2016

ANNUAL REPORT

2017

Western Health

OUR VISION

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

OUR PURPOSE

Leading the delivery of a connected and consistent patient experience and providing the best care to save and improve the lives of those in our community most in need.

OUR VALUES

Compassion

Consistently acting with empathy and integrity

Accountability

Taking responsibility for our decisions and actions

Respect

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

OUR STRATEGIC AIMS

Growing & improving the delivery of safe, high quality care.

Connecting the care provided to our community.

Communicating with our patients, our partners and each other with transparency and purpose.

Being socially responsible and using resources sustainably.

Valuing and empowering our people.

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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BOARD CHAIR AND ACTING CEO MESSAGE

A message from the Board Chair and the Acting Chief Executive

The past year has been a highly productive one for Western Health as construction commenced on the Joan Kirner Women's and Children's Hospital and the fantastic announcement of the Victorian Government's commitment to rebuild Footscray Hospital came through in the May State Budget.

Our staff and volunteers were excited to see Western Health once again named as a finalist in the Premier's Large Health Service of the Year Award at the prestigious Victorian Public Healthcare Awards in 2016. Other finalists included the Royal Children's and the Women's, and we congratulate The Women's for their well deserved win.

FOOTSCRAY HOSPITAL TO BE REBUILT

Our patients, families, staff and volunteers were all thrilled to hear of the fantastic commitment to rebuild Footscray Hospital. The need for a new hospital is extremely urgent, with significant structural issues limiting the life of the now 64 year old building.

Premier Daniel Andrews, Health Minister The Hon Jill Hennessy and local MP Marsha Thomson toured the hospital the day after the State Budget, to formally announce the commitment.

The 2017 State Budget provided an initial $50 million to support the planning for the new hospital and essential maintenance work. Intensive work is now well advanced on the next steps.

BETTER SERVICES FOR WOMEN AND CHILDREN

The past 12 months have seen key milestones met for one of the most important developments in the west of Melbourne – the commencement of construction of the Joan Kirner Women's and Children's Hospital.

More than 300 consumers, staff and members of the community, took part in workshops on the schematic design and development phases for the new building.

The Minister for Health visited the site several times, in October 2016 with the Premier, for the turning of the sod and in May 2017 to award school children their prize for naming the cranes – Big Billy and Betty.

As we look ahead to the completion of the wonderful new Joan Kirner Women's and Children's Hospital, we continue to seek new ways to respond to the continuing extremely high demand for maternity services.

In September 2016 we saw the highest number of births at Sunshine Hospital on record and this led us to develop a peak demand strategy and collaborative arrangement, in consultation with Werribee Mercy; the Women's Hospital; Djerriwarrh Health Services and the Royal Children's. The management plan proved to be a valuable strategy as numbers continued to grow in a number of subsequent months.

Over the past year, our capacity to manage demand has also increased following considerable success in our recruitment into key positions within the maternity and neonatal areas of our service, resulting in many high calibre candidates joining Western Health.

An antenatal clinic dedicated to women with a higher body mass index has treated 94 mums and helped bring 58 babies into the world in its first year at Sunshine Hospital. Western Health's DIAMOND Clinic (DIAbetes, Maternal Obesity, Nutrition and Diet) is believed to be one of the most comprehensive services of its kind in Australia. The clinic is a virtual one-stop-shop of specialists including obstetricians, midwives, dietitians, psychologists, foetal monitoring specialists, physiotherapists and endocrinologists, supporting pregnant women who are at higher risk of complications including diabetes, blood pressure problems, and preeclampsia.

Both paediatric and cardiology patients have seen the benefits of new measures and equipment at Western Health in the past 12 months. For the first time in the West of Melbourne, we are able to offer a Paediatric Cardiology Echo Service, providing a highly specialised service for children with heart conditions.

The lives of more than 50 children have been transformed thanks to a program run by Western Health's Growth and Nutrition Clinic. The program teaches children to eat once again, after prolonged periods on tube feeding. The program is the only public service of its kind in Australia and has developed a strong reputation for being able to assist children when no other method has been successful. The program helps transition a wide range of paediatric patients from tube feeding, including premature babies, and children with conditions as varied as autism, congenital heart defects and metabolic disorders.

SUPPORTING VULNERABLE MEMBERS OF OUR COMMUNITY

The vulnerability of many of our patients extends beyond their immediate healthcare needs to encompass issues such as family violence or sexual abuse. Western Health is a continuing pilot site of the Strengthening Hospital Responses to Family Violence project led by The Royal Women's and Bendigo Health.

