolkit

Capacity to eat and drink is a basic life skill. Sudden loss of this ability can significantly impact health and wellbeing. Timely assessment and intervention of swallowing problems is essential to support optimal outcomes.

Western Health Speech Pathology recognised that high demand for interpreter services meant that at times patients for whom English was not their first language were unable to access timely comprehensive swallowing assessment.

The 'Cultural Key Phrases Tool' (CKPT) was developed to address challenges of conducting efficient and effective swallowing assessments with this patient group when there was limited interpreter access. Professionally produced, it comprises key phrases represented pictorially, in writing and verbally for the ten most common languages spoken by patients at Western Health

Qualitative feedback from patients, carers and staff has been very positive with high satisfaction expressed in all responses.

Cultural Key Phrases Tool (2nd Edition) is now a commercial product, with multiple copies purchased by six major metropolitan health services.

COMMUNITY & PARTNERSHIPS

Consumer involvement with drug and alcohol services

Over the past year, the Consumer Participation Advisory Group (CPAG) for the drug and alcohol service at Western Health, has been going strong and has a number of significant achievements to its name. The group meets monthly and has been working with staff from across the range of services to develop, monitor and evaluate a range of strategies to increase consumer, family and carer involvement in the service.

To date the group has:

- Developed a mission statement to drive consumer involvement
- Overseen the development of a three year Consumer Involvement Plan for the drug and alcohol service
- Overseen the implementation of a client satisfaction survey
- Suggested a range of strategies for service improvement from the survey feedback
- Been involved in consultation around service planning and development

COMMUNITY PARTICIPATION AT WESTERN HEALTH

Western Health is constantly expanding the opportunities for consumer involvement in service planning and during the 2011/12 year, a number of new forums have been developed to enable more extensive consumer involvement.

The group also coordinates a series of events throughout the year such as Drug Action Week, Overdose Awareness Day and Hepatitis Awareness Day.

CLOSING THE GAP STRATEGY

Western Health is strongly committed to improving the health of Aboriginal patients in the western suburbs.

Over the last 12 months, Western Health sought endorsement for the development of a new framework to support and integrate Western Health strategies aimed at improving the health of Aboriginal patients.

We committed to work with Aboriginal Health services and elders to address 'Closing the Gap' priority areas, and specifically to progress work with St Vincent's and Northern Health on Closing the Gap for the North West Region.

Prior to adopting this new approach, Western Health had a number of isolated projects focusing on Aboriginal Health, including:

- The Establishment of the Koori Maternity Service (KMS) at Western Health
- Funding an Aboriginal specific component to the Renal Clinical Network project
- Funding from the Closing the Gap ICAP review to resource an Aboriginal Health and Culture resource section of the Western Health libraries

Like many health services, Western Health has encountered various systemic challenges and issues in regards to providing optimal support for Aboriginal patients.

It was recommended that a clear framework be developed to ensure the integration and co-ordination of projects focused on improving the care of Aboriginal patients.

Western Health has since appointed an Aboriginal Health, Policy and Planning Manager to lead improvement in the care of Aboriginal patients.

LARGEST HEALTH SERVICE VOLUNTEER PROGRAM

Western Health continues to manage the largest volunteer program of any Victorian health service, Currently the volunteer team boasts over 400 active members.

The focus for the volunteer program during 2011-2012 was on patient support. Currently more than 200 of the volunteers are involved in supporting our patients by driving them to and from appointments, making them a tea or coffee while waiting for an appointment, sitting and playing cards or reading the paper with them, assisting them with their meals, listening to their life story or reassuring them in the Emergency Departments.

Community Engagement has seen the involvement of a partnership with Keilor Downs Secondary College where students have visited the Sunshine Hospital, assisted with events and also now have a yearly committed fundraising program for the Sunshine Hospital.

The Sunshine Hospital, Maribyrnong & Craft Group auxiliaries have raised funds to assist with the purchase of equipment at all of the hospitals. The Williamstown Hospital and Sunshine Hospital Opportunity Shops have also contributed to the fundraising efforts.

Passion rewarded for meal assistance volunteers

Western Health volunteers were honoured in the 2012 Minister for Health Volunteer Awards during the year, with the Volunteer Meal Assistance Program receiving an Outstanding Achievement award.

Minister for Health and Ageing the Hon. David Davis paid tribute to the generous and inspiring unsung heroes who volunteer in the health and wellbeing sector.

The Minister said the Volunteer Awards, now in their fourth year, were established to celebrate the remarkable achievements of our health volunteers.

The Western Health Volunteer Meal Assistance Program evolved in response to a Western Health Nutrition Department study that identified a range of benefits in providing one-on-one meal assistance to high-needs hospital patients.

Known affectionately as VMAP, the eight volunteers offer meal-time support seven days a week to patients identified as having difficulty feeding themselves as a result of physical and/or cognitive impairment.

Caption: (l to r) VMAP volunteer Julie Tran; Dietician Rachael Evans; VMAP volunteer Elaine Bo; and Nurse Unit Manager Jeff Garner; with Awards Presenter, Dr Feelgood.

President of the Sunshine Hospital Auxiliary, Pauline Murphy, was also Highly Commended at the Awards as an individual volunteer, for her work in outreach within her local community, which included knitting workshops for inmates at the women's prison to support the Auxiliary Shop at Sunshine Hospital.

COMMUNITY & PARTNERSHIPS

FUNDRAISING

Western Health is fortunate to have the support of many people and organisations in Melbourne's West and from philanthropic supporters here in Victoria. This support continues to be vital in supporting Western Health's programs. Funds raised provide additional equipment and facilities to improve patient care.

In 2011/12 Western Health received $826,403 in donations, grants and bequests income. This significant income means that we have been able to purchase equipment such as an additional bladder scanner for the radiology unit at Sunshine Hospital thanks to a generous grant from The E.J. Whitten Foundation.

In December 2011 the Victorian Racing Club held the Western Health Community Raceday. This event, now in its sixth year continues to provide growing income for Western Health. Over $100,000 was raised through the event, to support the work of the Australian Institute for Musculoskeletal Science (AIMSS). AIMSS was established in 2011 and is located in the Western Centre for Health Research and Education at Sunshine Hospital.

All donations are important to Western Health and we thank the thousands of individual donors who support our health service or local hospital each year.

COMMUNITY SUPPORTERS

Western Health receives significant support from the many community groups that reside in our catchments. These groups add greatly to the success of our fundraising initiatives and we continue to develop and strengthen these relationships and look for opportunities to develop new ones.

Western Health is grateful to the groups and auxiliaries that support staff and patients across Western Health. During the year these groups raised significant funds to support our health service.

THERE ARE MANY WAYS TO MAKE A DIFFERENCE

The time and energy of a variety of people and groups is the fabric that supports Western Health.

In kind and pro bono assistance from supporters such as the Victoria Racing Club, Eynesbury Golf Course, Highpoint, Qenos, City West Water and many of our suppliers helps us to achieve our goals in a cost effective manner.

WHERE THE MONEY GOES

Donations are receipted into special purpose accounts and distributed to the specific cause or Department for which they are given. Western Health is grateful for the support we have received this year that has seen the purchase of vital pieces of equipment for the varied services of Western Health. Cancer, cardiac, palliative care, renal, radiography, women's and children's.

High quality teaching, training and research support excellence in health care. The past 12 months have seen a significant amount of research and training across all our campuses, spanning a wide range of health disciplines. Our recent research achievements would not have been possible without the drive and passion our leading clinicians and researchers bring to their work.

RESEARCH & LEARNING

1ST YEAR OF WESTERN CENTRE FOR HEALTH RESEARCH AND EDUCATION

Over the past year, the Western Centre for Health Research and Education (WCHRE) has enabled a number of new opportunities to emerge including the launch of the Australian Institute for Musculoskeletal Science (AIMSS).

The profile and reputation of research and learning at Western Health has been elevated through the hosting of events at the Centre, such as the Post Graduate Medical Council's Annual Symposium; the first inter-professional Western Health Research Week, and the inaugural seminar for AIMSS.

In June 2011 the $51.6 million Centre opened to staff, students and visitors. In its first year of operation:

- 2,128 bookings were made for the various training rooms
- 116 video conferences were booked
- more than 1,600 staff and students used and visited the simulation laboratories
- 60 internal and external formal courses were offered through the simulation lab. A large number of these courses were interdisciplinary
- there were more than 37,300 gate counts at the new library

Western Health would like to acknowledge its partners, the University of Melbourne and Victoria University for helping us shape WCHRE to date.

EDUCATION STRATEGY IMPLEMENTATION

The Western Health Education Strategy 2011/2015 continued to be a primary focus for Western Health over the past year.

As the western suburbs continue to see rapid population growth, Western Health must also grow and be responsive to the changing community needs.

Western Health continued to work with the people and key stakeholders in the west over the last 12 months to build upon and improve the range of health and well-being services.

By 2013 Western Health expects to be a health service that:

- continues to deliver and enhance culturally appropriate health care
- remains proactive in building a healthy community
- is a major collaborator with community health partners in the West to deliver health care
- has the resources to respond to ongoing growth and demand
- recruits and retains a compassionate, motivated and competent workforce
- is an effective advocate to improve health outcomes in the West
- is able to provide sustainable health services to the West
- is recognised as a leader in research and learning
- is recognised for excellence and innovation.

The Western Centre for Health Research and Education continued to grow throughout the year, developing strategies to promote, educational activities, commercial training opportunities and promote Western Health's reputation as a leader in this field.

RESEARCH STRATEGY IMPLEMENTATION

During the year, formal steps were taken to establish a standing Research Advisory Committee, providing governance of research activities at Western Health.

The Western Health vision is to cement a strong foundation for investigator-led research and as we continue to implement the Western Health Research Strategy, this will drive the research effort, increase research capacity in priority areas and support the development and management of patient-focused research at Western Health.

The innovative Western Centre for Health Research and Education is leading the way with a breakthrough approach to research and learning, enabling Western Health researchers to collaborate more closely with its two main partners, the University of Melbourne and Victoria University.

RESEARCH & LEARNING

Major grant to boost clinical trial capacity at Western Health

During the year, Western Health welcomed the award of funding from the Victorian Government as part of the Victorian Cancer Agency's Clinical Trial Capacity Building Grants program.

Professor Michael Green, Director of Oncology at Western Health, was awarded $250,000 to increase Western Health's capability to conduct research that can be put into practice at the bedside, and enable participation in more clinical trials in the Western Region. This will be done by expanding Western Health's existing research programs and promoting developing tumour streams.

"The aim of the grant is to provide funds to develop an infrastructure so that clinical trials can be further developed at Western Health and in the Western region," said Professor Green.

"To this end, we are focusing on two tumour streams, one is colorectal and the other is a new stream of haemotology. The aim is to increase the number of patients recruited to clinical trials - often clinical trials with a high degree of sophistication - which will be done here at Western Health.

"The purpose of doing these clinical trials is obviously to offer patients newer medications, the best types of treatment according to international standards but also to provide a high degree of quality for our cancer treatments.

"Cancer treatments are developed by investigating new medications and new strategies in clinical trials, and those of us who participate in clinical trials feel that we are offering patients the latest developments in the care of their disease."

Caption: The Clinical Trials area within the Western Centre for Health Research and Education at Sunshine Hospital.

Clinical Tutor of the Year Award

The encouraging and inspiring nature of Western Clinical School tutors was brought to the forefront when two tutors tied for the highly esteemed Tutor of the Year award. This year also marked the first time a registrar had won the award.

University of Melbourne medical students named Western Health's Clinical Services Director, Associate Professor Garry Lane and Dr Tim Bennett as the 2010/11 Tutors of the Year.

At a special dinner honouring the students and tutors, Associate Professor Lane and Dr Bennett said they were "thrilled and humbled" at the recognition.

Over 25 tutors were nominated by the 38 medical students - the first full cohort of students to be Western Clinical School students.

Professor of Medical Education Geoff McColl spoke of the importance of the tutors in the building up of the Western Clinical School. He said the school was well placed to lead the University in community-orientated medical education and that its intimate size, devoted staff and willing tutors boded well for the future of the Western Clinical School.

A significant component of the research being conducted at Western Health is targeted at chronic diseases such as diabetes, chronic kidney disease, osteoporosis and cardiovascular disease, as well as cancer. This is in keeping with the Federal Government's designated National Research Priorities and also reflects the incidence and prevalence of these diseases within the local communities served by Western Health.

The Western Health Research Strategy identified Obstetrics and Gynaecology as one of the areas of significance to Western Health with Sunshine Hospital being the third largest maternity hospital in Victoria. It was seen as important to develop and foster research activities in these fields. Other areas which have been identified include aged care, paediatrics and drug and alcohol services.

RESEARCH WEEK REPORT

The depth and breadth of research undertaken at Western Health was celebrated in the first week of November with Western Health Research Week and the launch of the Western Health Research report.

Victorian Minister for Health and Ageing, the Hon. David Davis, officially launched the event, pledging the government's support for ongoing research.

Vice Chancellor and President of Victoria University, Professor Peter Dawkins presented a thought-provoking opening keynote address on the impact of research partnerships in improving the health of Melbourne's West, highlighting the many significant projects already underway.

To mark the close of Research Week, Professor Terry Nolan, Head of the Melbourne School of Population Health at Melbourne University, delivered a public lecture on the pandemic of non- communicable diseases and the associated challenges for the healthcare system and community.

This year saw the submission of a record number of research abstracts, highlighting the amount of high quality research occurring at Western Health.

Congratulations to the following prize winners:

Inaugural Neville Yeomans Prize for the Best Medical Research (Registrars & Advanced Trainees) Dr Nadia Maqboul from Gastroenterology: A single centre

RESEARCH & LEARNING

study on the complications and outcomes following percutaneous endoscopic gastronomy (peg) tube insertion.

Kendall Francis Prize for the Best Surgical Registrar Research: Dr Tracey Lam, Surgical Registrar: The determinants of complete pathological response to chemo-radiation for rectal cance.

Best Allied Health Research: Ms Narelle Watson from Physiotherapy: The reliability of x-ray anatomic parameters for classifying distal radius fractures in adults.

Best Nursing Research: Ms Margaret McCormick: The effectiveness of simulation training in neonatal resuscitation.

Best Research Poster Prize (two joint winners): Dr Linda Appiah-Kubi, from Aged Care: The incidences of acute urinary retention in older acute inpatients at Sunshine Hospital; Ms Catherine Shore-Lorrenti, from Endocrinology & Diabetes: Determinants of Vitamin D requirements in a multi-ethnic group at high risk of developing Type 2 diabetes.

In 2011, Western Health officially separated from The Royal Melbourne Hospital to create its own Physiotherapy Clinical School to The University of Melbourne, with Alicia Martin appointed as honorary Clinical Dean. The University of Melbourne physiotherapy students named Western Health's Senior Physiotherapist, Ms Claire Boote as the 2010/11 Clinical Student Supervisor of the Year, in their inaugural year. This will be an ongoing prize.

NURSING AND MIDWIFERY STRATEGIC PLAN

The Nursing and Midwifery Strategic Plan 2012 – 2015 supports Western Health and the achievement of positive patient experiences. Nurses and midwives are engaged in making the difference through the following professional agendas:

- Supporting professional training, skills and experience
- Provision of opportunities for patients, nurses and midwives to discuss patient care experiences
- Review of clinical practice and improvement by applying research based change
- Participation in nursing and midwife led research
- Attract, support and retain the best qualified workforce possible.

WESTERN HEALTH RESEARCH ADVISORY COMMITTEE

At the end of 2011 formal steps were taken to establish a standing Western Health Research Advisory Committee, providing operational oversight of research activities at Western Health.

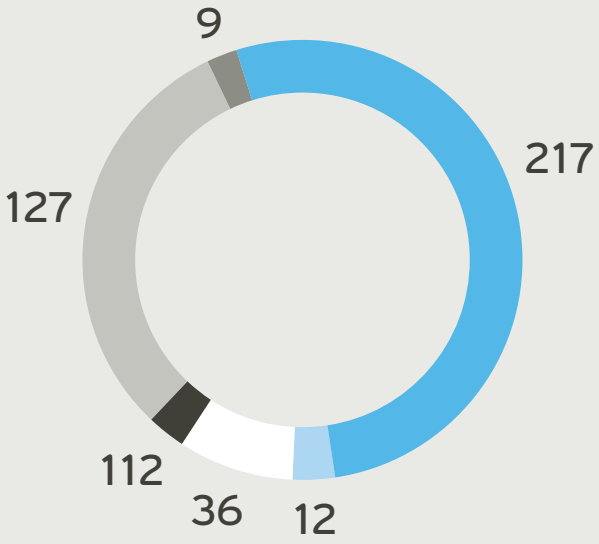
Membership of the Committee includes:

- Dr David Newman – Director, Office for Research (Chair)
- Dr Tam Nguyen – Manager, Office for Research (Secretary)
- Ms Wendy Calder – Acting Executive Director, Nursing & Midwifery
- Professor Steven Chan – Professor of Surgery
- Professor Peter Ebeling – Professor of Medicine; Chair of the NorthWest Academic Centre
- Dr Mark Garwood – Executive Director Medical Services
- Professor Michael Green – Director of Cancer Services
- Mr Ian Higgins – Director, Western Health Foundation
- Professor Edward Janus – Director, General Medicine
- Dr Harin Karunajeewa – Director, Clinical Research Division of Medicine
- Dr Debra Kerr – Senior Lecturer, School of Nursing Victoria University Associate
- Professor Ruth McNair – Director, General Practice and Primary Health Care Academic Centre (University of Melbourne)
- Mr Silvio Pontonio – Executive Director, Community Integration and Partnership
- Dr John Violet – Director, Sunshine Hospital Radiation Therapy Centre

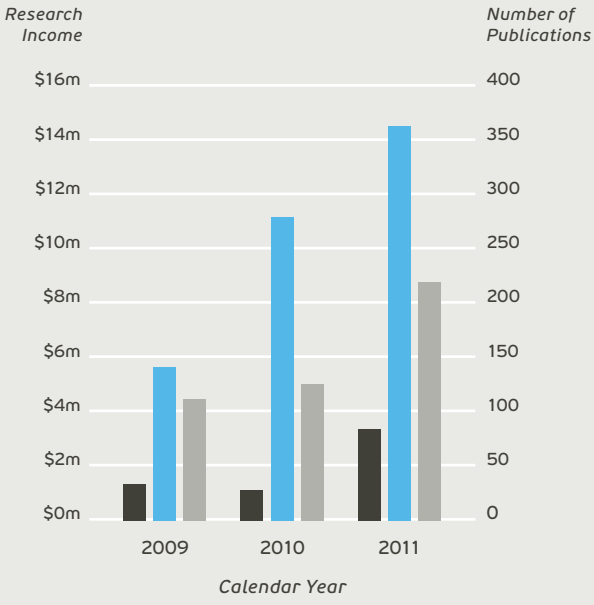
Research Highlights*

$3.45m
Income from Commercially Sponsored Clinical Trials

$14.51m
Awarded or held for Research Grants during 2011**



Western Health Research Output Data Comparison 2009-2011



- **9** Prestigious Research Awards
- **217** Published Journal Articles
- **12** Published Book Chapters
- **36** Research Grants
- **112** Seminar and Conference Presentation
- **127** Research Projects Approved

- Clinical Trial Income
- Research Grants
- Publications

* These figures relate to the 12 month period of 2011
** Total awarded for the duration of the grants to our researchers and their collaborators

SELF-SUFFICIENCY & SUSTAINABILITY

$15.1 MILLION TO FUND ICU AT SUNSHINE HOSPITAL

The Victorian Government budget for the 2012-13 year included some welcome news for Western Health, with the allocation of $15.1 million to fund critical care services at Sunshine Hospital, including an Intensive Care Unit.

Western Hospital has the only ICU in the western suburbs of Melbourne.

There has been a steady increase in the number of patients requiring transfer from Sunshine to Western Hospital to receive care that is unavailable at Sunshine. In addition, many patients bypass Sunshine Hospital altogether, and need to be taken by ambulance to other hospitals outside the western suburbs, because Western Health cannot meet their need for critical care.