We have brought together a diverse group of leaders to consider how we provide a more organisational approach to supporting vulnerable members of our community. This includes consideration of Child Safe Standards, supporting victims of family violence, and consideration of other forms of trauma and vulnerability in our community.

In August 2016, we were very grateful to receive a grant of $200,000 from Better Care Victoria, to fund the extended development of the special app our staff designed, to assist in communicating with patients with little or no English. This will now allow it to be rolled out for nursing staff to use across the state. The initial allied health version of this app became available on iTunes in early 2017.

TACKLING CHRONIC DISEASE

As we continued to address the challenges of the need for growth in demand for our services, we took the opportunity to improve care while also expanding our capacity. We embarked on a new path in our bid to provide a better response for patients with chronic and complex conditions when we launched the Western HealthLinks program in November 2016.

This innovative program, made possible through a new funding option provided by the Victorian Government, has allowed us to take a different approach to how we manage the needs of patients with complex illness. The aim is to help these patients remain in their homes and avoid preventable hospital admissions. In the first seven months, we have identified 2262 patients for enrolment in this program, run in collaboration with the Silver Chain Group.

While it was anticipated that the vast majority of the patients requiring intensive coordination and support in their homes would be older patients, we have also seen patients as young as 35 suffering chronic cardiac disease and a small number of pregnant women with a range of complex conditions.

Our commitment to push ahead with new frontiers in research to address the chronic disease burden impacting the patients of the west of Melbourne, led to the creation of the Western Health Chronic Disease Alliance. This new alliance will target research across a number of clinical disciplines including nephrology, endocrinology, cardiology, neurology and general medicine. Once fully established and operational, the scope will also expand to include nursing, allied health, respiratory medicine, rheumatology and potentially, mental health.

The research direction and outcomes that will emanate from the Alliance are complimentary to the objectives and aims of the Healthlinks project and our wide range of other work to support our tens of thousands of chronic disease patients every year.

Western Health researchers have also led an initiative aimed at detecting chronic diseases early, expanding a GP screening program that was already improving the detection of kidney disease, to support screening for a wider range of chronic diseases such as heart disease, stroke and diabetes.

Further details about Western Health's broader research achievements can be found in our annual Research Report, located on our website.

CANCER SERVICES

A substantial Cancer Council grant that will make clinical trials more accessible to our oncology patients, was awarded to Western Health during the year. The funding – worth $632,000 over three years – will maximise the number and types of trials available to Western Health patients, with a particular focus on those from culturally and linguistically diverse backgrounds. The grant was one of four, totalling $2.5 million and chosen from a highly competitive pool of 15 applicants from around the state.

Western Health was also pleased to receive Victorian Government funding for the General Practice Placement in Cancer Survivorship Program for GPs and practice nurses, aimed at improving the understanding of how specialist care and primary care can work together in post treatment cancer care. The program provides an opportunity for GPs and practice nurses to undertake a 10 hour clinical placement to work with oncology specialist teams in multidisciplinary hospital-based care settings. This project has shown great potential to support connected care.

Our innovation in addressing the cancer burden within our community was recognised in the 2016 Victorian Public Healthcare Awards. The increased demand for endoscopic procedures for our patients led to Western Health becoming the joint winners of the Excellence in Cancer Care Award in recognition of the benefits gained through the Rapid Access to Gastrointestinal Endoscopy (RAGE) program. This program provides a clear pathway for GPs to identify and expediate access for patients with symptoms suggestive of increased risk of a cancer diagnosis.

BOARD CHAIR AND ACTING CEO MESSAGE (CONTINUED)

PROVIDING BEST CARE

Western Health welcomed the release of the Victorian Government's Towards Zero report and the strengthened support for Victorian health services with the establishment of Safer Care Victoria.

Our own organisational drive to continuously improve care and the patient experience received a further boost when our second Best Care Forum was held in March 2017. Three days of presentations, attended by hundreds of staff, culminated in the naming of the best projects in the four Best Care domains – Safe Care, Right Care, Coordinated Care and Person Centred Care.

The past year has seen older patients at Williamstown Hospital benefit from a remarkable achievement by one of its largest wards, which has now reached a milestone of close to 500 days at the end of June (489) without a single pressure injury. Less than three years after implementing an internationally renowned program for preventing pressure injuries, the 30-bed aged care unit that achieved the record includes the Geriatric Evaluation and Management ward, rehabilitation and transition care. Its patients are particularly susceptible to pressure injuries because of their frailty and reduced mobility.

TIMELY ACCESS TO EMERGENCY CARE

Space and increasing demand continues to create pressure at Footscray and Sunshine Hospital Emergency Departments and this pressure is felt particularly during the winter months.

Work at Western Health has continued over the past 12 months to support improved performance with ambulance off load times and timely patient flow through our Emergency Departments.

This work has been supported by involvement in Better Care Victoria's Collaborative to redesign and improve emergency care, and engagement in car manufacturer Toyota's social contribution project to optimise processes for the care journey of emergency patients. With the support of this work and our emergency staff's dedication to provide timely care, we have maintained and in some cases, enhanced upon, performance gains of last year.

In conjunction with Melbourne Health, we recently opened Australia's first virtual fracture clinics. The Virtual Fracture Care service is being trialled this year and funded by Better Care Victoria and allows adult patients with simple fractures to be managed remotely by physiotherapists and consultants. The innovative program is already improving patient access to fracture care and reducing demand on the orthopaedic fracture clinic. To be eligible for the virtual clinic, patients must have a simple orthopaedic fracture, such as a toe fracture or shoulder dislocation, or soft tissue injury.

We have also worked with Werribee Mercy Hospital to set up a transfer protocol for cardiac patients requiring acute care at a Western Health hospital, for example in the event of a heart attack. This arose from the collaboration which took place as part of the Strengthening Hospitals in Melbourne's West project. The region's health services, together with Ambulance Victoria, worked together in the project to address areas where patients' needs could be better met through improved partnership.

Over 2016/17, there has been significant demand through our Emergency Departments in relation to patients seeking mental health care. We have worked closely with the agencies who provide mental health care services to our patients (Werribee Mercy Hospital and North West Mental Health) and the Office of the Chief Psychiatrist to support the establishment of new funding, changes to pathways and greater support to the patients and staff in the Emergency Departments.

THUNDERSTORM ASTHMA

Victoria's Inspector-General for Emergency Management Tony Pearce has "commended" the response of hospitals and emergency services to last year's unprecedented thunderstorm asthma crisis which hit on November 21-22.

Footscray, Sunshine and Williamstown Hospitals were key contributors in responding to the emergency, with our emergency departments treating more than 1260 patients across the Monday early evening and Tuesday of the asthma outbreak. The scale of the demand on our health service was extraordinary, as was the way our staff and community responded under such pressure.

TIMELY ACCESS TO ELECTIVE SURGERY

In recent months, we have implemented a valuable new approach as part of our commitment to improve timely access to elective surgery and improve the quality of life for patients awaiting surgery. A partnership was developed between Western Health and Alfred Health to enable more rapid access to orthopaedic surgery for patients who have been waiting for long periods and to provide an effective use of state-wide elective surgery capacity. The elective surgery partnership pilot has been developed with the support of the Department of Health and Human Services.

Support from the Department has also enabled additional weekend surgery lists to be undertaken to achieve our year end targeted elective surgery waiting list number. Whilst we admitted significantly more patients off our elective surgery waiting list in 2016/17 than targeted, there has been a sharp increase in numbers of patients added to the list since January 2017. Factors contributing to this are improved performance in managing outpatient waiting lists and an increasing number of patients being referred for surgery from private rooms.

INTRODUCING AN ELECTRONIC MEDICAL RECORD

The past year saw Western Health begin the major process of working towards the implementation of an Electronic Medical Record (EMR). This is a detailed and complex process but it is an important step in supporting clinical decision making and electronic ordering of medications, pathology, imaging and more. This is a large scale project and one which will eventually bring about significant benefits for both our staff and our patients. The program of work commenced with an assessment of the current state in late 2016 and involved 70 focus group sessions and walkthroughs, as well as the exploration of workflows. The program has since moved into the review of the proposed future state, with around 300 Western Health clinicians taking part in a 'Future State Review' of the proposed design for the EMR in March and April 2017.

SUSTAINING A POSITIVE WORKPLACE

A record 42% of our staff completed the 2016 People Matter Survey, following a concerted effort to generate as high a rate of completion as possible. The overall results were very positive and helped to inform a significant amount of work over the past year to drive a positive workplace for our staff and volunteers.

We developed a Positive Workplace Strategy and invited the 2016 Australian of the Year, Lt Gen David Morrison AO (ret'd), to Sunshine Hospital in August, to lead an interactive discussion with our senior medical staff. David Morrison received the Australian of the Year award in recognition of his leadership on issues related to gender diversity and his response to bullying and harassment within the armed forces. His quote "The standard you walk past is the standard you accept" inspired our Positive Workplace Strategy theme "Don't Walk Past".