This funding means that thousands of patients will be able to receive critical care services without being transferred a considerable distance away.

Planning by Western Health and the Department of Health has taken into account the need for services associated with an ICU. Western Health is now working closely with the Department of Health to establish a program of capital development that will enable the ICU at Sunshine Hospital to open as soon as possible.

NEW ACUTE SERVICES BUILDING

All construction milestones were achieved for the construction of the new Acute Services Building at Sunshine Hospital, with construction completed on time and on budget soon after the end of the financial year. Planning around proposed bed configuration and service delineation is now taking place.

Following completion of the building, work commenced on installation of furniture, fixtures and other internal fittings, along with placement of the information technology components. The first patient services within the building are planned to commence in March 2013.

The new building will house a range of services on site at Sunshine Hospital, which have not previously been available at that campus.

STRATEGIC MASTER PLAN REVIEW

During the year, Western Health completed a full review of the Strategic Master Plan for Western, Sunshine and Williamstown Hospitals.

The Master Plan presents options for the future development of the various campuses in line with the Department of Health direction that Sunshine Hospital gradually transition to become the major tertiary hospital for the Western suburbs.

BUSINESS INTELLIGENCE

The Western Health Monitoring & Performance (MaP) Central Data Warehouse continues to be developed to support increased access to up to date management decision making information. A total of 13 Clinical Quality indicators have been approved by the Clinical Governance Committee and are being reported on the MaP system. A Finance reporting suite has been developed and reporting from the MaP system is scheduled to commence for July 2012 reporting.

Development priorities for 2012/13 include the establishment of data interfaces and management reporting for Clinical Risk, Rostering, Staff Credentialling and Community Care Services.

NEW PATHOLOGY PROVIDER

With Western Health growing at an extraordinary rate, changes were required in order to meet the increasing demand on services. Pathology was identified as one of the many areas undergoing significant transition in line with the growth of the organisation.

From 1 October 2011, Dorevitch Pathology commenced provision of all pathology services to Western Health, following a competitive tender process.

While the transition of a pathology service is no easy task, teams from Dorevitch and Western Health worked intensely to ensure the changeover to the new service has been as seamless and continuous as possible, given the complexities involved.

Extensive training was provided to staff and dedicated teams were on hand throughout the changeover process to assist staff and address any questions or concerns.

The change to a new provider is enabling Western Health to respond more effectively to the needs of patients and the growing demand for pathology services.

MATERNITY SERVICE EXPANSION

The State Budget also included an allocation of funds to increase birthing services at Sunshine Hospital to help address the extraordinary level of demand which saw close to 4,600 babies born at Sunshine over the past year. Sunshine Hospital is the third largest single site maternity hospital in Victoria, after the Women's and the Mercy at Heidelberg.

ENVIRONMENTAL SUSTAINABILITY

Western Health is moving strongly towards its reduction targets to:

- reduce energy consumption by 2.5% / m2 floor space by July 2013, from the 2007/08 baseline
- reduce water consumption by 8% / m2 floor space by July 2013, from the 2007/08 baseline
- reduce waste to landfill by 30% percent by July 2013, from 2007/08 the baseline

Some of the highlights during 2011/12 include:

- the introduction of recycling in public areas
- the successful pilot and rollout of recycling programs to divert 27% of clean medical waste from landfill
- energy efficiency measures to reduce energy consumption by 3.86% per m2 floor space
- the introduction of a green transport option in bus transfer for students and staff travelling between Sunshine and Footscray sites
- hosting the Australian Government Climate Commission and other health care professionals for discussion of climate change as a health issue
- the retrofit of tap ware to ensure greater water efficiency in day to day operations
- participation in National Tree Day and Sustainability Victoria's Greenhouse Games.

WESTERN HEALTH MANAGEMENT

EXECUTIVE

Kathryn Cook
Chief Executive Officer

Juliette Alush
Executive Director People, Culture and Communications

Wendy Calder
Acting Executive Director Nursing and Midwifery

Bruce Clark
Executive Director Finance (until February 2012)

Lydia Dennett
Executive Director Nursing & Midwifery (until Dec 2011)

Shaun Drummond
Executive Director Acute Programs (until April 2012)

Dr Mark Garwood
Executive Director Medical Services

Russell Jones
Corporate Counsel

Mark Lawrence
Executive Director Finance and Performance

Silvio Pontonio
Executive Director Community Integration and Partnerships

Dr Arlene Wake
Acting Executive Director Operations

Jason Whakaari
Executive Director Information Technology and Commercial Contracts

DIVISIONAL DIRECTORS

Claire Culley
Divisional Director Perioperative and Critical Care Services

Susan Gannon
Divisional Director Women's and Children's Services

Christine Neumann-Neurode
Divisional Director Health Support Services

Susan Race
Divisional Director Sub Acute and Aged Care

Sally Taylor
Divisional Director Allied Health and Clinical Support

Jenny Walsh
Divisional Director Emergency, Medicine and Cancer Services

CLINICAL SERVICES DIRECTORS

Mr Trevor Jones
Clinical Services Director Perioperative and Critical Care Services

Dr Ian Kronborg
Clinical Services Director Allied Health and Clinical Support

Dr Garry Lane
Clinical Services Director Emergency, Medicine and Cancer Services

Associate Professor Glyn Teale
Clinical Services Director Women's and Children's Services

Dr Richard Whiting
Clinical Services Director Sub Acute and Aged Care

DIVISIONAL DIRECTORS OF NURSING

Wendy Davis
Director of Nursing Sunbury, Perioperative and Critical Care Services

Douglas Mill
Director of Nursing Williamstown, Subacute and Aged Care

Wendy Watson
Director of Nursing Sunshine, Emergency, Medicine and Cancer Services

SENIOR MANAGEMENT

Jennie Allen
Group Manager Community Services

Scott Bennett
Director Service Planning and Development (commenced June 2012)

Sharon Desmond
Group Manager Drug and Alcohol

Leanne Dillon
Director Clinical Governance and Medico-Legal

Sean Downer
Director Health Information Management

Stephen Gow
Director Service Planning and Development (until March 2012)

Leonie Hall
Director People Services

Ian Higgins
Director Western Health Foundation

Wendy Lacey
Director of Nursing Reg Geary

Andrew Leong
Chief Technology Officer

Bruce MacIsaac
Director Capital Development

Kent MacMillan
Director Pharmacy Services

Louise McKinlay
Director Education and Learning

Debbie Munro
Acting Director Allied Health

David Newman
Director Office for Research

Dean Palmby
Director Clinical Support

Steven Parker
Director OH&S, Wellbeing and Emergency Management Services

Rebecca Power
Group Manager Care Coordination

Vanessa Raines
Director Patient Access and Service Improvement

Alison Rule
Director Corporate Governance and Planning

Cathy Sommerville
Director Stakeholder Relations and Public Affairs

Natasha Toohey
Project Director Community Services and Redesign

Jennifer Williams
Director of Nursing, Hazeldean Transition Care

WESTERN HEALTH SERVICES

EMERGENCY, MEDICINE AND CANCER SERVICES

Acute Ambulatory Care
Addiction Medicine
Dermatology
Endocrinology & Diabetes
Emergency Medicine
Gastroenterology
General Medicine
Geriatric Medicine – acute
Haematology
Hospital In The Home
Immunology
Infection Disease
Medical Oncology
Migrant Screening Program
Nephrology
Neurology
Renal Dialysis
Respiratory and Sleep Disorders
Rheumatology
Palliative Care
Stroke Service

PERIOPERATIVE AND CRITICAL CARE SERVICES

Anaesthetics and Pain Management
Centre for Cardiovascular Therapeutics (incorporating Cardiology Services)
Colorectal and General Surgery
Elective Booking Service
General, Breast and Endocrine Surgery
Intensive Care Services (incorporating ICU Liaison)
Neurosurgery
Ophthalmology
Orthopaedic Surgery
Otolaryngology, Head, Neck Surgery
Paediatric Surgery
Plastic, Reconstructive and Facio-Maxillary Surgery
Preadmission Service
Thoracic Surgery
Upper Gastro Intestinal and General Surgery
Urology Surgery
Vascular Surgery

SUBACUTE AND AGED CARE SERVICES

Aged and Complex Care Access Service
Best Care for Older People Program
Geriatric Evaluation and Management
Rehabilitation
Restorative Care
Palliative Care (inpatient service)
Hazeldean Transition Care

WOMEN'S AND CHILDREN'S SERVICES

Gynaecology
Maternity Services
Special Care Nursery
Paediatric Medicine

ALLIED HEALTH AND CLINICAL SUPPORT

Aboriginal Liaison Service
Audiology
Language Services
Nutrition and Dietetics
Occupational Therapy
Pastoral Care
Physiotherapy
Podiatry
Psychology
Social Work
Speech Pathology
Specialist Clinics (Adult)
Interventional Radiology
Medical Imaging
Pathology
Pharmacy

CARE COORDINATION

Aged Care Assessment Service
Immediate Response Service
Hospital Admission Risk Program

CLINICAL SUPPORT SERVICES

Interventional Radiology
Medical Imaging
Pathology
Pharmacy

COMMUNITY AND AMBULATORY CARE SERVICES

Aboriginal Health, Policy and Planning
Cognition, Dementia and Memory Services
Community Based Rehabilitation
Community Nursing Service
Community Transition Care Program
Continence Clinic
Falls Clinic
GP Integration Unit
Parkinson's Disease Service
Post Acute Care Program

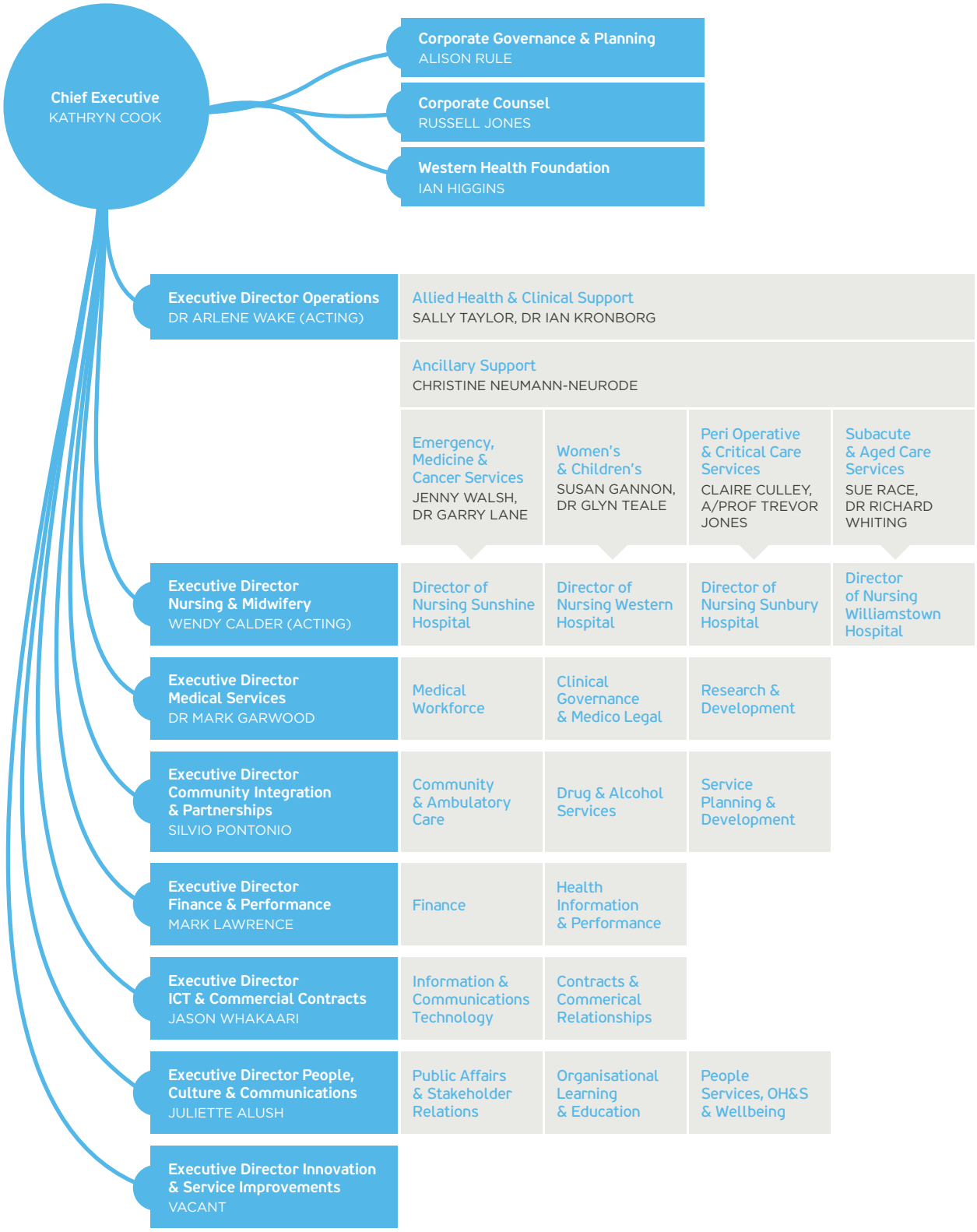
DRUG AND ALCOHOL SERVICES

Youth and Family Services
Adult and Specialist Services
Community Residential Withdrawal Services

RESIDENTAL AGED CARE

Reg Geary House

ORGANISATIONAL STRUCTURE



CORPORATE GOVERNANCE

The Board of Western Health consists of independent non-executive members from a range of backgrounds and with local ties to Melbourne's West. The Board consists of nine Directors. Each Director also has a role on one or more Board Committees.

THE HON RALPH WILLIS, AO

BCOM
CHAIR

Ralph Willis is a life-long resident of Melbourne's West and represented the seat of Gellibrand in the Federal Parliament for 26 years. For 13 of those years, he was a Cabinet Minister in the Hawke and Keating Government, holding the portfolios of Employment and Industrial Relations, Transport and Communications, Finance and Treasurer.

Mr Willis is also a Director of Victoria University Foundation and Trustee of the Stan Willis (Charitable) Trust. He was previously Chair of the Construction and Building Industry Superannuation Fund (CBUS) and LeadWest, a regional representational body for the western suburbs of Melbourne.

Mr Willis is a member of Western Health's Finance Committee, Governance and Remuneration Committee, Quality and Safety Committee and the Primary Care and Population Health Advisory Committee.

Appointed July 2004

MRS ELLENI BEREDED-SAMUEL

ME, POST-GRAD DIP COUNSELLING, BA FOREIGN LANGUAGE & LITERATURE

Elleni Bereded-Samuel was born in Ethiopia and has focused her life's work on strengthening education, training and employment for Culturally and Linguistically Diverse (CALD) communities in Australia. Currently, Elleni is the Community Engagement Advisor & Coordinator at Victoria University.

For six years Mrs Bereded-Samuel served on the Board of Directors of The Women's Hospital and chaired their Community Advisory Committee. She served as the inaugural member of the Australian Social Inclusion Board and is a Director of the SBS Board & member of the Community Engagement Committee. From 2005-2011 Mrs Bereded-Samuel served as the first African Commissioner appointed to the Victorian Multicultural Commission. In 2012, she was appointed as a People of Australia Ambassador.

Mrs Bereded-Samuel is Chair of the Cultural Diversity and Community Advisory Committee and Member of the Education, Research and Development Committee.

Appointed July 2011

MS JULIANN BYRON

BCOM, GRAD DIP (CORP MGT), FCPA, FAICD, FTIA, ACIS

Juliann Byron has extensive experience as a Director, having a background in Finance and Company Secretarial roles with public and private companies. She is currently a consultant in the areas of financial management, corporate governance and company secretarial matters.

Ms Bryon is also the Treasurer of the Victorian Cytology Service and Director and Treasurer of the Bendigo Community Bank in Canterbury, Surrey Hills, Ashburton and Balwyn.

Ms Byron is Chair of the Audit and Risk Committee and Chair of the Governance and Remuneration Committee.

Appointed July 2004

CORPORATE GOVERNANCE

PROFESSOR COLIN CLARK

BBUS, DIP ED, MBA, PHD, FCPA, FCA, FIPAA

Colin Clark is Professor of Accounting at Victoria University. He has served as Executive Dean and earlier as Deputy Dean of the Faculty of Business and Law.

He has been active within CPA Australia having been a member of the Victorian Council, including as State President, and also a member of the board of CPA Australia including serving as Vice President. He has undertaken a number of research and consulting projects including international projects. His area of specialisation is public sector accounting and management and corporate governance.

Professor Clark is Chair of the Finance and Resources Committee.

Appointed July 2010

ASSOCIATE PROFESSOR AFIF HADJ

MB, BS FRACS

Afif Hadj graduated in Medicine from the University of Melbourne in 1971 and became a surgeon in 1979. He has since specialised in Breast and Trauma surgery. He held the position of Director of Surgery at Maroondah Hospital, which is part of the Eastern Health network and has been in private practice and a consultant surgeon at PANCH.

Associate Professor Hadj is a Fellow of the Royal Australasian College of Surgeons and a member of its General Surgery Division, Breast Section and Trauma Section.

During the year, Associate Professor Hadj was Chair of the Quality and Safety Committee and Chair of the Education, Research and Development Committee.

Appointed July 2006

Term completed 30 June 2011

MR PHILIP MORAN

BA (HONS), GRAD DIP (BUS ADMIN), MAICD, MACHSE

Philip Moran is a member of the Executive of Benetas Aged Care where he operates the Benetas at Home business unit. Prior to this he ran his own consultancy business providing strategic planning expertise and advice to a number of Not For Profit organisations. His previous employment experience includes 14 years as the CEO of Merri Community Health Service Inc. Merri Community Health Service is a major provider of community-based health and welfare services in the north-west region of Melbourne.

Mr Moran served nine years on the Council of Box Hill Institute of TAFE, including three years as Council Chair and a member of its Finance and Audit Committees.

During the year, Mr Moran was Chair of the Primary Care and Population Health Advisory Committee and a member of the Audit and Risk Committee and the Quality and Safety Committee.

Appointed July 2003

Term completed 30 June 2011

MR ROBERT MITCHELL

LLB, MPHIL, GRAD DIP TAX, MTHST, GRAD DIP THEOL

Robert (Bob) Mitchell has been a solicitor for 25 years, and was a Tax Partner at PricewaterhouseCoopers for 14 years. He has served on boards of several not-for-profit organisations including BlueCare, The Timor Children's Foundation, World Relief, and the PwC Foundation.

Mr Mitchell has a strong interest in international development work and justice issues. He has served as the Director of Legal Risk and Governance and the Chief of Mission at World Vision Australia, and has been appointed interim CEO of Anglican Overseas Aid.

Mr Mitchell is also an ordained Uniting Church Minister, and a member of the Federal Attorney-General's International Pro Bono Advisory Group.

Mr Mitchell is a member of the Governance and Remuneration Committee and Audit and Risk Committee.

Appointed July 2010

MS VIVIENNE NGUYEN

BCOM, MAPPLFIN

Vivienne Nguyen is the Group Head of Diversity at ANZ, responsible for the diversity portfolio at a global level. She had many years in financial services before joining ANZ in 2004 and held a number of roles in Retail and Risk prior to her current appointment. She holds a Master of Applied Finance and a Bachelor of Commerce from Melbourne University.

Outside work, she is a keen advocate for community participation, particularly youth leadership in non-English speaking communities.

During the year, Vivienne was a member of the Finance Committee and the Primary Care and Population Health Committee.

Appointed July 2009

MRS PATRICIA VEJBY

JP, MAICD, CMC

Patricia (Trish) Vejby has previously held Board positions which include Director of the Board of Management of Manor Court Aged Care Hostel for over 15 years (Life Governor), Commissioner to Board of the Legal Aid Commission of Victoria, and Director, Royal Victorian Association of Honorary Justices Board.

She is currently a Justice of the Peace and is a founding Chairperson of the Royal Victorian Association Honorary Justices, Wyndham Branch. Memberships include Biznet Wyndham, Women's Health Service Western Region, the Swedish Church Abroad, Melbourne and she is involved in various community activities.

Mrs Vejby enjoys her role as a Civil Celebrant/ Commonwealth Authorised Marriage Celebrant and as a Legal Office Co-ordinator.

Trish is a Member of the Cultural Diversity and Community Advisory Committee and the Primary Care and Population Health Advisory Committee.

Appointed July 2011

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CORPORATE GOVERNANCE

Western Health is incorporated as a metropolitan health service pursuant to the Health Services Act 1988 (VIC). Western Health operates under the authority of the Act and its own by-laws.

Western Health is governed by a Board of Directors appointed by the Governor in Council on the recommendation of the Minister for Health. The Board's role is to govern the health service, consistent with applicable legislation and the terms and conditions attached to the funds provided to it.

The Board is responsible to the Minister for Health for setting the strategic direction of Western Health, within the framework of government policy, and ensuring that the health service:

- is effective and efficiently managed
- provides high quality care and service delivery
- meets the needs of the community; and
- meets financial and non-financial performance targets.

14.1.1 BOARD COMMITTEES

The Board has established several standing committees to assist it in carrying out its responsibilities.

AUDIT AND RISK COMMITTEE

The Audit and Risk Committee is responsible for ensuring that the financial and related reporting systems produce timely, accurate and relevant reports on the financial operations of the health service and that sufficient resources are allocated to identifying and managing organisational risk.

CULTURAL DIVERSITY AND COMMUNITY ADVISORY COMMITTEE

The role of the Cultural Diversity and Community Advisory Committee is to advise the Board on relevant structures, processes, key priority areas and issues to ensure effective consumer and community participation at all levels of service planning and delivery. It also advises the Board on matters involving access and equity for patients and their families from culturally and linguistically diverse backgrounds.

FINANCE AND RESOURCES COMMITTEE

The Finance and Resources Committee is responsible for advising the Board on matters relating to financial strategies and the financial performance, capital management and sustainability of Western Health.

GOVERNANCE AND REMUNERATION COMMITTEE

The role of the Governance and Remuneration Committee is to advise the Board and monitor matters involving organisational governance and administration, and executive and senior staff recruitment, remuneration and performance.

PRIMARY CARE AND POPULATION HEALTH ADVISORY COMMITTEE

The Primary Care and Population Health Advisory Committee provides advice and recommendations to the Board on health issues affecting the population served by Western Health.

QUALITY AND SAFETY COMMITTEE

The Quality and Safety Committee is responsible for ensuring that quality monitoring activities are systematically performed at all levels of the organisation and that deviations from quality standards are acted upon in a timely and effective manner.

EDUCATION, RESEARCH AND DEVELOPMENT COMMITTEE

The role of the Education, Research and Development Committee is to oversee the development of plans and strategies that enable staff education and training to be linked with workforce needs, and the integration and alignment of these needs with patient care. It also oversees and monitors the development of strategy and activities which encourage, promote and support research across all levels of the organisation.

BOARD MEMBERS

The Board of Western Health consists of independent non-executive members from a range of backgrounds and with local ties to Melbourne's West. For the period 1 July 2011 to 30 June 2012 the Board comprised of nine members, including the Chair.

14.1.2
ATTESTATION OF WESTERN HEALTH'S RISK MANAGEMENT SYSTEM - COMPLIANCE WITH AUSTRALIAN/NEW ZEALAND RISK MANAGEMENT STANDARD

I, Kathryn Cook, Chief Executive of Western Health, certify that Western Health has risk management processes in place consistent with the Australian/New Zealand Risk Management Standard (AS/NZS ISO 31000-2009) and an internal control system is in place that enables the executives to understand, manage and satisfactorily control risk exposures relevant to our core functions. The Audit and Risk Committee verifies this assurance and notes that the organisational risk profile, supported by a range of ongoing risk assessment activities, corresponding to our strategic risk framework and strategy, has been critically reviewed within the last 12 months..

Kathryn Cook
Chief Executive
14 August 2012

14.1.3
ATTESTATION ON DATA ACCURACY

I, Kathryn Cook, Chief Executive certify that Western Health has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. Western Health has critically reviewed these controls and processes during the year.

Kathryn Cook
Chief Executive
14 August 2012

14.1.4
THE FREEDOM OF INFORMATION ACT

The Freedom of Information (FOI) Act (Vic) 1982 grants the public a legally enforceable right to access documents in the possession of Government agencies, including clinical and non-clinical records. Western Health processes all requests for access to documents in accordance with the provisions of the FOI Act.

TOTAL REQUESTS	1193
Full Access	989
Partial Access	0
Access Denied	2
Application Withdrawn	120
No Documents	22
Applications Not Processed	0
VCAT Appeal	0
Appeal Withdrawn	0

14.1.5
OCCUPATIONAL HEALTH AND SAFETY 2011/12

To minimise risk and promote staff health and wellbeing, the following programs and activities were provided:

- Regular reports provided to the Western Health Board of Directors and the Occupational Health and Safety Committee detailing OH&S and WorkCover performance.
- Mandatory OH&S training courses for managers and supervisors – as part of the Diploma of Management (OH&S unit) – Ensure a Safe Workplace.
- OH&S training provided to Patient Services Assistants trainees.
- Efficient and effective staff rehabilitation and return to work processes embedded into organisational standard practice.
- Enhancements to the "Back 4 Life" (No Lift) program with strategies progressively introduced to address the risks associated with patient and general manual handling and to foster a safe working culture.

CORPORATE GOVERNANCE

- Maintaining staff competencies for the "Back for Life" program, which included ward in-services, refresher and "Train the Trainer" training sessions.
- Education provided to staff in relation to managing risks i.e. general manual handling, workstation ergonomics, gas cylinder storage and handling, hospital danger tags, chemical handling storage, ChemAlert chemical data base, and Hazstop chemical information folder training.
- The ongoing development of a comprehensive intranet site to facilitate an easy reference source for obtaining information on OH&S, wellbeing and emergency management for staff.
- A proactive approach adopted and maintained to minimise and control risks by management, in conjunction with staff Health and Safety representatives (HSRs).
- Ongoing support for staff Health and Safety Representatives including the initial 5 day and annual refresher training.
- The introduction of a HSR monthly report card, which is designed to encourage a proactive risk management approach working with management to ensure a safe working environment for staff in designated work areas.
- Ensuring dangerous goods and hazardous substances manifests and information are readily available and up to date.
- Introduction of new OH&S related policies and procedures to ensure systematic standardised and effective processes.
- Continuation of the annual OH&S staff Award which acknowledges significant contributions in improving the health, safety or well-being by individuals and groups.
- Psychological support made available to staff offering critical incident stress management, employee assistance programs and counselling services.

14.1.6 WORKCOVER CLAIMS AND WORKSAFE NOTIFIABLE INCIDENTS

Forty (40) standard WorkCover claims (19 Western Hospital, 17 Sunshine Hospital, 1 Williamstown and 3 Reg Geary House) and eleven (11) minor claims were recorded for the year. Six (6) of the standard claims have been rejected where the liability outcome has not been fully determined.

Forty nine (49) standard claims were registered by WH's insurer, which were the standard claims received and minor claims converting to standard claims from previous years.

There were six (6) Notifiable Incidents [where either the injury or event is deemed as serious defined from section 38 (3) OH&S Act 2004 and regulation 904 Equipment (Public Safety) Regulations 2007] which resulted in only one (1) Improvement Noticed issued by WorkSafe Victoria. Suitable actions were taken by Western Health and the issue was resolved.

14.1.7 OPEN ACCESS BOARD MEETING

An Open Access Board Meeting was held in May 2012 at the Western Centre for Health Research and Education, to provide an opportunity for members of the community to learn more about Western Health and participate in decision-making processes, while also gaining an understanding of the rationale, context and environment for board plans and decisions.

The meeting included the presentation of information on the health challenges facing communities in the West and the development of Western Health's hospitals and services to help meet these challenges.

Input was sought from those in attendance and discussions related to the three primary areas of focus for Western Health's Board Committees: Patient Care, Involving the Community and Funding & Resources.

During the evening, there was also an opportunity to meet Board members and to hear a report from the Chief Executive, Ms Kathryn Cook, who gave an overview of Western Health and a snapshot of the extent of the services we provide and the demands we face.

A total of 35 people participated in the Open Access Board Meeting and discussed a range of topics. Some of the points raised included the need for good communication with our patients and between staff. Participants also discussed the importance of not making assumptions about patients or what they understand about their condition – often they will also need additional information on what to expect. There was a general consensus that clinical care at Western Health was of a good standard.

Health literacy and language barriers were widely acknowledged as being key challenges across the communities served by Western Health. It was also seen as important to involve carers and families in patient care decisions wherever possible.

Discharge and getting this right was a topic of some discussion at the meeting as well, with references to the impact this can have on a patient if the patient or their carer or family member does not have a clear idea of what to expect once they leave hospital.

It was agreed that a number of strategies were required in order to engage consumers in providing feedback about care and services. To this end it was suggested that Western Health take the Open Access meeting to the community next year, rather than expect the community to come to Western Health in order for us to engage.

14.1.8
STATEMENT OF MERIT AND EQUITY

Further to the requirements of the Public Sector Administration Act 2004, Western Health has established that the organisational values of caring, accountability, respect, excellence and safety align with the public sector values of responsiveness, integrity, impartiality, accountability, respect, leadership and human rights.

Western Health is committed to the application of the public sector employment principles and has reviewed employment processes to ensure that employment decisions are based on merit. All employees are treated fairly and reasonably, equal employment opportunity is provided and employees are afforded a structured grievance procedure for redress against unfair or unreasonable treatment.

Western Health has an established Code of Conduct, which aligns with and supports the public sector employment principles.

14.1.9
BUILDING ACT 1993

Western Health fully complied with the building and maintenance provisions of the Building Act 1993 for the period 1 July 2011 to 30 June 2012. Where applicable, the appropriate Building Permits and Certificates of Occupancy were obtained in line with the requirements of the Building Act 1993.

14.1.10
WHISTLE BLOWERS PROTECTION ACT

In accordance with Part 6 of the Whistleblowers Protection Act (Vic) 2001, Western Health has developed procedures and guidelines to facilitate the disclosure of improper conduct, to investigate such allegations and to ensure that the person making such a disclosure is protected from reprisal. To ensure staff awareness the procedure and guidelines are available on the Western Health intranet.

In accordance with the provisions of section 104 of the Act, no disclosures were received during the 2011/12 financial year.

14.1.11
VICTORIAN INDUSTRY PARTICIPATION POLICY

Western Health complies with the intent of the Victorian Industry Participation Policy Act (Vic) 2003 which is to encourage, where possible, local industry participation in the supply of goods and services to government agencies.

CORPORATE GOVERNANCE

14.1.12
NATIONAL COMPETITION POLICY

Western Health has implemented, and continues to comply with, the National Competition Policy and the requirements of the Victorian Government's Competitive Neutrality Policy.

14.1.13
ADDITIONAL INFORMATION

In compliance with the requirements of the Standing Direction FRD22B of the Minister for Finance, details in respect of the items listed below have been retained by Western Health and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

(a) Statement that declarations of pecuniary interests have been completed by all relevant officers.

(b) Details of shares held by senior officers as nominee or held beneficially.

(c) Details of publications produced by Western Health about its activities, and where they can be obtained.

(d) Details of changes in prices, fees, charges, rates and levies charged by Western Health.

(e) Details of any major external reviews carried out on Western Health.

(f) Details of major research and development activities undertaken by Western Health that are not otherwise covered either in the Report of Operations or in a document that contains the financial report and Report of Operations.

(g) Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit.

(h) Details of major promotional, public relations and marketing activities undertaken by Western Health to develop community awareness of the entity and its services.

(i) Details of assessments and measures undertaken to improve the occupational health and safety of employees.

(j) General statement on industrial relations within Western Health and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations.

(k) A list of major committees sponsored by Western Health, the purposes of each committee and the extent to which the purposes have been achieved.

KEY PERFORMANCE STATISTICS

SERVICE PERFORMANCE

WIES ACTIVITY PERFORMANCE	2011-12 RESULT	TARGET
WIES (public and private) performance to target (%)	100.8	98% - 102%
ELECTIVE SURGERY		
Elective surgery admissions – quarter 1	3282	3070
Elective surgery admissions – quarter 2	2839	3019
Elective surgery admissions – quarter 3	2892	2785
Elective surgery admissions – quarter 4	3035	3062
CRITICAL CARE		
Number of days below the minimum operating capacity	26	0
QUALITY AND SAFETY		
Health service accreditation	accredited	
Residential aged care accreditation	accredited	
Cleaning standards		
• Footscray Hospital	full compliance	
• Sunshine Hospital	full compliance	
• Williamstown Hospital	full compliance	
Submission of data to VICNISS (%)	full compliance	
VICNISS Infection Clinical Indicators	no outliers	
Hand Hygiene Program compliance (%)	full compliance	
SAB rate (OBDs)	full compliance	
Victorian Patient Satisfaction Monitor (VPSM)		
• Footscray Hospital	below benchmark	
• Sunshine Hospital	below benchmark	
• Williamstown Hospital	exceed benchmark	
Consumer Participation Index		
• Footscray Hospital	below benchmark	
• Sunshine Hospital	below benchmark	
• Williamstown Hospital	exceed benchmark	
MATERNITY		
Postnatal home care	96%	100%

ACCESS PERFORMANCE	WESTERN	SUNSHINE	WILLIAMSTOWN	TARGET
Percentage of operating time on hospital bypass	3.3%	1.2%	n/a	3.0%
Percentage of emergency patients admitted to an inpatient bed within 8 hours	54%	58%	100%	80%
Percentage of non-admitted emergency patients with length of stay of less than 4 hours	53%	62%	95%	80%
Number of patients with length of stay in the emergency department greater than 24 hours	44	46	n/a	0
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%	100%	100%
Percentage of Triage Category 2 emergency patients seen within 10 minutes	79%	67%	94%	80%
Percentage of Triage Category 3 emergency patients seen within 30 minutes	75%	64%	97%	75%

KEY PERFORMANCE STATISTICS

ELECTIVE SURGERY		TARGET
Percentage of Category 1 elective patients admitted within 30 days	100%	100%
Percentage of Category 2 elective surgery patients waiting less than 90 days	85%	80%
Percentage of Category 3 elective surgery patients waiting less than 365 days	92%	90%
Number of patients on the elective surgery waiting list	3,620	3675
Number of Hospital Initiated Postponements (HiPs) per 100 scheduled admissions	6.9	8.0

PART C: ACTIVITY AND FUNDING

ACTIVITY WEIGHTED INLIER EQUIVALENT SEPARATIONS	2011-12 RESULT
WIES Public	65,550
WIES Private	4,034
Total WIES (Public and Private)	69,584
WIES Renal	1,445
WIES DVA	988
WIES TAC	337
WIES TOTAL	72,354
SUB ACUTE INPATIENT	
CRAFT	514
Rehab L1 (non DVA)	246
Rehab L2 (non DVA)	501
Rehab - Paediatric	n/a
GEM (non DVA)	31,783
Palliative Care - Inpatient	3,898
Transition Care (non DVA) – bed day	11,009
Restorative Care	1,714
Rehab 2 - DVA	323
GEM -DVA	1,587
Palliative Care – DVA	196
AMBULATORY	
VACS – Allied Health	35,935
VACS - Variable	139,880
Transition Care (non DVA) - Homeday	9,648
SACS – Non DVA	35,136
SACS - Paediatric	n/a
Post Acute Care	3,969
VACS – Allied Health - DVA	n/a
VACS - Variable - DVA	162
SACS - DVA	156
Post Acute Care – DVA	164
AGED CARE	
Aged Care Assessment Service	4,727
Residential Aged Care	20,583

DISCLOSURE INDEX

The annual report of Western Health is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

FINANCIAL SNAPSHOT

WORKFORCE FULL TIME EQUIVALENT (FTE) PER ANNUAL ACCOUNTS

LABOUR CATEGORY	JUNE MONTH FTE 2012	JUNE MONTH FTE 2011	JUNE YTD FTE 2012	JUNE YTD FTE 2011
Nursing	1,820	1,727	1,683	1,664
Administration and Clerical	567	524	547	508
Medical Support	344	317	331	302
Hotel and Allied Services	313	302	305	296
Medical Officers	97	93	92	87
Hospital Medical Officers	390	343	367	287
Sessional Clinicians	72	67	68	58
Ancilliary Staff (Allied Health)	329	304	312	275
Total	**3,932**	**3,677**	**3,705**	**3,477**

FINANCIAL SNAPSHOT

$'000	2012	2011	2010	2009	2008
Total Revenue	585,579	566,530	511,627	453,741	409,568
Total Expenses	570,352	523,254	482,653	433,125	388,646
Net Result for the Year (inc. Capital and Specific Items)	**15,227**	**43,276**	**28,974**	**20,616**	**20,922**
Transfer to accumulated surplus		3			
Share of joint venture accumulated surplus	59				
Retained Surplus/(Accumulated Deficit)	92,654	77,424	34,148	5,174	(15,442)
Total Assets	658,515	629,085	572,014	541,267	300,533
Total Liabilities	120,441	106,297	92,490	90,729	86,168
Net Assets	**538,074**	**522,788**	**479,524**	**450,538**	**214,365**
TOTAL EQUITY	**538,074**	**522,788**	**479,524**	**450,538**	**214,365**

FINANCIAL ANALYSIS OF OPERATING REVENUES & EXPENSES

'000	2012	2011
REVENUES		
Services Supported by Health Services Agreements		
Government Grants	469,027	439,825
Indirect Contributions by Department of Health	1,322	7,879
Patient Fees	15,044	10,501
Recoupment from Private Practice	13,974	10,637
Interest	2,772	2,856
Other Revenue	13,388	9,038
	515,527	**480,736**
Services Supported by Hospital & Community Initiatives		
Private Practice Fees	149	128
Donations and Bequests	4,207	522
Property Income	328	363
Other Revenue	5,587	4,646
	10,271	**5,659**
	525,798	**486,395**
EXPENSES		
Services Supported by Health Services Agreements		
Employee Benefits	380,223	341,783
Non Salary Labour Costs	10,780	11,747
Supplies and Consumables	75,916	77,579
Other Expenses	56,945	52,853
	523,864	**483,962**
Services Supported by Hospital & Community Initiatives		
Employee Entitlements	1,779	1,339
Non Salary Labour Costs	0	106
Supplies and Consumables	441	107
Other Expenses	1,394	857
	3,614	**2,409**
	527,478	**486,371**
Surplus/(Deficit) for the Year Before Capital Purpose Income & Depreciation	**(1,680)**	**24**
Gain on disposal of Available-for-Sale Investment		1
Available-for-Sale Revaluation Surplus gain recognised		12
Capital Purpose Income	57,220	79,321
Depreciation	(40,313)	(36,082)
Surplus for the Year	**15,227**	**43,276**

FINANCIAL SNAPSHOT

FINANCIAL PERFORMANCE

OPERATING RESULT	TARGET	2011-12 ACTUALS
Annual Operating result ($'m)	0	-1.68

CASH MANAGEMENT / LIQUIDITY	TARGET	2011-12 ACTUALS
Creditors (days)	60	24
Debtors (days)	60	54

CONSULTANCIES

OVER $10,000

CONSULTANT	PURPOSE OF CONSULTANCY	START DATE	END DATE	TOTAL APPROVED (EXCL GST)	EXPENDITURE 2011-12 (EXCL GST)	FUTURE COMMITMENT (EXCL GST)
Alcidion	Interactive patient journey system feasibility study	Jun-11	Sep-11	$100,000	$25,000	-
Advisory Board	Theatre management and advisory and best practice processes	Jul-11	Jun-12	$143,125	$143,125	-
Caraniche Pty Ltd	Clinical incident supervision	Jul-11	Jun-12	$14,900	$14,900	-
CDCE Civil Consulting Design	Sunshine (FF&E) tender	Aug-11	Aug-11	$11,126	$11,126	-
Core Medical Solutions Pty Ltd	BOSSnet coding process enhancement project	Jul-11	Nov-11	$54,000	$54,000	-
Data Agility	DMR Integration	Aug-11	Oct-11	$66,087	$66,087	-
Donald Cant Watts Corke Pty Ltd	Daswest private practice model	Jun-11	Jul-11	$45,000	$20,000	-
DW Bowe	Cardiac services investigation	Oct-11	Oct-11	$18,953	$18,953	-
Hart Design Australia Pty Ltd	Sunshine hospital feasibility study re: SSU, ICU, CCU, Birthing	Jul-11	Jul-11	$13,100	$13,100	-
IHR Australia	Senior workplace relations advisory	Sep-11	Sep-11	$10,620	$10,620	-
KPMG	Private practice arrangements and billing processes in cardiology	Mar-11	Jul-11	$66,300	$39,780	-
Mercer Consulting Pty Ltd	Review of the current process in which EFT calculations are determined across the organisation, including nursing template	May-12	May-12	$44,100	$44,100	-
NOUS Group Pty Ltd	Development of a regional health plan, i.e. Better Health Plan for the West	Mar-11	Aug-11	$129,500	$38,880	-
OBS Pty Ltd	Discovery workshop and recommendations report	Sep-11	Sep-11	$11,976	$11,976	-

PWC	Development of a long term car parking strategy and traffic engineering consulting services	Jul-11	Jul-11	$88,890	$88,890	-
UXC Consulting Pty Ltd	Unified communications review	Jan-12	Jan-12	$11,360	$11,360	-
Victoria University	Value added intervention project for older nurses and midwives	Jul-11	Jul-11	$45,000	$45,000	-
TOTAL					**$656,897**	

UNDER $10,000

In 2011-12, Western Health engaged 34 consultancies where the total fees payable to the consultants were less than $10,000, with a total expenditure of $145,099 (excl. GST).

REVENUE INDICATORS

AVERAGE COLLECTION DAYS

	2012	2011
Private	73	77
Transport Accident Commission	86	79
Victorian Workcover Authority	101	102
Other Compensable	86	96
Nursing Home	45	46

DEBTORS OUTSTANDING AS AT 30 JUNE 2012

$'000	UNDER 30 DAYS	31 - 60 DAYS	61 - 90 DAYS	OVER 90 DAYS	TOTAL 2011
Private	843	103	72	770	1,788
Transport Accident Commission	34	22	27	121	204
Victorian Workcover Authority	202	102	79	300	683
Other Compensable	1,106	185	106	286	1,683
Nursing Home	64	11	39	-	114
Total	**2,249**	**423**	**323**	**1,477**	**4,472**

FINANCIAL STATEMENTS

BOARD MEMBER'S, ACCOUNTABLE OFFICER'S AND CHIEF FINANCE & ACCOUNTING OFFICER'S DECLARATION

We certify that the attached financial statements for Western Health have been prepared in accordance with Standing Direction 4.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards, Australian Accounting Interpretations and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the Comprehensive Operating Statement, Balance Sheet, Statement of Changes In Equity, Cash Flow Statement and notes to and forming part of the financial statements, presents fairly the financial transactions during the year ended 30 June 2012 and the financial position of Western Health at 30 June 2012.

At the time of signing, we are not aware of any circumstance which would render any particulars in the financial statements to be misleading or inaccurate.

We authorise the attached financial statements for issue on this day.

Ralph Willis
Board Chairperson

Melbourne
17th August 2012

Kathryn Cook
Chief Executive Officer

Melbourne
17th August 2012

Mark Lawrence
Chief Finance & Accounting Officer

Melbourne
17th August 2012

COMPREHENSIVE OPERATING STATEMENT

For the Year Ended 30 June 2012

	NOTE	2012 $'000	2011 $'000
Revenue from Operating Activities	2	523,026	483,539
Revenue from Non-operating Activities	2	2,772	2,856
Employee Expenses	3	(382,002)	(343,122)
Non Salary Labour Costs	3	(10,780)	(11,853)
Supplies & Consumables	3	(76,357)	(77,686)
Other Expenses From Continuing Operations	3	(58,339)	(53,710)
Net Result Before Capital & Specific Items		**(1,680)**	**24**
Gain on disposal of Available-for-Sale Investment	2	-	1
Available-for-Sale Revaluation Surplus gain recognised	2	-	12
Capital Purpose Income	2	58,631	80,122
Assets Received Free of Charge	2	1,150	-
Expenditure using Capital Purpose Income	3	(2,561)	(801)
Depreciation and Amortisation	4	(40,313)	(36,082)
NET RESULT FOR THE YEAR		**15,227**	**43,276**
OTHER COMPREHENSIVE INCOME			
Gain on disposal of Available-for-Sale Investment	14a	-	(12)
COMPREHENSIVE RESULT FOR THE YEAR		**15,227**	**43,264**

This Statement should be read in conjunction with the accompanying notes.

BALANCE SHEET

As at 30 June 2012

	NOTE	2012 $'000	2011 $'000
CURRENT ASSETS			
Cash and Cash Equivalents	5	36,868	49,523
Receivables	6	12,800	10,059
Other Financial Assets	7	15,000	-
Inventories	8	1,479	1,322
Other Current Assets	9	947	785
Total Current Assets		**67,094**	**61,689**
NON-CURRENT ASSETS			
Receivables	6	6,266	5,611
Property, Plant and Equipment	10	582,544	561,062
Intangible Assets	11	2,611	723
Total Non-Current Assets		**591,421**	**567,396**
TOTAL ASSETS		**658,515**	**629,085**
CURRENT LIABILITIES			
Payables	12	23,128	25,053
Provisions	13	88,950	73,826
Total Current Liabilities		**112,078**	**98,879**
NON-CURRENT LIABILITIES			
Provisions	13	8,363	7,418
Total Non-Current Liabilities		**8,363**	**7,418**
TOTAL LIABILITIES		**120,441**	**106,297**
NET ASSETS		**538,074**	**522,788**
EQUITY			
Property, Plant & Equipment Revaluation Surplus	14a	242,216	242,216
Restricted Specific Purpose Reserve	14a	165	165
Contributed Capital	14b	202,980	202,980
Accumulated Surplus	14c	92,713	77,427
TOTAL EQUITY	14d	**538,074**	**522,788**
Commitments for Expenditure	17		
Contingent Assets and Contingent Liabilities	18		

This Statement should be read in conjunction with the accompanying notes.

STATEMENT OF CHANGES IN EQUITY

For the Year Ended 30 June 2012

	NOTE	PROPERTY, PLANT & EQUIPMENT REVALUATION SURPLUS $'000	FINANCIAL ASSET AVAILABLE FOR SALE REVALUATION SURPLUS $'000	RESTRICTED SPECIFIC PURPOSE SURPLUS $'000	CONTRIBUTED BY OWNERS $'000	ACCUMULATED SURPLUSES/ (DEFICITS) $'000	TOTAL $'000
Balance at 1 July 2010		**242,216**	**12**	**168**	**202,980**	**34,148**	**479,524**
Net result for the year	14c	-	-	-	-	43,276	43,276
Other comprehensive income for the year	14a	-	(12)	-	-	-	(12)
Transfer to accumulated surplus	14a	-	-	(3)	-	3	-
Balance at 30 June 2011		**242,216**	**-**	**165**	**202,980**	**77,427**	**522,788**
Net result for the year	14c	-	-	-	-	15,227	15,227
Share of joint venture accumulated surplus	14c	-	-	-	-	59	59
Other comprehensive income for the year	14a	-	-	-	-	-	-
Transfer to accumulated surplus	14a	-	-	-	-	-	-
Balance at 30 June 2012		**242,216**	**-**	**165**	**202,980**	**92,713**	**538,074**

This Statement should be read in conjunction with the accompanying notes.

STATEMENT OF CASH FLOWS

For the Year Ended 30 June 2012

		$'000	$'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		463,656	445,096
Patient and Resident Fees Received		12,062	9,423
Private Practice Fees Received		14,151	11,017
Donations and Bequests Received		4,367	546
GST Received from ATO		13,394	14,012
Recoupment from Private Practice		476	354
Interest Received		2,702	2,867
Other Receipts		19,886	14,486
Employee Expenses Paid		(366,807)	(333,683)
Non Salary Labour Costs		(11,632)	(12,802)
Payments for Supplies & Consumables		(95,852)	(84,896)
Other Payments		(52,795)	(41,437)
Cash Generated from Operations		**3,608**	**24,983**
Capital Grants from Government		65,694	72,527
Capital Grants from Non-Government		85	29
NET CASH INFLOW FROM OPERATING ACTIVITIES	15	**69,387**	**97,539**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Property, Plant & Equipment		(67,042)	(101,892)
Proceeds from Sale of Property, Plant & Equipment		-	16
Purchase of Investments		(15,000)	
Proceeds from Sale of Investments		-	500
NET CASH OUTFLOW FROM INVESTING ACTIVITIES		**(82,042)**	**(101,376)**
CASH FLOWS FROM FINANCING ACTIVITIES		-	-
NET CASH INFLOW FROM FINANCING ACTIVITIES		**-**	**-**
NET (DECREASE)/INCREASE IN CASH HELD		**(12,655)**	**(3,837)**
CASH AND CASH EQUIVALENTS AT BEGINNING OF THE YEAR		49,523	53,360
CASH AND CASH EQUIVALENTS AT END OF THE YEAR	5	**36,868**	**49,523**

This Statement should be read in conjunction with the accompanying notes.

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

(A) STATEMENT OF COMPLIANCE

These financial statements are a general purpose financial report which have been prepared in accordance with the Financial Management Act 1994 and applicable Australian Accounting Standards (AASs) issued by the Australian Accounting Standards Board (AASB).

The financial statements also comply with relevant Financial Reporting Directions (FRDs) issued by the Department of Treasury and Finance, and relevant Standing Directions (SDs) authorised by the Minister for Finance.

Western Health (the "Health Service") is a not-for profit entity and therefore applies the additional Aus paragraphs applicable to "not-for-profit" Health Services under the AASs.

The annual financial statements were authorised for issue by the Board of Western Health on 17 August 2012.

(B) BASIS OF ACCOUNTING PREPARATION AND MEASUREMENT

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events are reported.

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2012, and the comparative information presented in these financial statements for the year ended 30 June 2011.

The going concern basis was used to prepare the financial statements.

These financial statements are presented in Australian dollars, the functional and presentatiion currency of the Health Service.

The financial statements, except for cash flow information, have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

The financial statements are prepared in accordance with the historical cost convention, except for the revaluation of certain non-financial assets and financial instruments, as noted. Exceptions to the historical cost convention include:

- Non-current physical assets, which subsequent to acquisition, are measured at valuation and are re-assessed with sufficient regularity to ensure that the carrying amounts do not materially differ from their fair values.
- Available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised.
- The fair value of assets other than land is generally based on their depreciated replacement value.

Historical cost is based on the fair values of the consideration given in exchange for assets.

In the application of AASs management is required to make judgements, estimates and assumptions about carrying values of assets and liabilties that are not readily apparent from other sources. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision, and future periods if the revision affects both current and future periods. Judgements made by management in the application of AASs that have significant effects on the financial statements and estimates, with a risk of material adjustments in the subsequent reporting period, relate to:

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 1(j));
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 1(k)).

(C) REPORTING ENTITY

The financial statements include all the controlled activities of the Health Service.

Its principle address is:
Gordon Street, Footscray
Victoria 3011

A description of the nature of the Health Service's operations and its principal activities is included in the report of operations, which does not form part of these financial statements.

(D) PRINCIPLES OF CONSOLIDATION

Intersegment Transactions

Transactions between segments within the Health Service have been eliminated to reflect the extent of the Health Service's operations as a group.

Interest in Joint Venture

The Health Service has an interest in a jointly controlled entity, the Victorian Comprehensive Cancer Centre ("VCCC"), with effect from 1 July 2011. The arrangements of the joint venture is similar to that of a jointly controlled asset and accordingly the Health Service has carried out proportionate consolidation to account for its proportionate share of the joint venture's assets, liabilities, revenue and expense. The details of the joint venture are separately disclosed in Note 20.

(E) SCOPE AND PRESENTATION OF FINANCIAL STATEMENTS

Fund Accounting

The Health Service operates on a fund accounting basis and maintains three funds:

Operating, Specific Purpose and Capital Funds. The Health Service's Capital and Specific Purpose Funds include unspent capital donations and receipts from fund-raising activities conducted solely in respect of these funds.

Services Supported By Health Services Agreement and Services Supported By Hospital and Community Initiatives

Activities classified as Services Supported by Health Services Agreement (HSA) are substantially funded by the Department of Health and include Residential Aged Care Services (RACS) and are also funded from other sources such as Commonwealth, patients and residents, while Services Supported by Hospital and Community Initiatives (H&CI) are funded by the Health Service's own activities or local initiatives and/or the Commonwealth.

Residential Aged Care Service

The Residential Aged Care Service operations are an integral part of the Health Service and shares its resources. The results of the two operations have been segregated based on actual revenue earned and expenditure incurred by each operation in Note 2b to the financial statements.

The Residential Aged Care Service is substantially funded from Commonwealth bed day subsidies.

Comprehensive Operating Statement

The comprehensive operating statement includes the subtotal entitled 'Net Result Before Capital & Specific Items' to enhance the understanding of the financial performance of the Health Service. This subtotal reports the result excluding items such as capital grants, assets received or provided free of charge, depreciation, expenditure using capital purpose income and items of an unusual nature and amount such as specific income and expenses. The exclusion of these items is made to enhance matching of income and expenses so as to facilitate the comparability and consistency of results between years and Victorian Public Health Services. The 'Net Result Before Capital & Specific Items' is used by the management of the Health Service, the Department of Health and the Victorian Government to measure the ongoing performance of Health Services in operating hospital services.

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

Capital and specific items, which are excluded from this sub-total, comprise:

- Capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer Note 1 (e)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.
- Specific income/expense, comprises the following items, where material:
  - Voluntary departure packages
  - Write-down of inventories
  - Non-current asset revaluation increments/ decrements
  - Diminution/impairment of investments
  - Restructuring of operations (disaggregation/ aggregation of Health Services)
  - Reversals of provisions
  - Voluntary changes in accounting policies (which are not required by an accounting standard or other authoritative pronouncement of the Australian Accounting Standards Board)
- Impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), which have been recognised in accordance with Note 1 (i) and (j).
- Depreciation and amortisation, as described in Note 1 (g).
- Assets provided or received free of charge (refer to Note 1 (f) and (g)).
- Expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold or does not meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

Balance Sheet

Assets and liabilities are categorised either as current or non-current. Current assets are cash or other resources that are expected to be realised in cash or sold/consume within the next twelve months and current liabilities are obligations or debts that are expected to be paid or settled within the next twelve months of the balance sheet date. Assets and liabilities that are not current would fall into the non-current assets and liabilities respectively.

Statement Of Changes In Equity

The Statement of changes in equity presents reconciliations of each non-owner and owner equity opening balance at the beginning of the reporting period to the closing balance at the end of the reporting period. It also shows separately changes due to amounts recognised in the comprehensive result and amounts recognised in other comprehensive income related to other non-owner changes in equity.

Cash Flow Statement

Cash flows are classified according to whether or not they arise from operating activities, investing activities, or financing activities. This classification is consistent with requirements under AASB 107 *Statement of Cash Flows*.

(F) INCOME RECOGNITION

Income is recognised in accordance with AASB 118 Revenue and is recognised to the extent that it is probable that economic benefits will flow to the Health Service and the income can be reliably measured. Unearned income at reporting date is reported as income received in advance.

Amounts disclosed as revenue are, where applicable, net of returns, allowances and duties and taxes.

Government Grants and other transfers of income (other than contributions by owners)

In accordance with AASB 1004 *Contributions*, government grants and other transfers of income (other than contributions by owners) are recognised as income when the Health Service gains control

of the underlying assets irrespective of whether conditions are imposed on the Health Service's use of the contributions.

Contributions are deferred as income and treated as a liability when the Health Service has a present obligation to repay them and the present obligation can be reliably measured.

Indirect Contributions from the Department of Health

- Insurance paid on behalf of the Health Service by the Department of Health is recognised as revenue following advice from the Department of Health.
- Long Service Leave (LSL) – revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 14/2009.

Patient and Resident Fees

Patient fees are recognised as revenue at the time invoices are raised.

Private Practice Fees

Private practice fees are recognised as revenue at the time invoices are raised.

Donations and Bequests

Donations and bequests are recognised as revenue when received. If donations are for a special purpose, they may be appropriated to a specific purpose fund.

Interest Revenue

Interest revenue is recognised on a time proportionate basis that takes into account the effective yield of the financial asset.

Sale of Investment

The gain/(loss) on the sale of investments is recognised when the investment is realised.

Resources Received Free of Charge or for Nominal Consideration

Resources received free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another health service or agency as a consequence of a restructuring of administrative arrangements. In the latter case, such transfer will be recognised at carrying value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

(G) EXPENSE RECOGNITION

Expenses are recognised as they are incurred and are reported in the financial year to which they relate.

Cost of Goods Sold

Cost of goods sold are recognised when the sale of an item occurs by transferring the cost or value of the item(s) from inventories.

Employee Expenses

Employee expenses include:

- Wages and salaries;
- Annual leave;
- Sick leave;
- Long service leave; and
- Superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Defined Contribution Superannuation Plans

In relation to defined contribution (i.e. accumulation) superannuation plans, the associated expense is simply the employer contributions that are paid or payable in respect of employees who are members of these plans during the reporting period. Contributions to defined contribution superannuation plans are expensed when incurred.

Defined Benefit Superannuation Plans

The amount charged to the comprehensive operating statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation plans in respect of the services of current Health Service staff during the reporting period.

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

Superannuation contributions are made to the plans based on the relevant rules of each plan and are based upon actuarial advice.

Employees of the Health Service are entitled to receive superannuation benefits and the Health Service contributes to both the defined benefit and defined contribution plans. The defined benefit plan(s) provide benefits based on years of service and final average salary.

The name and details of the major employee superannuation funds and contributions made by the Health Service are as follows:

FUND	CONTRIBUTIONS PAID OR PAYABLE FOR THE YEAR 2012 $'000	2011 $'000
Defined benefit plans:		
- Health Super Fund	792	839
Defined contribution plans:		
- Health Super Fund	20,708	19,646
- Hesta Super Fund	7,035	5,871
Total	**28,535**	**26,356**

Depreciation

Assets with a cost in excess of $2,500 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives. Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health.

Depreciation is provided on property, plant and equipment and freehold buildings. Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

The following table indicates the expected useful lives of non-current assets on which the depreciation charges are based.

	2012	2011
Buildings		
- Structures Shell Building Fabric	40-52 years	40-52 years
- Site Engineering Services and Central Plant	23-40 years	23-40 years
Central Plant		
- Fit Out	15-40 years	15-40 years
- Trunk Reticulated Building System	21-40 years	21-40 years
Plant and Equipment	10 Years	10 Years
Medical Equipment	10 Years	10 Years
Non Medical Equipment	10 Years	10 Years
Furniture and Fittings	10 Years	10 Years
Motor Vehicles	4 Years	4 Years
Computer Equipment	3 Years	3 Years
Intangible Assets	3 Years	3 Years

As part of the Buildings valuation, building values were componentised and each component assessed for its useful life which is represented above.

Amortisation

Amortisation is allocated to intangible assets with finite useful lives on a systematic straight-line basis over the asset's useful life. Amortisation begins when the asset is available for use, that is, when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the assets concerned are tested as to whether its carrying value exceeds its recoverable amount.

Any excess of the carrying amount over the recoverable amount is recognised as an impairment loss.

Intangible assets with finite useful lives are amortised over a 3 year period (2011: 3 years).

Resources Provided Free of Charge or for Nominal Consideration

Resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another health service or agency as a consequence of a restructuring or administrative arrangements. In the latter case, such transfer will be recognised at carrying value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

(H) FINANCIAL INSTRUMENTS

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of the Health Service's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

Where relevant, for note disclosure purposes, a distinction is made between those financial assets and financial liabilities that meet the definition of financial instruments in accordance with AASB 132 and those that do not.

The following refers to financial instruments unless otherwise stated.

Categories of Non-Derivative Financial Instruments

Loans and Receivables

Loans and receivables are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets are initially recognised at fair value plus any directly attributable transaction costs. Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method, less any impairment.

Loans and receivables category includes cash and deposits (refer to Note 1(i)), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

The effective interest method is a method of calculating the amortised cost of a financial asset and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, or, where appropriate, a shorter period.

Available-For-Sale Financial Assets

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Gains and losses arising from changes in fair value are recognised directly in equity until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in net result for the period.

Financial Liabilities at Amotised Cost

Financial instrument liabilities are initially recognised on the date they are originated. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these financial instruments are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in profit and loss over the period of the interest-bearing liability, using the effective rate method.

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

Financial instrument liabilities measured at amortised cost include all of the Health Service's contractual payables, deposits held and advances received, and interest-bearing arrangements other than those designated at fair value through profit and loss.

(I) FINANCIAL ASSETS

Cash and Cash Equivalents

Cash and cash equivalents comprise cash on hand and cash at bank, deposits at call and highly liquid investments with an original maturity of three months or less, which are held for the purpose of meeting short term cash commitments rather than for investment purposes, which are readily convertible to known amounts of cash and are subject to insignificant risk of changes in value.

Receivables

Receivables consist of:

- Contractual receivables, which includes mainly debtors in relation to goods and services and accrued investment income; and
- Statutory receivables, which includes predominantly amounts owing from the Victorian Government and GST input tax credits recoverable.

Receivables that are contractual are classified as financial instruments and categorised as loans and receivables. Statutory receivables are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments because they do not arise from a contract.

Receivables are recognised initially at fair value and subsequently measured at amortised cost, using the effective interest method, less any accumulated impairment.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition. Collectability of debts is reviewed on an ongoing basis and debts which are known to be uncollectible are written off. A provision for doubtful debts is recognised when there is objective evidence that the debts may not be collected and bad debts are written off when identified.

Investments and Other Financial Assets

Investments are recognised and derecognised on the trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned and are initially measured at fair value, net of transaction costs.

Investments are classified in the following categories:

- Loans and receivables; and
- Available-for-sale financial assets

The Health Service assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

All financial assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

Investments in Jointly Controlled Assets and Operations

In respect of any interest in jointly controlled assets, the Health Service recognises in the financial statements:

- its share of jointly controlled assets;
- any liabilities that it had incurred;
- its share of liabilities incurred jointly by the joint venture;
- any income earned from the selling or using of its share of the output from the joint venture; and
- any expenses incurred in relation to being an investor in the joint venture.

Derecognition of Financial Assets

A financial asset is derecognised when:

- the rights to receive cash flows from the asset have expired; or
- the Health Service retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or
- the Health Service has transferred its rights to receive cash flows from the asset and either:

(a) has transferred substantially all the risks and rewards of the asset; or

(b) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

Where the Health Service has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Health Service's continuing involvement in the asset.

Impairment of Financial Assets

At the end of each reporting period the Health Service assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowances for doubtful receivables are expensed.

The amount of the allowance is the difference between the financial asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate.

In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

(J) NON-FINANCIAL ASSETS

Inventories

Inventories include goods and other property held either for sale, consumption or for distribution at no or nominal cost in the ordinary course of business operations. It excludes depreciable assets.

Inventories held for distribution are measured at cost adjusted for any loss of service potential. All other inventories are measured at the lower of cost and net realisable value.

The basis used in assessing loss of service potential for inventories held for distribution include current replacement cost and technical or functional obsolescence. Technical obsolescence occurs when an item still functions for some or all of the tasks it was originally acquired to do but no longer matches existing technologies. Functional obsolescence occurs when an item no longer functions the way it did when it was first acquired.

Cost for all other inventory is measured on the basis of weighted average cost.

Property, Plant and Equipment

All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition.

Land and Buildings are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and impairment.

Plant, Equipment and Vehicles are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and impairment. Depreciated historical cost is generally a reasonable proxy for fair value because of the short lives of the assets concerned.

Revaluations of Non-current Physical Assets

Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103D Non-current physical assets. This revaluation process normally occurs at least every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

Revaluation increments are added directly to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

recognised as an expense in net result, the increment is recognised as income in the net result.

Revaluation decrements are recognised immediately as expenses in the net result, except that, to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of assets, they are debited directly to the asset revaluation surplus.

Revaluation increases and revaluation decreases relating to individual assets within an asset class are offset against one another within that class but are not offset in respect of assets in different classes.

Revaluation surplus is not transferred to accumulated funds on derecognition of the relevant asset.

In accordance with FRD 103D, the Health Service's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required (refer to Note 10).

Intangible Assets

Intangible assets represent identifiable non-monetary assets without physical substance, such as computer software and development costs.

Intangible assets are initially recognised at cost. Subsequently, intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses. Costs incurred subsequent to initial acquisition are capitalised when it is expected that additional future economic benefits will flow to the Health Service.

Other Non-Financial Assets

Prepayments

Other non-financial assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

Disposal of Non-Financial Assets

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive income statement at the date that control of the asset is passed to the buyer and is determined after deducting from the proceeds the carrying value of the asset at that time.

Impairment of Non-Financial Assets

Apart from intangible assets with indefinite useful lives, all other non-financial assets are assessed annually for indications of impairment, except for:

- inventories; and
- assets arising from construction contracts

If there is an indication of impairment, the assets concerned are tested as to whether their carrying value exceeds their possible recoverable amount. Where an asset's carrying value exceeds its recoverable amount, the difference is written-off as an expense to the extent that the write-down can be debited to an asset revaluation surplus amount applicable to that same class of asset.

If there is any indication that there has been a change in the estimate of an asset's recoverable amount since the last impairment loss was recognised, the carrying amount shall be increased to its recoverable amount. This reversal of the impairment loss occurs only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

It is deemed that, in the event of the loss or destruction of an asset, the future economic benefits arising from the use of the asset will be replaced unless a specific decision to the contrary has been made. The recoverable amount for most assets is measured at the higher of depreciated replacement cost and fair value costs to sell. Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less cost to sell.

(K) LIABILITIES

Payables

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the health service prior to the end of the financial year that are unpaid, and arise when the health service becomes obliged to make future

payments in respect of the purchase of those goods and services. The normal credit terms for accounts payable is usually Net 30 days.

- statutory payables, such as goods and services tax and fringe benefits tax payables.

Contractual payables are initially recognised at fair value, and then subsequently carried at amortised cost. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from a contract.

Provisions

Provisions are recognised when the Health Service has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

When some or all of the economic benefits required to settle a provision are expected to be received from a third party, the receivable is recognised as an asset if it is virtually certain that recovery will be received and the amount of the receivable can be measured reliably.

Employee Benefits

Wages and Salaries, Annual Leave, Sick Leave and Accrued Days Off

Liabilities for wages and salaries, including non-monetary benefits, annual leave, accumulated sick leave and accrued days off which are expected to be settled within 12 months of the reporting date are recognised in the provision for employee benefits in respect of the employee's services up to the reporting date, and are classified as current liabilities and measured at nominal values.

Those liabilities that are not expected to be settled within 12 months are also recognised in the provision for employee benefits as current liabilities, but are measured at present value of the amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

Long Service Leave (LSL)

The liability for LSL is recognised in the provision for employee benefits.

Current Liability – unconditional LSL (representing 10 or more years of continuous service) is disclosed in the notes to the financial statements as a current liability even where the Health Service does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months.

The components of this current LSL liability are measured at:

- present value – component that the Health Service does not expect to settle within 12 months; and
- nominal value – component that the Health Service expects to settle within 12 months.

Non-Current Liability – conditional LSL (representing less than 10 years of continuous service) is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. Conditional LSL is required to be measured at present value.

Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using interest rates of Commonwealth Government guaranteed securities in Australia.

Termination Benefits

Termination benefits are payable when employment is terminated before the normal retirement date or when an employee accepts voluntary redundancy in exchange for these benefits.

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

Liabilities for termination benefits are recognised when a detailed plan for the termination has been developed and a valid expectation has been raised with those employees affected that the terminations will be carried out. The liabilities for terminations benefits are recognised in other creditors unless the amount or timing of the payments is uncertain, in which case they are recognised as a provision.

On-Costs

Employee benefit on-costs, such as workers compensation and superannuation are recognised together with provisions for employee benefits.

Superannuation Liabilities

The Health Service does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the Health Service has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance administers and discloses the State's defined benefits liabilities in its financial statements.

Make Good Provisions

Make good provisions are recognised when the Health Service has contractual obligations to remove leasehold improvements from leased properties and restore the leased premises to their original condition at the end of the lease term. The related expenses of making good such properties are recognised when leasehold improvements are made.

Derecognition of Financial Liabilities

A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

(L) LEASES

Leases are classified at their inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee. All other leases are classified as operating leases.

Finance Leases

The Health Service does not hold any finance lease arrangements, either as a lessor or as a lessee, with other parties.

Operating Leases

Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset.

Lease Incentives

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are received by the lessee to enter into operating leases, such incentives are recognised as a liability. The aggregate benefits of incentives are recognised as a reduction of rental expense on a straight-line basis, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset is diminished.

(M) EQUITY

Contributed Capital

Consistent with Australian Accounting Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public Sector Entities and FRD 119 Contributions by Owners, appropriations for additions to the net asset base have been designated as contributed capital. Other transfers that are in the nature of contributions or distributions that have been designated as contributed capital are also treated as contributed capital.

Property, Plant & Equipment Revaluation Surplus

The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

Financial Asset Available-for-Sale Revaluation Surplus

The available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold that portion of the surplus which relates to that financial asset is effectively realised and is recognised in the comprehensive operating statement. Where a revalued financial asset is impaired that portion of the surplus which relates to that financial asset is recognised in the comprehensive operating statement.

Specific Restricted Purpose Surplus

A specific restricted purpose surplus is established where the Health Service has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

(N) COMMITMENTS

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer to Note 17) at their nominal value and are inclusive of the goods and services tax ("GST") payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

(O) CONTINGENT ASSETS AND CONTINGENT LIABILITIES

Contingent assets and contingent liabilities are not recognised in the balance sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

(P) GOODS AND SERVICES TAX ("GST")

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case it is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the taxation authority is included with other receivables or payables in the balance sheet.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to the taxation authority, are presented as operating cash flow.

Commitments for expenditure and contingent assets and liabilities are presented on a gross basis.

(Q) FOREIGN CURRENCY

All foreign currency transactions during the financial year are brought to account using the exchange rate in effect at the date of the transaction. Foreign monetary items existing at the end of the reporting period are translated at the closing rate at the date of the end of the reporting period. Non-monetary assets carried at fair value that are denominated in foreign currencies are translated at the rates prevailing at the date when the fair value was determined.

(R) ROUNDING

All amounts shown in the financial statements are expressed to the nearest $1,000.

Minor discrepancies in tables between totals and sum of components are due to rounding.

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

(S) AASS ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards and interpretations have been published that are not mandatory for the 30 June 2012 reporting period.

As at 30 June 2012, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. The Health Service has not and does not intend to adopt these standards early.

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 9 Financial Instruments	This standard simplifies requirements for the classification and measurement of financial assets resulting from Phase 1 of the IASB's project to replace IAS 39 Financial Instruments: Recognition and Measurement (AASB 139 Financial Instruments: Recognition and Measurement).	1-Jan-13	Detail of impact is still being assessed.
AASB 10 Consolidated Financial Statements	This Standard establishes principles for the presentation and preparation of consolidated financial statements when an entity controls one or more other entities and supersedes those requirements in AASB 127 Consolidated and Separate Financial Statements and Interpretation 112 Consolidation – Special Purpose Entities.	1-Jan-13	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 10 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 11 Joint Arrangements	This Standard requires entities that have an interest in arrangements that are controlled jointly to assess whether the arrangement is a joint operation or joint venture. AASB 11 shall be applied for an arrangement that is a joint operation. It also replaces parts of requirements in AASB 131 Interests in Joint Ventures.	1-Jan-13	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 11 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 12 Disclosure of Interests in Other Entities	This Standard requires disclosure of information that enables users of financial statements to evaluate the nature of, and risks associated with, interests in other entities and the effects of those interests on the financial statements. This Standard replaces the disclosure requirements in AASB 127 and AASB 131.	1-Jan-13	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 12 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 13 Fair Value Measurement	This Standard outlines the requirements for measuring the fair value of assets and liabilities and replaces the existing fair value definition and guidance in other AASs. AASB 13 includes a 'fair value hierarchy' which ranks the valuation technique inputs into three levels using unadjusted quoted prices in active markets for identical assets or liabilities; other observable inputs; and unobservable inputs.	1-Jan-13	Disclosure for fair value measurements using unobservable inputs are relatively onerous compared to disclosure for fair value measurements using observable inputs. Consequently, the Standard may increase the disclosures for public sector entities that have assets measured using depreciated replacement cost.

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 119 Employee Benefits	In this revised Standard for defined benefit superannuation plans, there is a change to the methodology in the calculation of superannuation expenses, in particular there is now a change in the split between superannuation interest expense (classified as transactions) and actuarial gains and losses (classified as 'Other economic flows – other movements in equity') reported on the comprehensive operating statement.	1-Jan-13	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. While the total superannuation expense is unchanged, the revised methodology is expected to have a negative impact on the net result from transactions of the general government sector and for those few Victorian public sector entities that report superannuation defined benefit plans.
AASB 127 Separate Financial Statements	This revised Standard prescribes the accounting and disclosure requirements for investments in subsidiaries, joint ventures and associates when an entity prepares separate financial statements.	1-Jan-13	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 127 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 128 Investments in Associates and Joint Ventures	This revised Standard sets out the requirements for the application of the equity method when accounting for investments in associates and joint ventures.	1-Jan-13	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 128 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 1053 Application of Tiers of Australian Accounting Standards	This Standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for peparing general purpose financial statements.	1-Jul-13	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) for certain public sector entities and has not decided if RDRs will be implemented in the Victorian public sector.
AASB 2009-11 Amendments to Australian Accounting Standards arising from AASB 9 [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 121, 127, 128, 131, 132, 136, 139, 1023 and 1038 and Interpretations 10 and 12]	This Standard gives effect to consequential changes arising from the issuance of AASB 9.	1-Jan-13	No significant impact is expected from these consequential amendments on entity reporting.

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 2010-2 Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements	This Standard makes amendments to many Australian Accounting Standards, including Interpretations, to introduce reduced disclosure requirements to the pronouncements for application by certain types of entities.	1-Jul-13	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) for certain public sector entities and has not decided if RDRs will be implemented in the Victorian public sector.
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127]	These consequential amendments are in relation to the introduction of AASB 9.	1-Jan-13	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2010-8 Amendments to Australian Accounting Standards – Deferred Tax: Recovery of Underlying Assets [AASB 112]	This amendment provides a practical approach for measuring deferred tax assets and deferred tax liabilities when measuring investment property by using the fair value model in AASB 140 *Investment Property*.	Beginning 1 Jan 2012	This amendment provides additional clarification through practical guidance.
AASB 2010-10 Further Amendments to Australian Accounting Standards – Removal of Fixed Dates for First-time Adopters [AASB 2009-11 & AASB 2010-7]	The amendments ultimately affect AASB 1 First-time Adoption of Australian Accounting Standards and provide relief for first-time adopters of Australian Accounting Standards from having to reconstruct transactions that occurred before their date of transition to Australian Accounting Standards.	1-Jan-13	No significant impact is expected on entity reporting.
AASB 2011-2 Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements [AASB 101 & AASB 1054]	The objective of this amendment is to include some additional disclosure from the Trans-Tasman Convergence Project and to reduce disclosure requirements for entities preparing general purpose financial statements under Australian Accounting Standards – Reduced Disclosure Requirements.	1-Jul-13	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) and has not decided if RDRs will be implemented in the Victorian public sector.

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 2011-3 Amendments to Australian Accounting Standards – Orderly Adoption of Changes to the ABS GFS Manual and Related Amendments [AASB 1049]	This amends AASB 1049 to clarify the definition of the ABS GFS Manual, and to facilitate the adoption of changes to the ABS GFS Manual and related disclosures.	1-Jul-12	This amendment provides clarification to users preparing the whole of government and general govovernment sector financial reports on the version of the GFS Manual to be used and what to disclose if the latest GFS Manual is not used. No impact on departmental or entity reporting.
AASB 2011-4 Amendments to Australian Accounting Standards to Remove Individual Key Management Personnel Disclosure Requirements [AASB 124]	This Standard amends AASB 124 Related Party Disclosures by removing the disclosure requirements in AASB 124 in relation to individual key management personnel (KMP).	1-Jul-13	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2011-6 Amendments to Australian Accounting Standards – Extending Relief from Consolidation, the Equity Method and Proportionate Consolidation – Reduced Disclosure Requirements [AASB 127, AASB 128 & AASB 131]	The objective of this Standard is to make amendments to AASB 127 Consolidated and Separate Financial Statements, AASB 128 Investments in Associates and AASB 131 Interests in Joint Ventures to extend the circumstances in which an entity can obtain relief from consolidation, the equity method or proportionate consolidation.	1-Jul-13	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) and has not decided if RDRs will be implemented in the Victorian public sector.
AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 9, 2009-11, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1038 and Interpretations 5, 9, 16 & 17]	This Standard outlines consequential changes arising from the issuance of the five 'new Standards' to other Standards. For example, references to AASB 127 Consolidated and Separate Financial Statements are amended to AASB 10 Consolidated Financial Statements or AASB 127 Separate Financial Statements, and references to AASB 131 Interests in Joint Ventures are deleted as that Standard has been superseded by AASB 11 and AASB 128 (August 2011).	1-Jan-13	No significant impact is expected from these consequential amendments on entity reporting.

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 9, 2009-11, 2010-7, 101, 102, 108, 110, 116, 117, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 & 1038 and Interpretations 2, 4, 12, 13, 14, 17, 19, 131 & 132]	This amending Standard makes consequentical changes to a range of Standards and Interpretations arising from the issuance of AASB 13. In particular, this Standard replaces the existing definition and guidance of fair value measurements in other Australian Accounting Standards and Interpretations.	1-Jan-13	Disclosures for fair value measurements using unobservable inputs is potentially onerous, and may increase disclosures for assets measured using depreciated replacement cost.
AASB 2011-9 Amendments to Australian Accounting Standards – Presentation of Items of Other Comprehensive Income [AASB 1, 5, 7, 101, 112, 120, 121, 132, 133, 134, 1039 & 1049]	The main change resulting from this Standard is a requirement for entities to group items presented in other comprehensive income (OCI) on the basis of whether they are potentially reclassifiable to profit or loss subsequently (reclassification adjustments). These amendments do not remove the option to present profit or loss and other comprehensive income in two statements, nor change the option to present items of OCI either before tax or net of tax.	1-Jul-12	This amending Standard could change the current presentation of 'Other economic flows- other movements in equity' that will be grouped on the basis of whether they are potentially reclassifiable to profit or loss subsequently. No other significant impact will be expected.
AASB 2011-10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, AASB 8, AASB 101, AASB 124, AASB 134, AASB 1049 & AASB 2011-8 and Interpretation 14]	This Standard makes consequential changes to a range of other Australian Accounting Standards and Interpretaion arising from the issuance of AASB 119 Employee Benefits.	1-Jan-13	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2011-11 Amendments to AASB 119 (September 2011) arising from Reduced Disclosure Requirements	This Standard makes amendments to AASB 119 Employee Benefits (September 2011), to incorporate reduced disclosure requirements into the Standard for entities applying Tier 2 requirements in preparing general purpose financial statements.	1-Jul-13	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) and has not decided if RDRs will be implemented in the Victorian public sector.

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 2011-12 Amendments to Australian Accounting Standards arising from Interpretation 20 [AASB 1]	This Standard makes amendments to AASB 1 First-time Adoption of Australian Accounting Standards, as a consequence of the issuance of IFRIC Interpretation 20 Stripping Costs in the Production Phase of a Surface Mine. This Standard allows the first-time adopters to apply the transitional provisions contained in Interpretation 20.	1-Jan-13	There may be an impact for new agencies that adopt Australian Accounting Standards for the first time. No implication is expected for existing entities in the Victorian public sector.
2011-13 Amendments to Australian Accounting Standard – Improvements to AASB 1049	This Standard aims to improve the AASB 1049 Whole of Government and General Government Sector Financial Reporting at the operational level. The main amendments clarify a number of requirements in AASB 1049, including the amendment to allow disclosure of other measures of key fiscal aggregates as long as they are clearly distinguished from the key fiscal aggregates and do not detract from the the information required by AASB 1049. Furthermore, this Standard provides additional guidance and examples on the classification between 'transactions' and 'other economic flows' for GAAP items without GFS equivalents.	1-Jul-12	No significant impact is expected from these consequential amendments on entity reporting.
2012-1 Amendments to Australian Accounting Standards - Fair Value Measurement - Reduced Disclosure Requirements [AASB 3, AASB 7, AASB 13, AASB 140 & AASB 141]	This amending Standard prescribes the reduced disclosure requirements in a number of Australian Accounting Standards as a consequence of the issuance of *AASB 13 Fair Value Measurement.*	1-Jul-13	As the Victorian whole of government and the general government (GG) sector are subject to Tier 1 reporting requirements (refer to AASB 1053 Application of Tiers of Australian Accounting Standards), the reduced disclosure requirements included in AASB 2012-1 will not affect the financial reporting for Victorian whole of government and GG sector.
AASB Interpretation 20 Stripping Costs in the Production Phase of a Surface Mine	This Interpretation clarifies when production stripping costs should lead to the recognition of an asset and how that asset should be initially and subsequently measured.	1-Jan-13	No significant impact is expected on entity reporting.

In 2009 the AASB issued an omnibus of amendments to its Standards as part of the Annual Improvements Project, primarily with the view of resolving inconsistencies and clarifying wording. These are separate transitional provisions and application dates for each amendment. The adoption of the amendments did not have any impact on the financial position or performance of the Health Service.

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

(T) CATEGORY GROUPS

The Health Service has used the following category groups for reporting purposes for the current and previous financial years.

Admitted Patient Services (Admitted Patients) comprises all recurrent health revenue/expenditure on admitted patient services, where services are delivered in public hospitals, or free standing day hospital facilities, or alcohol and drug treatment units or hospitals specialising in dental services, hearing and ophthalmic aids.

Outpatient Services (Outpatients) comprises all recurrent health revenue/expenditure on public hospital type outpatient services, where services are delivered in public hospital outpatient clinics, or free standing day hospital facilities, or rehabilitation facilities, or alcohol and drug treatment units, or outpatient clinics specialising in ophthalmic aids or palliative care.

Emergency Department Services (EDS) comprises all recurrent health revenue/expenditure on emergency department services that are available free of charge to public patients.

Aged Care comprises revenue/expenditure from Home and Community Care (HACC) programs, Allied Health, Aged Care Assessment and support services.

Primary Health comprises revenue/expenditure for Community Health Services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy.

Off Campus Ambulatory Services (Ambulatory) comprises all recurrent health revenue/expenditure on public hospital type services including palliative care facilities and rehabilitation facilities, as well as services provided under the following agreements: Services that are provided or received by hospitals (or area health services) but are delivered/received outside a hospital campus, services which have moved from a hospital to a community setting since June 1998, services which fall within the agreed scope of inclusions under the new system, which have been delivered within hospital, i.e. in rural/remote areas.

Residential Aged Care including Mental Health (RAC incl. Mental Health) referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from DH under the mental health program. It excludes all other residential services funded under the mental health program, such as mental health funded community care units (CCUs) and secure extended care units (SECs).

Other Services excluded from Australian Health Care Agreement (AHCA) (Other) comprises revenue/expenditure for services not separately classified above, including: Public Health Services including Laboratory testing, Blood Borne Viruses/ Sexually Transmitted Infections clinical services, Koori liaison officers, immunisation and screening services, Drugs services including drug withdrawal, counselling and the needle and syringe program, Dental Health services including general and specialist dental care, school dental services and clinical education, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also fall into this category group.

NOTE 2: REVENUE

	HSA 2012 $'000	HSA 2011 $'000	NON HSA 2012 $'000	NON HSA 2011 $'000	TOTAL 2012 $'000	TOTAL 2011 $'000
REVENUE FROM OPERATING ACTIVITIES						
Government Grants						
- Department of Health	452,518	421,548	-	-	452,518	421,548
- Department of Human Services	94	5,605	-	-	94	5,605
- Commonwealth Government						
- Residential Aged Care Subsidy	2,686	3,367	-	-	2,686	3,367
- Other	13,729	9,305	-	-	13,729	9,305
Total Government Grants	**469,027**	**439,825**	**-**	**-**	**469,027**	**439,825**
Indirect Contributions by Department of Health						
- Insurance	667	6,997	-	-	667	6,997
- Long Service Leave	655	882	-	-	655	882
Total Indirect Contributions by Department of Health	**1,322**	**7,879**	**-**	**-**	**1,322**	**7,879**
Patient and Resident Fees						
- Patient and Resident Fees (refer note 2b)	13,994	9,270	-	-	13,994	9,270
- Residential Aged Care (refer note 2b)	1,050	1,231	-	-	1,050	1,231
Total Patient and Resident Fees	**15,044**	**10,501**	**-**	**-**	**15,044**	**10,501**
Commercial Activities & Specific Purpose Funds						
- Private Practice Fees	13,498	10,283	149	128	13,647	10,411
- Research	731	70	1,361	1,507	2,092	1,577
- Pharmacy	813	829	-	-	813	829
- Property Income	220	212	328	363	548	575
- Cafeteria and Kiosk	-	-	221	202	221	202
- Car Park	-	-	2,491	1,875	2,491	1,875
- Opportunity Shops	-	-	17	29	17	29
- Television	-	-	76	70	76	70
Total Commercial Activities & Specific Purpose Funds	**15,262**	**11,394**	**4,643**	**4,174**	**19,905**	**15,568**
Donations and Bequests	39	29	4,207	522	4,246	551
Recoupment from Private Practice for Use of Hospital Facilities	476	354	-	-	476	354
Other Revenue from Operating Activities	11,585	7,898	1,421	963	13,006	8,861
Total Revenue from Operating Activities	**512,755**	**477,880**	**10,271**	**5,659**	**523,026**	**483,539**
REVENUE FROM NON-OPERATING ACTIVITIES						
Interest	2,772	2,856	-	-	2,772	2,856
Total Revenue from Non-Operating Activities	**2,772**	**2,856**	**-**	**-**	**2,772**	**2,856**

NOTE 2: REVENUE

CAPITAL PURPOSE INCOME						
State Government Capital Grants						
- Targeted Capital Works and Equipment	-	-	57,646	72,613	57,646	72,613
Commonwealth Government Capital Grants	-	-	873	7,600	873	7,600
Assets Received Free of Charge (refer note 2d)	-	-	1,150	-	1,150	-
Net Gain/(Loss) On Disposal Of Non-Financial Assets (refer note 2c)	-	-	(33)	(91)	(33)	(91)
Other Capital Purpose Income	-	-	145	-	145	-
Total Capital Purpose Income	**-**	**-**	**59,781**	**80,122**	**59,781**	**80,122**
Available-for-Sale Revaluation Surplus gain recognised (refer note 14a)	-	-	-	1	-	1
Recognition of revaluation increment on disposal of Available-for-Sale investment (refer note 14a)	-	-	-	12	-	12
Total Revenue (refer to note 2a)	**515,527**	**480,736**	**70,052**	**85,794**	**585,579**	**566,530**

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

This note relates to revenues above the net result line only, and does not reconcile to comprehensive income.

NOTE 2A: ANALYSIS OF REVENUE BY SOURCE

2012	ADMITTED PATIENTS $'000	OUT-PATIENTS $'000	EDS $'000	AMBUL-ATORY $'000	RAC $'000	AGED CARE $'000	OTHER $'000	TOTAL $'000
REVENUE FROM SERVICES SUPPORTED BY HEALTH SERVICES AGREEMENT								
Government Grants	274,720	21,652	56,982	40,111	4,886	3,604	67,072	469,027
Indirect contributions by Department of Health	662	66	198	66	-	66	264	1,322
Patient and Resident Fees (refer note 2b)	11,319	561	493	1,439	1,050	182	-	15,044
Donations and Bequests (non capital)	-	-	-	-	-	-	39	39
Recoupment from Private Practice for use of Hospital Facilities	-	-	-	-	-	-	476	476
Private Practice Fees	-	-	-	-	-	-	13,498	13,498
Other Revenue from Operating Activities	-	-	236	-	-	-	13,113	13,349
Interest	-	-	-	-	-	-	2,772	2,772
Total Revenue from Services Supported by Health Services Agreement	**286,701**	**22,279**	**57,909**	**41,616**	**5,936**	**3,852**	**97,234**	**515,527**
REVENUE FROM SERVICES SUPPORTED BY HOSPITAL AND COMMUNITY INITIATIVES								
Commercial Activities and Specific Purpose Funds							4,166	4,166
Donations & Bequests (non capital)							3,970	3,970
Fundraising							237	237
Private Practice Fees							149	149
Rental Income							328	328
Other							1,421	1,421
Capital Purpose Income (refer note 2)							59,781	59,781
Sub-Total Revenue from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**-**	**-**	**70,052**	**70,052**
Total Revenue	**286,701**	**22,279**	**57,909**	**41,616**	**5,936**	**3,852**	**167,286**	**585,579**

NOTE 2A: ANALYSIS OF REVENUE BY SOURCE

2011	ADMITTED PATIENTS $'000	OUT-PATIENTS $'000	EDS $'000	AMBUL-ATORY $'000	RAC $'000	AGED CARE $'000	OTHER $'000	TOTAL $'000
REVENUE FROM SERVICES SUPPORTED BY HEALTH SERVICES AGREEMENT								
Government Grants	250,656	18,806	56,938	40,503	5,073	3,794	64,055	439,825
Indirect contributions by Department of Health	-	-	-	-	-	-	7,879	7,879
Patient and Resident Fees (refer note 2b)	8,049	780	178	263	1,231	-	-	10,501
Donations and Bequests (non capital)	11	-	-	18	-	-	-	29
Recoupment from Private Practice for use of Hospital Facilities	354	-	-	-	-	-	-	354
Private Practice Fees	647	589	-	-	-	-	9,047	10,283
Other Revenue from Operating Activities	2,120	43	261	162	7	28	6,388	9,009
Interest	-	-	-	-	-	-	2,856	2,856
Sub-Total Revenue from Services Supported by Health Services Agreement	**261,837**	**20,218**	**57,377**	**40,946**	**6,311**	**3,822**	**90,225**	**480,736**
REVENUE FROM SERVICES SUPPORTED BY HOSPITAL AND COMMUNITY INITIATIVES								
Commercial Activities and Specific Purpose Funds							3,683	3,683
Donations & Bequests (non capital)							417	417
Fundraising							105	105
Private Practice Fees							128	128
Rental Income							363	363
Other							976	976
Capital Purpose Income (refer note 2)							80,122	80,122
Sub-Total Revenue from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**-**	**-**	**85,794**	**85,794**
Total Revenue	**261,837**	**20,218**	**57,377**	**40,946**	**6,311**	**3,822**	**176,019**	**566,530**

Indirect contributions by Department of Health:

The Department of Health makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

NOTE 2B: PATIENT AND RESIDENT FEES

	2012 $'000	2011 $'000
PATIENT AND RESIDENT FEES		
Acute		
– Inpatients	13,305	9,077
– Outpatients	14	16
– Other	675	177
Residential Aged Care	1,050	1,231
Total Patient and Resident Fees	**15,044**	**10,501**

NOTE 2C: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS

	2012 $'000	2011 $'000
PROCEEDS FROM DISPOSALS OF NON-CURRENT ASSETS		
Medical Equipment	-	-
Plant and Equipment	-	16
Total Proceeds from Disposal of Non-Current Assets	**-**	**16**
LESS: WRITTEN DOWN VALUE OF NON-CURRENT ASSETS SOLD		
Medical Equipment	33	-
Plant and Equipment	-	107
Total Written Down Value of Non-Current Assets Sold	**33**	**107**
Net gains/(losses) on Disposal of Non-Current Assets	**(33)**	**(91)**

NOTE 2D: ASSETS RECEIVED FREE OF CHARGE

	2012 $'000	2011 $'000
During the reporting period, the fair value of assets received free of charge was as follows:		
Land - Sunbury	1,150	-
Total Assets Received Free of Charge	**1,150**	**-**

NOTE 3: EXPENSES

	HSA 2012 $'000	HSA 2011 $'000	NON HSA 2012 $'000	NON HSA 2011 $'000	TOTAL 2012 $'000	TOTAL 2011 $'000
EMPLOYEE EXPENSES						
Salaries & Wages	337,035	303,810	1,565	1,166	338,600	304,976
WorkCover Premium	4,917	3,621	24	16	4,941	3,637
Departure Packages	393	244	-	-	393	244
Long Service Leave	9,565	7,883	47	37	9,612	7,920
Superannuation	28,313	26,225	143	120	28,456	26,345
Total Employee Expenses	**380,223**	**341,783**	**1,779**	**1,339**	**382,002**	**343,122**
NON SALARY LABOUR COSTS						
Fees for Visiting Medical Officers	3,359	3,973	-	-	3,359	3,973
Agency Costs - Nursing	3,908	4,487	-	-	3,908	4,487
Agency Costs - Other	3,513	3,287	-	106	3,513	3,393
Total Non Salary Labour Costs	**10,780**	**11,747**	**-**	**106**	**10,780**	**11,853**
SUPPLIES AND CONSUMABLES						
Drug Supplies	18,272	15,034	279	3	18,551	15,037
S100 Drugs	3,114	5,241	-	-	3,114	5,241
Medical, Surgical Supplies and Prosthesis	33,806	36,491	149	78	33,955	36,569
Pathology Supplies	11,386	12,074	-	10	11,386	12,084
Food Supplies	9,338	8,739	13	16	9,351	8,755
Total Supplies and Consumables	**75,916**	**77,579**	**441**	**107**	**76,357**	**77,686**
OTHER EXPENSES						
Domestic Services & Supplies	5,476	5,191	-	-	5,476	5,191
Fuel, Light, Power and Water	4,369	3,943	-	-	4,369	3,943
Insurance costs funded by the Department of Health	8,204	6,997	-	-	8,204	6,997
Motor Vehicle Expenses	268	269	-	-	268	269
Repairs & Maintenance	3,949	4,157	11	6	3,960	4,163
Maintenance Contracts	5,097	3,953	-	-	5,097	3,953
Patient Transport	3,022	3,147	21	16	3,043	3,163
Bad & Doubtful Debts	642	76	-	-	642	76
Lease Expenses	3,810	3,754	-	-	3,810	3,754
Other Administrative Expenses	15,958	14,783	1,202	797	17,160	15,580
Other	5,862	6,281	160	38	6,022	6,319
Audit Fees		-		-		-
- VAGO - Audit of Financial Statements	108	116	-	-	108	116
- Internal Audit Fees	180	186	-	-	180	186
Total Other Expenses	**56,945**	**52,853**	**1,394**	**857**	**58,339**	**53,710**
EXPENDITURE USING CAPITAL PURPOSE INCOME						
Employee Expenses						
- Salaries & Wages	-	-	955	126	955	126
- WorkCover Premium	-	-	13	1	13	1
- Superannuation	-	-	79	10	79	10
- Long Service Leave	-	-	1	10	1	10
Total Employee Benefits	**-**	**-**	**1,048**	**147**	**1,048**	**147**
Non Salary Labour Costs						
- Agency/Contract Labour Costs	-	-	53	142	53	142
Total Non Salary Labour Costs	**-**	**-**	**53**	**142**	**53**	**142**
Other Expenses						
- Administrative Expenses	-	-	773	233	773	233
- Other	-	-	687	279	687	279
Total Other Expenses	**-**	**-**	**1,460**	**512**	**1,460**	**512**
Total Expenditure using Capital Purpose Income	**-**	**-**	**2,561**	**801**	**2,561**	**801**
Depreciation and Amortisation	-	-	40,313	36,082	40,313	36,082
Total Depreciation and Amortisation	**-**	**-**	**40,313**	**36,082**	**40,313**	**36,082**
Total Expenses	**523,864**	**483,962**	**46,488**	**39,292**	**570,352**	**523,254**

NOTE 3A: ANALYSIS OF EXPENSES BY SOURCE

2012	ADMITTED PATIENTS $'000	OUT-PATIENTS $'000	EDS $'000	AMBUL-ATORY $'000	RAC $'000	AGED CARE $'000	OTHER $'000	TOTAL $'000
SERVICES SUPPORTED BY HEALTH SERVICES AGREEMENT								
Employee Expenses	185,253	5,305	37,819	29,183	5,205	3,744	113,714	380,223
Non Salary Labour Costs	6,619	1,020	689	402	111	1	1,938	10,780
Supplies & Consumables	36,441	595	5,050	1,259	444	76	32,051	75,916
Other Expenses from Continuing Operations	24,995	1,023	3,797	5,553	562	735	20,280	56,945
Total Expenses from Services Supported by Health Services Agreement	**253,308**	**7,943**	**47,355**	**36,397**	**6,322**	**4,556**	**167,983**	**523,864**
SERVICES SUPPORTED BY HOSPITAL AND COMMUNITY INITIATIVES								
Employee Expenses							1,779	1,779
Non Salary Labour Costs							-	-
Supplies & Consumables							441	441
Other Expenses from Continuing Operations							1,394	1,394
Total Expenses from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**-**	**-**	**3,614**	**3,614**
EXPENDITURE USING CAPITAL PURPOSE INCOME								
Employee Expenses							1,048	1,048
Non Salary Labour Costs							53	53
Other Expenses							1,460	1,460
Total Expenditure using Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**-**	**2,561**	**2,561**
Depreciation & Amortisation (refer note 4)							40,313	40,313
Total Expenditure from Services Supported by Health Services Agreement and by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**-**	**-**	**40,313**	**40,313**
Total Expenses	**253,308**	**7,943**	**47,355**	**36,397**	**6,322**	**4,556**	**214,471**	**570,352**

NOTE 3A: ANALYSIS OF EXPENSES BY SOURCE

2011	ADMITTED PATIENTS $'000	OUT-PATIENTS $'000	EDS $'000	AMBUL-ATORY $'000	RAC $'000	AGED CARE $'000	OTHER $'000	TOTAL $'000
SERVICES SUPPORTED BY HEALTH SERVICES AGREEMENT								
Employee Expenses	168,956	5,036	34,907	23,919	5,161	2,928	100,876	341,783
Non Salary Labour Costs	7,482	1,445	652	319	200	4	1,645	11,747
Supplies & Consumables	37,240	523	5,383	1,342	85	56	32,950	77,579
Other Expenses from Continuing Operations	22,107	1,578	3,773	6,395	301	647	18,052	52,853
Total Expenses from Services Supported by Health Services Agreement	**235,785**	**8,582**	**44,715**	**31,975**	**5,747**	**3,635**	**153,523**	**483,962**
SERVICES SUPPORTED BY HOSPITAL AND COMMUNITY INITIATIVES								
Employee Expenses							1,339	1,339
Non Salary Labour Costs							106	106
Supplies & Consumables							107	107
Other Expenses from Continuing Operations							857	857
Total Expenses from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**-**	**-**	**2,409**	**2,409**
EXPENDITURE USING CAPITAL PURPOSE INCOME								
Employee Expenses							147	147
Non Salary Labour Costs							142	142
Other Expenses							512	512
Total Expenditure using Capital Purpose Income							**801**	**801**
Depreciation & Amortisation (refer note 4)	-	-	-	-	-	-	36,082	36,082
Total Expenditure from Services Supported by Health Services Agreement and by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**-**	**-**	**36,082**	**36,082**
Total Expenses	**235,785**	**8,582**	**44,715**	**31,975**	**5,747**	**3,635**	**192,815**	**523,254**

NOTE 3B: ANALYSIS OF EXPENSES BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS FOR SERVICES SUPPORTED BY HOSPITAL AND COMMUNITY INITIATIVES

	2012 $'000	2011 $'000
COMMERCIAL ACTIVITIES		
Car Park	776	661
Opportunity Shops	52	42
Property Expenses	-	7
Other	443	785
OTHER ACTIVITIES		
Fundraising and Community Support	415	31
Research	1,928	883
TOTAL	**3,614**	**2,409**

NOTE 4: DEPRECIATION AND AMORTISATION

	2012 $'000	2011 $'000
DEPRECIATION		
Buildings	29,934	28,282
Plant and Equipment	954	878
Medical Equipment	5,483	4,441
Computers and Communication	1,376	1,114
Furniture and Equipment	485	141
Motor Vehicles	-	4
Non Medical Equipment	404	228
Total Depreciation	**38,636**	**35,088**
AMORTISATION		
Intangibles Assets	1,677	994
Total Amortisation	**1,677**	**994**
Total Depreciation and Amortisation	**40,313**	**36,082**

NOTE 5: CASH AND CASH EQUIVALENTS

For the purposes of the Cash Flow Statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value.

	2012 $'000	2011 $'000
Cash on Hand	14	14
Cash at Bank	26,854	14,509
Deposits at Call	10,000	35,000
Total Cash and Cash Equivalents	**36,868**	**49,523**
REPRESENTED BY:		
Cash for Health Service Operations (as per Cash Flow Statement)	36,868	49,523
Total Cash and Cash Equivalents	**36,868**	**49,523**

NOTE 6: RECEIVABLES

	2012 $'000	2011 $'000
CURRENT		
Contractual		
Inter Hospital Debtors	724	638
Trade Debtors	1,778	1,059
Patient Fees	4,472	6,020
Accrued Investment Income	321	251
Accrued Revenue	6,495	2,208
Less Allowance for Doubtful Debts		
Inter Hospital Debtors	-	-
Trade Debtors	(122)	(24)
Patient Fees	(1,549)	(1,149)
	12,119	**9,003**
Statutory		
GST Receivable	681	1,056
	681	**1,056**
TOTAL CURRENT RECEIVABLES	**12,800**	**10,059**
NON CURRENT		
Statutory		
Long Service Leave - DH	6,266	5,611
TOTAL NON CURRENT RECEIVABLES	**6,266**	**5,611**
TOTAL RECEIVABLES	**19,066**	**15,670**

(A) AGEING ANALYSIS OF RECEIVABLES

Please refer to note 16 for the ageing analysis of contractual receivables.

(B) NATURE AND EXTENT OF RISK ARISING FROM RECEIVABLES

Please refer to note 16 for the nature and extent of credit risk arising from contractual receivables.

NOTE 7: INVESTMENTS AND OTHER FINANCIAL ASSETS

	OPERATING FUND		SPECIFIC PURPOSE FUND		CAPITAL FUND		TOTAL	
	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000
CURRENT								
Term Deposit								
- Australian Dollar Term Deposits > 3 months	15,000	-	-	-	-	-	15,000	-
Total Current	**15,000**	**-**	**-**	**-**	**-**	**-**	**15,000**	**-**
NON CURRENT								
Term Deposit	-	-	-	-	-	-	-	-
Total Non Current	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**15,000**	**-**	**-**	**-**	**-**	**-**	**15,000**	**-**
Represented by:								
Health Service Investments	15,000	-	-	-	-	-	15,000	-
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**15,000**	**-**	**-**	**-**	**-**	**-**	**15,000**	**-**

(A) AGEING ANALYSIS OF INVESTMENTS AND OTHER FINANCIAL ASSETS

Please refer to note 16 (b) for the ageing analysis of investments and other financial assets

(B) NATURE AND EXTENT OF RISK ARISING FROM INVESTMENTS AND OTHER FINANCIAL ASSETS

Please refer to note 16 (b) for the nature and extent of credit risk arising from investments and other financial assets

NOTE 8: INVENTORIES

	2012 $'000	2011 $'000
Pharmaceuticals - at cost	1,288	1,180
Radiology - at cost	191	142
TOTAL INVENTORIES	**1,479**	**1,322**

NOTE 9: OTHER ASSETS

	2012 $'000	2011 $'000
CURRENT		
Prepayments	947	785
	947	**785**
Statutory		
Prepayments	-	-
	-	**-**
TOTAL OTHER CURRENT ASSETS	**947**	**785**

NOTE 10: PROPERTY, PLANT & EQUIPMENT

	2012 $'000	2011 $'000
LAND		
- Land at Fair Value	38,604	35,374
Total Land	**38,604**	**35,374**
BUILDINGS		
- Buildings under Construction at Cost	68,550	122,655
- Buildings at Fair Value	514,222	422,850
Less Accumulated Depreciation	(86,021)	(56,086)
Total Buildings	**496,751**	**489,419**
PLANT AND EQUIPMENT		
- Plant and Equipment at Fair Value	10,576	15,697
- Less Accumulated Depreciation	(4,984)	(4,030)
Total Plant and Equipment	**5,592**	**11,667**
MEDICAL EQUIPMENT		
- Medical Equipment at Fair Value	66,401	50,485
- Less Accumulated Depreciation	(33,948)	(28,659)
Total Medical Equipment	**32,453**	**21,826**
NON MEDICAL EQUIPMENT		
- Non Medical Equipment at Fair Value	4,653	2,773
- Less Accumulated Depreciation	(1,941)	(1,538)
Total Non Medical Equipment	**2,712**	**1,235**
COMPUTERS AND COMMUNICATION		
- Computers and Communication at Fair Value	12,046	8,817
- Less Accumulated Depreciation	(9,663)	(8,291)
Total Computers and Communications	**2,383**	**526**
FURNITURE AND FITTINGS		
- Furniture and Fittings at Fair Value	5,176	1,657
- Less Accumulated Depreciation	(1,127)	(642)
Total Furniture and Fittings	**4,049**	**1,015**
MOTOR VEHICLES		
- Motor Vehicles at Fair Value	175	181
- Less Accumulated Depreciation	(175)	(181)
Total Motor Vehicles	**-**	**-**
TOTAL PROPERTY, PLANT & EQUIPMENT	**582,544**	**561,062**

Reconciliations of the carrying amounts of each class of asset for the entity at the beginning and end of the previous and current financial year is set out below.

	LAND $'000	BUILDINGS $'000	BUILDINGS WIP $'000	PLANT AND EQUIPMENT $'000	MEDICAL EQUIPMENT $'000	NON MEDICAL EQUIPMENT $'000	COMPUTER AND COMM $'000	FURNITURE AND FITTINGS $'000	MOTOR VEHICLES $'000	TOTAL $'000
Balance at 1 July 2010	**35,374**	**393,412**	**37,838**	**8,605**	**22,397**	**1,276**	**1,308**	**675**	**4**	500,889
Additions	-	1,634	84,817	3,940	3,974	189	332	481	-	95,367
Disposals	-	-	-	-	(104)	(2)	-	-	-	(106)
Net transfer between classes	-	-	-	-	-	-	-	-	-	-
Depreciation and Amortisation (note 4)	-	(28,282)	-	(878)	(4,441)	(228)	(1,114)	(141)	(4)	(35,088)
Balance at 1 July 2011	**35,374**	**366,764**	**122,655**	**11,667**	**21,826**	**1,235**	**526**	**1,015**	**-**	**561,062**
Additions	3,230	5,529	47,002	719	2,303	247	755	366	-	60,151
Disposals		-	-	-	(33)	-	-	-	-	(33)
Net transfer between classes	-	85,842	(101,107)	(5,840)	13,840	1,634	2,478	3,153	-	-
Depreciation and Amortisation (note 4)	-	(29,934)	-	(954)	(5,483)	(404)	(1,376)	(485)	-	(38,636)
Balance at 30 June 2012	**38,604**	**428,201**	**68,550**	**5,592**	**32,453**	**2,712**	**2,383**	**4,049**	**-**	**582,544**

LAND AND BUILDINGS CARRIED AT VALUATION

An independent valuation of the Health Service's land and buildings was performed by the Westlink Consulting on behalf of the Valuer-General Victoria to determine the fair value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation was 30 June 2009. Subsequent to this valuation, the Health Service assessed the carrying amounts of land and buildings based on indices made available by the Victorian Valuer-General to establish whether they materially approximate fair value at 30 June 2012. Indices applied to the carrying amount of land and buildings indicated that the balances in respect of land and buildings does approximate fair value.

A fair value assessment of plant and equipment was conducted by management as to whether the fair value of plant and equipment differs materially from its carrying amount at 30 June 2012. The outcome indicated that the carrying amount of plant and equipment does approximate fair value.

NOTE 11: INTANGIBLE ASSETS

	2012 $'000	2011 $'000
Development Costs Capitalised	8,032	4,468
- Less Accumulated Amortisation	(5,421)	(3,745)
Total Written Down Value	**2,611**	**723**

Reconciliation of the carrying amounts of intangible assets for the consolidated entity at the beginning and end of the previous and current financial year:

	DEVELOPMENT COST $'000	TOTAL $'000
Balance at 1 July 2010	**1,613**	**1,613**
Additions	104	104
Disposals	-	-
Amortisation (note 4)	(994)	(994)
Balance at 1 July 2011	**723**	**723**
Additions	3,565	3,565
Disposals	-	-
Amortisation (note 4)	(1,677)	(1,677)
Balance at 30 June 2012	**2,611**	**2,611**

NOTE 12: PAYABLES

	2012 $'000	2011 $'000
CURRENT		
Contractual		
Trade Creditors	5,469	4,781
Accrued Expenses	8,485	12,210
Salary Packaging	1,457	1,308
Other - Melbourne Health	4,615	6,567
Other	1,238	127
	21,264	**24,993**
Statutory		
Repayable Grants - DH	1,864	60
	1,864	**60**
TOTAL PAYABLES	**23,128**	**25,053**

(A) MATURITY ANALYSIS OF PAYABLES

Please refer to note 16 (c) for the ageing analysis of payables

(B) NATURE AND EXTENT OF RISK ARISING FROM PAYABLES

Please refer to note 16 (c) for the nature and extent of risk arising from contractual payables

NOTE 13: PROVISIONS

	2012 $'000	2011 $'000
CURRENT PROVISIONS		
Employee Benefits (i)		
- Unconditional and expected to be settled within 12 months (ii)	44,363	33,366
- Unconditional and expected to be settled after 12 months (iii)	36,461	33,044
	80,824	**66,410**
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months (ii)	3,405	3,131
- Unconditional and expected to be settled after 12 months (iii)	4,721	4,285
	8,126	**7,416**
Total Current Provisions	**88,950**	**73,826**
NON CURRENT PROVISIONS		
Employee Benefits (i)	7,406	6,563
Provisions related to Employee Benefit On-Costs	957	855
Total Non Current Provisions	**8,363**	**7,418**
Total Provisions	**97,313**	**81,244**
(A) EMPLOYEE BENEFITS AND RELATED ON-COSTS		
Current Employee Benefits and related on-costs		
Unconditional Long Service Leave Entitlements	40,531	36,582
Annual Leave Entitlements	31,658	28,864
Accrued Wages and Salaries	14,734	6,668
Accrued Days Off	930	917
Superannuation	859	593
Others	238	202
NON CURRENT EMPLOYEE BENEFITS AND RELATED ON-COSTS		
Conditional Long Service Leave Entitlements (iii)	8,363	7,418
Total Employee Benefits and Related On-Costs	**97,313**	**81,244**
(B) MOVEMENTS IN PROVISIONS		
Movement in Long Service Leave:		
Balance at start of year	**43,998**	**39,314**
Provision made during the year		
- Revaluations	791	(79)
- Expense recognising Employee Service	7,950	8,046
Settlement made during the year	(3,846)	(3,283)
Balance at end of year	**48,893**	**43,998**

Notes:

(i) Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by employees, not including on-costs

(ii) The amounts disclosed are nominal amounts

(iii) The amounts disclosed are discounted to present values

NOTE 14: EQUITY

	2012 $'000	2011 $'000
(A) SURPLUSES		
Property, Plant and Equipment Revaluation Surplus (1)		
Balance at the beginning of the reporting period	242,216	242,216
Balance at the end of the reporting period	**242,216**	**242,216**
Represented by:		
- Land	25,735	25,735
- Buildings	216,481	216,481
	242,216	**242,216**
Financial Asset Available-for-Sale Revaluation Surplus (2)		
Balance at the beginning of the reporting period	-	12
Valuation gain recognised	-	-
Cumulative gain transferred to Operating Statement on sale of financial asset	-	(12)
Balance at the end of the reporting period	**-**	**-**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	165	168
Transfer to and from Restricted Specific Purpose Surplus	-	(3)
Balance at the end of the reporting period	**165**	**165**
Total Surpluses	**242,381**	**242,381**
(B) CONTRIBUTED CAPITAL		
Balance at the beginning of the reporting period	202,980	202,980
Balance at the end of the reporting period	**202,980**	**202,980**
(C) ACCUMULATED SURPLUS		
Balance at the beginning of the reporting period	77,427	34,148
Net Result for the Year	15,227	43,276
Share of Joint Venture Accumulated Surplus	59	
Transfers to and from Restricted Specific Purpose Surplus	-	3
Balance at the end of the reporting period	**92,713**	**77,427**
(D) TOTAL EQUITY AT END OF FINANCIAL YEAR	**538,074**	**522,788**

(1) The property, plant & equipment asset revaluations surplus arises on the revaluation of property, plant & equipment

(2) The financial assets available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold, that portion of the reserve which relates to the financial asset, and is effectively realised, is recognised in the net result. Where a revalued financial asset is impaired that portion of the reserve which relates to that financial asset is recognised in the net result.

NOTE 15: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES

	2012 $'000	2011 $'000
Net Result for the Year	15,227	43,276
Depreciation & Amortisation	40,313	36,082
Provision for Doubtful Debts	642	76
Assets Received Free of Charge	(1,150)	-
Net (Gain)/Loss from Disposal of Non Financial Physical Assets	33	91
Change in Operating Assets & Liabilities		
- (Increase)/Decrease in Receivables	(2,252)	(4,416)
- (Increase)/Decrease Other Assets	4,743	6,593
- (Increase)/Decrease in Prepayments	(156)	(289)
- Increase/(Decrease) in Payables	(4,070)	6,589
- Increase/(Decrease) in Provisions	16,214	9,586
- Change in Inventories	(157)	(49)
NET CASH INFLOW FROM OPERATING ACTIVITIES	**69,387**	**97,539**

NOTE 16: FINANCIAL INSTRUMENTS

(A) FINANCIAL RISK MANAGEMENT OBJECTIVES AND POLICIES

The Health Service's principal financial instruments comprises:

- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)

Details of the significant accounting policies and methods adopted, including the criteria for recognition, the basis of measurement and the basis on which income and expenses are recognised, with respect to each class of financial asset, financial liability and equity instrument are disclosed in note 1 to the financial statements.

The main purpose in holding financial instruments is to prudentially manage the Health Service's financial risks within the government policy parameters.

NOTE 16: FINANCIAL INSTRUMENTS (continued)

Categorisation Of Financial Instruments

	NOTE	CARRYING AMOUNT 2012 $'000	CARRYING AMOUNT 2011 $'000
Financial Assets			
Cash and Cash Equivalents	5	36,868	49,523
Loans and Receivables			
- Trade Debtors	6	2,380	1,673
- Patient Fees	6	2,923	4,871
- Others	6	6,816	2,459
Other Financial Assets			
- Term Deposits	7	15,000	-
Total Financial Assets (i)		**63,987**	**58,526**
Financial Liabilities			
Financial Liabilities at Amortised Cost			
- Payables	12	21,264	24,993
Total Financial Liabilities (ii)		**21,264**	**24,993**

(i) The total amount of financial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable)

(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payable)

(B) CREDIT RISK

Credit risk arises from the contractual financial assets of the Health Service, which comprise cash and deposits, non-statutory receivables and available-for-sale contractual financial assets. The Health Service's exposure to credit risk arises from the potential default of a counter-party on their contractual obligations resulting in financial loss to the Health Service. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with the Health Service's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is the Health Service's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

In addition, the Health Service does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash assets, which are mainly cash at bank. As with the policy for debtors, the Health Service's policy is to only deal with banks with high credit ratings.

Provision of impairment for contractual financial assets is recognised when there is objective evidence that the Health Service will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, debts which are long overdue, and changes in debtor credit ratings.

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents the Health Service's maximum exposure to credit risk without taking account of the value of any collateral obtained.

Credit quality of contractual financial assets that are neither past due nor impaired

2012	FINANCIAL INSITUTIONS (AAA CREDIT RATING) $'000	OTHER $'000	TOTAL $'000
Financial Assets			
Cash and Cash Equivalents	36,868	-	36,868
Loans and Receivables			
- Trade Debtors	-	2,380	2,380
- Patient Fees	-	2,923	2,923
- Other Receivables (i)	-	6,816	6,816
Other Financial Assets			
- Term Deposit	15,000	-	15,000
Total Financial Assets	**51,868**	**12,119**	**63,987**
2011			
Financial Assets			
Cash and Cash Equivalents	49,523	-	49,523
Receivables			
- Trade Debtors	-	1,673	1,673
- Patient Fees	-	4,871	4,871
- Other Receivables (i)	-	2,459	2,459
Other Financial Assets			
- Term Deposit	-	-	-
Total Financial Assets	**49,523**	**9,003**	**58,526**

(i) The total amounts disclosed here exclude statutory amounts (e.g. amounts owing from Victorian Government and GST input tax credit recoverable).

NOTE 16: FINANCIAL INSTRUMENTS (continued)

Ageing analysis of Financial Asset as at 30 June

2012	CARRYING AMOUNT IMPAIRED $'000	NOT PAST DUE AND NOT I MONTH $'000	PAST DUE BUT NOT IMPAIRED LESS THAN MONTHS $'000	1-3 1 YEAR $'000	3 MONTHS- YEARS $'000	1-5 ASSETS $'000	IMPAIRED FINANCIAL $'000
Financial Assets							
Cash and Cash Equivalents	36,868	36,868	-	-	-	-	-
Receivables							
- Trade Debtors	2,380	1,262	380	519	171	48	122
- Patient Fees	2,923	2,249	423	251			1,549
- Other Receivables	6,816	6,816	-	-	-	-	-
Other Financial Assets							
- Term Deposit	15,000	15,000	-	-	-	-	-
Total Financial Assets	**63,987**	**62,195**	**803**	**770**	**171**	**48**	**1,671**
2011							
Financial Assets							
Cash and Cash Equivalents	49,523	49,523	-	-	-	-	-
Receivables							
- Trade Debtors	1,673	883	300	77	413	-	24
- Patient Fees	4,871	3,260	572	215	824	-	1,149
- Other Receivables	2,459	2,459	-	-	-	-	-
Other Financial Assets							
- Term Deposit	-	-	-	-	-	-	-
Total Financial Assets	**58,526**	**56,125**	**872**	**292**	**1,237**	**-**	**1,173**

(i) Ageing analysis of financial assets here exclude the types of statutory assets (i.e. GST input tax credit)

There are no material financial assets (receivables are individually assessed) which are individually determined to be impaired. Currently the Health Service does not hold any collateral as security nor credit enhancements relating to any of its financial assets.

There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired, and they are stated at the carrying amounts as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired.

(C) LIQUIDITY RISK

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due.

The Health Service's maximum exposure to liquidity risk is the carrying amount of financial liabilities as disclosed on the face of the balance sheet. The Health Service manages its liquidity risk as follows:

- maintaining an adequate level of uncommitted funds that can be drawn at short notice to meet its short term obligations;
- holding investments and other contractual financial assets that are readily tradeable in the financial markets; and
- careful maturity planning of its financial obligations based on forecasts of future cash flows.

The following table discloses the contractual maturity analysis for the Health Service's financial liabilities. For interest rates applicable to each class of liability refer to individual notes to the financial statements.

Maturity analysis of financial liabilities as at 30 June

2012	CARRYING AMOUNT $0'000	CONTR-ACTUAL CASH FLOWS $0'000	MATURITY DATES LESS THAN 1 MONTHS $0'000	1-3 MONTHS $0'000	3 MONTHS-1 YEAR $0'000	1-5 YEARS $0'000
Financial Liabilities						
Payables						
- Trade creditors and accruals	21,264	21,264	21,163	91	10	-
Total Financial Liabilities	**21,264**	**21,264**	**21,163**	**91**	**10**	**-**
2011						
Financial Liabilities						
Payables						
- Trade creditors and accruals	24,993	24,993	24,415	392	186	-
Total Financial Liabilities	**24,993**	**24,993**	**24,415**	**392**	**186**	**-**

(D) MARKET RISK

The Health Service's exposure to market risk is primarily through interest rate risk with only insignificant exposure to foreign currency and price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraphs below.

Currency Risk

The Health Service is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

NOTE 16: FINANCIAL INSTRUMENTS (continued)

Interest Rate Risk

Exposure to interest rate risk arises primarily through the Health Service's interest bearing liabilities. Minimisation of risk is achieved mainly by undertaking fixed rate or non-interest bearing financial instruments. For financial liabilities, the Health Service mainly undertakes financial liabilities with relatively even maturity profiles.

Other Price Risk

Upon review of the risks related to financial instruments the Health Service has not identified other risks to exist which could potentially impair the carrying value of the financial assets or liabilities.

Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

	WEIGHTED AVERAGE EFFECTIVE INTEREST RATE (%)	CARRYING AMOUNT $'000	INTEREST RATE EXPOSURE FIXED INTEREST RATE $'000	VARIABLE INTEREST RATE $'000	NON-INTEREST BEARING $'000
Financial Assets					
Cash and Cash Equivalents	4.5	36,868	10,000	26,854	14
Receivables					
- Trade Debtors	-	2,380	-	-	2,380
- Patient Fees	-	2,923	-	-	2,923
- Others	-	6,816	-	-	6,816
Other Financial Assets					
- Term Deposit	5.7	15,000	15,000	-	-
Total Financial Assets		**63,987**	**25,000**	**26,854**	**12,133**
Financial Liabilities					
Trade Creditors	-	5,469	-	-	5,469
Other Liabilities	-	15,795	-	-	15,795
Total Financial Liabilities	**-**	**21,264**	**-**	**-**	**21,264**
Net Financial Asset/Liabilities	**-**	**42,723**	**25,000**	**26,854**	**(9,131)**
2011					
Financial Assets					
Cash and Cash Equivalents	4.9	49,523	35,000	14,509	14
Receivables					
- Trade Debtors	-	1,673	-	-	1,673
- Patient Fees	-	4,871	-	-	4,871
- Others	-	2,459	-	-	2,459
Other financial assets					
- Term Deposit	-	-	-	-	-
Total Financial Assets		**58,526**	**35,000**	**14,509**	**9,017**
Financial Liabilities					
Trade creditors and accruals	-	4,781	-	-	4,781
Other Liabilities	-	20,212	-	-	20,212
Total Financial Liabilities	**-**	**24,993**	**-**	**-**	**24,993**
Net Financial Asset/Liabilities	**-**	**33,533**	**35,000**	**14,509**	**(15,976)**

Sensitivity Disclosure Analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the Health Service believes the following movements are 'reasonably possible' over the next 12 months (base rates are sourced from the Reserve Bank of Australia).

- A shift of +2% and -2% in market interest rates (AUD) from year-end rates of 4%
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%

The following table discloses the impact on net operating result and equity for each category of financial instrument held by the Health Service at year-end as presented to key management personnel, if changes in the relevant risk occur.

	CARRYING AMOUNT	INTEREST RATE RISK				OTHER PRICE RISK			
		-2%		+2%		-1%		+1%	
2012		PROFIT $'000	EQUITY $'000	PROFIT $'000	EQUITY $'000	PROFIT $'000	EQUITY $'000	PROFIT $'000	EQUITY $'000
Financial Assets									
Cash and Cash Equivalents	36,868	(737)	(737)	737	737	-	-	-	-
Receivables									
- Trade Debtors	2,380	-	-	-	-	-	-	-	-
- Patient Fees	2,923	-	-	-	-	-	-	-	-
- Others	6,816	-	-	-	-	-	-	-	-
Other financial assets									
- Term Deposit	15,000	(300)	(300)	300	300				
Total Financial Assets	**63,987**	**(1,037)**	**(1,037)**	**1,037**	**1,037**	**-**	**-**	**-**	**-**
Financial Liabilities									
Trade creditors and accruals	5,469	-	-	-	-	-	-	-	-
Other Liabilities	15,795	-	-	-	-	-	-	-	-
Total Financial Liabilities	**21,264**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net Financial Asset/Liabilities	**42,723**	**(1,037)**	**(1,037)**	**1,037**	**1,037**				
2011									
Financial Assets									
Cash and Cash Equivalents	49,523	(990)	(990)	990	990				
Receivables									
- Trade Debtors	1,673	-	-	-	-				
- Patient Fees	4,871	-	-	-	-				
- Others	2,459	-	-	-	-	-	-	-	-
Other financial assets									
- Term Deposit	-	-	-	-	-				
Total Financial Assets	**58,526**	**(990)**	**(990)**	**990**	**990**				
Financial Liabilities									
Trade creditors and accruals	4,781	-	-	-	-	-	-	-	-
Other Liabilities	20,212	-	-	-	-	-	-	-	-
Total Financial Liabilities	**24,993**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net Financial Asset/Liabilities	**33,533**	**(990)**	**(990)**	**990**	**990**				

NOTE 16: FINANCIAL INSTRUMENTS (continued)

(E) FAIR VALUE

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

- Level 1 - the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices;
- Level 2 - the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly; and
- Level 3 - the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

The Health Service considers that the carrying amount of financial intrument assets and liabilities recorded in the financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows that the fair values of most of the contractual financial assets and liabilities are the same as the carrying amounts.

Comparison between carrying amount and fair value

	CARRYING AMOUNT 2012 $'000	FAIR VALUE 2012 $'000	CARRYING AMOUNT 2011 $'000	FAIR VALUE 2011 $'000
Financial Assets				
Cash and Cash Equivalents	36,868	36,868	49,523	49,523
Receivables				
- Trade Debtors	2,380	2,380	1,673	1,673
- Patient Fees	2,923	2,923	4,871	4,871
- Others	6,816	6,816	2,459	2,459
Other Financial Assets				
- Term Deposit	15,000	15,000	-	-
Total Financial Assets	**63,987**	**63,987**	**58,526**	**58,526**
Financial Liabilities				
Trade creditors and accruals	5,469	5,469	4,781	4,781
Other Liabilities	15,795	15,795	20,212	20,212
Total Financial Liabilities	**21,264**	**21,264**	**24,993**	**24,993**

NOTE 17: COMMITMENTS FOR EXPENDITURE

	2012 $'000	2011 $'000
CAPITAL EXPENDITURE COMMITMENTS		
Payable:		
Buildings	39,017	48,540
Plant and Equipment	8,387	2,772
Total Capital Expenditure Commitments	**47,404**	**51,312**
Buildings		
Not later than one year	32,369	46,530
Later than 1 year and not later than 5 years	6,648	2,010
Total	**39,017**	**48,540**
Plant and Equipment		
Not later than one year	6,958	2,372
Later than 1 year and not later than 5 years	1,429	400
Total	**8,387**	**2,772**
Other Expenditure Commitments		
Payable:		
Computer Equipment	1,678	3,265
Total Other Expenditure Commitments	**1,678**	**3,265**
Not later than one year	1,392	3,265
Later than 1 year and not later than 5 years	286	-
TOTAL	**1,678**	**3,265**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	9,056	2,991
Total Lease Commitments	**9,056**	**2,991**
Operating Leases		
Non-cancellable		
Not later than one year	2,607	1,767
Later than 1 year and not later than 5 years	6,449	1,224
Sub Total	**9,056**	**2,991**
TOTAL LEASE COMMITMENTS	**9,056**	**2,991**
Total Commitments (inclusive of GST)	**58,138**	**57,568**
Less: GST Recoverable from the Australian Tax Office	**5,285**	**5,233**
Total Commitments (exclusive of GST)	**52,853**	**52,335**

NOTE 18: CONTINGENT ASSETS & CONTINGENT LIABILITIES

Details of estimates of maximum amounts of Contingent Assets or Contingent Liabilities are as follows:

	2012 $'000	2011 $'000
Contingent Assets		
The Directors are not aware of any quantifiable or non quantifiable contingent assets	-	-
	-	**-**
Contingent Liabilities		
Quantifiable		
Recallable capital grant - Digital Medical Record	1,400	1,500
Recallable capital grant - Patient & Client Management System	320	640
Total Quantifiable Contingent Liabilities	**1,720**	**2,140**

NOTE 19: OPERATING SEGMENTS

	RAC		PUBLIC HEALTH		TOTAL	
	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000
REVENUE						
External Segment Revenue	5,936	6,311	576,871	557,363	582,807	563,674
Total Revenue	**5,936**	**6,311**	**576,871**	**557,363**	**582,807**	**563,674**
EXPENSES						
External Segment Expenses	6,322	5,747	564,030	517,507	570,352	523,254
Total Expenses	**6,322**	**5,747**	**564,030**	**517,507**	**570,352**	**523,254**
Net Result from ordinary activities	**(386)**	**564**	**12,841**	**39,856**	**12,455**	**40,420**
Interest Income	-	-	2,772	2,856	2,772	2,856
Net Result for Year	**(386)**	**564**	**15,613**	**42,712**	**15,227**	**43,276**
OTHER INFORMATION						
Segment Assets	5,366	4,966	624,612	607,755	629,978	612,721
Unallocated Assets	-	-	-	-	28,537	16,364
Total Assets	**5,366**	**4,966**	**624,612**	**607,755**	**658,515**	**629,085**
Segment Liabilities	1,340	1,238	105,635	92,323	106,975	93,561
Unallocated Liabilities	-	-	-	-	13,466	12,736
Total Liabilities	**1,340**	**1,238**	**105,635**	**92,323**	**120,441**	**106,297**
Investments in associates and joint venture partnership	**-**	**-**	**-**	**-**	**-**	**-**
Acquisition of property, plant and equipment and intangible assets	**-**	**-**	**60,151**	**95,367**	**60,151**	**95,367**
Depreciation & amortisation expense	**126**	**40**	**40,187**	**36,042**	**40,313**	**36,082**
Non cash expenses other than depreciation	**462**	**531**	**42,898**	**37,891**	**43,360**	**38,422**
Impairment of inventories	**-**	**-**	**-**	**-**	**-**	**-**

The major products/services from which the above segments derive revenue are:

BUSINESS SEGMENTS	SERVICES
Residential Aged Care Services (RACS)	Commonwealth-registered residential aged care services subsidised by the Australian Department of Health & Ageing under the Aged Care Act (Cwlth) 1997, i.e. nursing homes and aged care hostels.
Public Health	Acute (Admitted and Non-Admitted Patients, Emergency Department, Subacute Care, Palliative Care, Acute Training & Development, and Blood Services). Also, Allied Health, Drug & Alcohol Service, Corporate (Administration, Finance, Human Resources, Information Technology), Infrastructure, Medical Records, Quality & Clinical Governance.

GEOGRAPHICAL SEGMENT

The Health Service operates predominantly in the western suburbs (Footscray, Sunshine, Williamstown & Sunbury) of Melbourne, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in that area.

NOTE 20: JOINTLY CONTROLLED OPERATIONS AND ASSETS

NAME OF ENTITY	PRINCIPAL ACTIVITY	OWNERSHIP INTEREST 2012 %	OWNERSHIP INTEREST 2011 %
Victorian Comprehensive Cancer Centre Joint Venture ("VCCC")	Cancer research, education and training and patient care	12.5%	niL

The Health Service interest in assets employed in the above jointly controlled operations and assets is detailed below. The amounts are included in the financial statements under their respective asset categories:

	2012 $'000	2011 $'000
Current Assets		
Cash and Cash Equivalents	152	-
Receivables	35	-
Prepayments	3	-
Total Current Assets	**190**	**-**
Non-Current Assets		
Property, Plant and Equipment	5	-
Total Non-Current Assets	**5**	**-**
SHARE OF TOTAL ASSETS	**195**	**-**
Current Liabilities		
Payables	44	-
Provisions	29	-
Total Current Liabilities	**73**	**-**
Non-Current Liabilities		
Payables	3	-
Total Non-Current Liabilities	**3**	**-**
SHARE OF TOTAL LIABILITIES	**76**	**-**
NET ASSETS	**119**	**-**
Share of VCCC's Net Assets	**119**	**-**

The Health Service's interest in revenues and expenses resulting from the jointly controlled operations and assets is detailed below:

	2012 $'000	2011 $'000
Grants	211	-
Interest	6	-
Other	3	-
Total Revenue	**220**	**-**
Employee Expenses	131	-
Other Expenses	28	-
Depreciation	1	-
Total Expenses	**160**	**-**
NET ASSETS	**60**	
Share of VCCC's Net Result After Income Tax	**60**	**-**
Contingent Assts and Contingent Liabilities	-	-
Commitments for Expenditure	-	-

NOTE 21A: RESPONSIBLE PERSONS DISCLOSURES

In accordance with the Ministerial Directions issued by the Minister for Finance under the Financial Management Act 1994, the following disclosures are made regarding responsible persons for the reporting period.

	PERIOD
Responsible Minister:	
The Honourable David Davis, M.P., Minister for Health and Ageing	1/7/2011 - 30/06/2012
The Honourable Mary Wooldridge, MLA, Minister for Mental Health	1/7/2011 - 30/06/2012
Governing Board	
Mr Ralph Willis (Chair)	1/7/2011 - 30/06/2012
Professor Colin Clark	1/7/2011 - 30/06/2012
Ms Vivienne Nguyen	1/7/2011 - 30/06/2012
Ms Juliann Byron	1/7/2011 - 30/06/2012
Mrs Elleni Bereded-Samuel	1/7/2011 - 30/06/2012
Mrs Patricia Vejby	1/7/2011 - 30/06/2012
Mr Robert Mitchell	1/7/2011 - 30/06/2012
Mr Philip Moran	1/7/2011 - 30/06/2012
Associate Professor Afif Hadj	1/7/2011 - 30/06/2012
Accountable Officer	
Ms Kathryn Cook	1/7/2011 - 30/06/2012

	2012 NO.	2011 NO.
REMUNERATION OF RESPONSIBLE PERSONS		
The number of Responsible Persons are shown in their relevant income bands;		
Income Band		
$0	1	1
$10000 - $19,999	0	1
$20000 - $29,999	7	6
$30000 - $39,999	0	0
$40,000 - $49,999	1	0
$50,000 - $59,999	0	1
$370,000 - $379,999	0	1
$410,000 - $419,999	1	0
Total Numbers	**10**	**10**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$655,848**	**$603,933**

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet.

Other Transactions of Responsible Persons and their Related Parties.

There were no other transactions paid by the Health Service in connection with the Responsible Persons of the Health Service. There are no monies receivable from or payable to Responsible Persons and Responsible Persons' Related Parties.

NOTE 21B: EXECUTIVE OFFICER DISCLOSURES

EXECUTIVE OFFICERS' REMUNERATION

The numbers of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the first two columns in the table below in their relevant income bands. The base remuneration of executive officers is shown in the third and fourth columns. Base remuneration is exclusive of bonus payments, long-service leave payments, redundancy payments and retirement benefits.

	TOTAL REMUNERATION		BASE REMUNERATION	
	2012	2011	2012	2011
$80,000 - $89,999	0	0	1	1
$100,000 - $109,999	0	0	0	1
$110,000 - $119,999	1	3	2	2
$120,000 - $129,999	2	1	1	1
$130,000 - $139,999	3	3	3	3
$140,000 - $149,999	3	3	3	2
$150,000 - $159,999	6	6	5	6
$160,000 - $169,999	2	3	2	3
$170,000 - $179,999	3	1	3	1
$180,000 - $189,999	1	2	3	2
$190,000 - $199,999	2	3	2	5
$200,000 - $209,999	5	4	4	2
$210,000 - $219,999	1	0	1	0
$220,000 - $229,999	1	0	0	0
$270,000 - $279,999	0	1	0	1
$290,000 - $299,999	0	0	1	0
$300,000 - $309,999	1	0	0	0
Total number of executives	**31**	**30**	**31**	**30**
Total annualised employee equivalent [1]	**28**	**28.5**	**28**	**28.5**
Total Remuneration	**$5,347,286**	**$4,951,878**	**$5,210,796**	**$4,843,656**

Note
(1) Annualised employee equivalent is based on working 76 ordinary hours per fortnight over the reporting period

NOTE 22: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

At the time the report was being prepared the Directors are not aware of any events occurring after the reporting date that would have a material impact on the financial statements.

NOTE 23: CONTROLLED ENTITIES

NAME OF ENTITY	COUNTRY OF INCORPORATION	EQUITY HOLDING
Western Health Foundation Limited	Australia	100%

Western Health Foundation Limited, a public company limited by guarantee was incorporated on 19th October 2011 with its principal activity being that of managing fundraising and philanthropic activities on behalf of the Health Service. The Foundation is dormant as at 30 June 2012.

NOTE 24: ECONOMIC DEPENDENCY

The financial statements are prepared on a going concern basis as at 30 June 2012. The Health Service has:

- A surplus from ordinary activities of $15 million for the year ended 30 June 2012 ($43 million surplus for the year ended 30 June 2011).
- Working capital ratio (excluding long-term employee entitlements) is calculated at 0.94 as at 30 June 2012 (1.0 as at 30 June 2011).

Health Service management are committed to the continued review of its financial and operating performance with a view to identifying further cost saving initiatives and revenue generating opportunities and providing the most effective and efficient service delivery model without compromising patient care and quality.

An ongoing budget strategy has been initiated by management of the Health Service which has identified a number of business initiatives required to effectively manage the available financial resources.

AUDITOR-GENERAL'S REPORT

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INDEPENDENT AUDITOR'S REPORT

To the Board Members of Western Health

The Financial Report

The accompanying financial report for the year ended 30 June 2012 of Western Health which comprises the comprehensive operating statement, balance sheet, statement of changes in equity, statement of cash flows, notes comprising a statement of significant accounting policies and other explanatory information, and the Board Member's, Accountable Officer's and Chief Finance and Accounting Officer's declaration has been audited. The financial report includes the consolidated financial statements of the economic entity, comprising Western Health and the entities it controlled at the year's end as disclosed in note 23 to the financial statements.

The Board Members' Responsibility for the Financial Report

The Board Members of Western Health are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*, and for such internal control as the Board Members determines is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

As required by the *Audit Act 1994*, my responsibility is to express an opinion on the financial report based on the audit, which has been conducted in accordance with Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Western Health and the consolidated entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Board Members, as well as evaluating the overall presentation of the financial report.

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

Auditing in the Public Interest

Independent Auditor's Report (continued)

Independence

The Auditor-General's independence is established by the *Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, the Auditor-General, his staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of Western Health and the economic entity as at 30 June 2012 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994.*

Matters Relating to the Electronic Publication of the Audited Financial Report

This auditor's report relates to the financial report of Western Health for the year ended 30 June 2012 included both in Western Health's annual report and on the website. The Board Members of Western Health are responsible for the integrity of Western Health's website. I have not been engaged to report on the integrity of Western Health's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in the website version of the financial report.

MELBOURNE
17 August 2012

for D D R Pearson
Auditor-General

NOTES

Sunbury

SUNBURY DAY HOSPITAL

Melton

REG GEARY HOUSE

WESTERN HOSPITAL

DRUG & ALCOHOL SERVICES

SUNSHINE HOSPITAL

SUNSHINE HOSPTIAL RADIATION THERAPY CENTRE

WESTERN CENTRE FOR HEALTH RESEARCH & EDUCATION

Melbourne

Werribee

WILLIAMSTOWN HOSPITAL

HAZELDEAN TRANSITION CARE

Western Health

WESTERN HOSPITAL

Gordon Street
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8345 6666

SUNSHINE HOSPITAL

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8345 1333

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8395 9999

WESTERN CENTRE FOR HEALTH RESEARCH AND EDUCATION

Sunshine Hospital
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SUNBURY DAY HOSPITAL

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WILLIAMSTOWN HOSPITAL

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www.westernhealth.org.au

Together, caring for the West