Our initial focus was on the issues of bullying and harassment within the medical profession and a Medical Advisory Committee was established to provide high level advice to the CEO and Executive.

In October, we held a Positive Workplace Day and encouraged staff and volunteers across all sites to contribute their thoughts and views on how to make Western Health a more positive workplace.

To provide an effective and formal framework for the management of bullying and harassment concerns, we also resourced the development of a detailed manual called EMPOWIR, which will now be rolled out across Western Health.

A wide range of management and leadership training initiatives have been implemented as a result of the clear request by staff for improved skills for managers. The Western Health Nursing and Midwifery Leadership Excellence for Accountable Patent Care program – known as LEAP - was launched in August 2016. LEAP was developed for Nurse and Midwife Unit Managers. Features include Nurse Unit Manager assessment, development planning, leadership skills labs, peer leadership groups, structured workshops with guest speakers and activities on accountable care, to address key development needs for our senior nursing staff.

DEVELOPING OUR WORKFORCE

Under a Victorian Government initiative aimed at tackling the problem of many newly graduated Victorian nurses missing out on jobs in public hospitals, Western Health has developed a successful new program targeting newly graduated nurses. The Early Career Nurse Program has been highly successful, enabling Western Health to increase its intake of graduate nurses by 27 per cent and reduce its reliance on agency staff. Of the first 32 nurses to complete the ECN program, two thirds went on to secure permanent jobs at Western Health while other ECN graduates were able to start their nursing careers in other health services.

Our current - and future - indigenous workforce has again been boosted with the second successful year of our Aboriginal Nursing Cadetship program, which offers up to 40 paid shifts a year for indigenous students in the second or third year of their nursing degrees. This year we have three cadets and they are making a great contribution. The cadetship program's many aims centre around "closing the gap", and are overseen by Western Health's Aboriginal Health Unit. The cadets will create professional networks and increase their nursing skills, so when they finish their degrees they will have the best possible opportunity of securing a graduate position.

OUR VOLUNTEERS

Volunteers continue to play an enormously important role at Western Health. More than 650 volunteers now support our patients and services, with an additional 250 students taking part in various school partnership programs.

More than 300 volunteers packed Sunshine's Club Italia to honour Western Health's dedicated team of volunteers during National Volunteer Week. The annual luncheon featured presentations to volunteers of long service and – for the first time – a DJ and a packed dance floor. Among the attendees was our oldest volunteer, 92-year-old Marie Marchant, who donates her time two days a week to Footscray Hospital.

Through the involvement of more than 90 volunteers, a unique Volunteer Meals Assistance Program is now assisting patients on nine wards across Footscray, Sunshine and Williamstown Hospitals. In the two years since the program commenced, the percentage of patients being offered assistance with their main meals has increased from 45% to 81% and there has been assistance offered on more than 24,000 occasions. Volunteers help patients with setting up their meal trays, opening packaging and cutting up meals if necessary, while also providing social support.

SUNSHINE PRECINCT

A major focus on development in the area around Sunshine Hospital has helped secure more than a half a billion dollars in new public and private funding and investment. The Sunshine Health, Wellbeing and Education Precinct, supported by Western Health, Brimbank Council, Victoria University, the University of Melbourne and private health and education providers has been a key contributor to the successful planning for the area.

The Precinct committee launched its new Action Plan at the Western Centre for Health Research and Education at Sunshine Hospital during the year, highlighting substantial progress towards the development of the precinct.

As the largest employer in one of the most disadvantaged urban areas in Australia, Western Health has a major influence on the wellbeing of communities across the west of Melbourne and our communities' socio economic gains are integral to improved health.

BOARD CHAIR AND ACTING CEO MESSAGE (CONTINUED)

COMMUNITY ACTIVITIES

The past year brought a great deal of excitement to Western Health when our wonderful community partners, the Western Bulldogs, won the AFL Premiership. The joy among our patients, staff and volunteers was palpable as the win was celebrated by those who had waited much of their lives to see this outcome. The tangible evidence of this joy then came in the form of the Premiership Cup tour taking in each of our larger campuses, with visits to Sunshine, Footscray and Williamstown Hospitals providing the opportunity for patients, visitors, staff and volunteers to see the Cup.

The Western Bulldogs' partnership comes in many different forms, and in August 2016 this was reflected once again through their generous involvement in the Western Health Foundation BreastWest Night of Nights, where Bulldogs players accompany women who are either survivors of or have a breast cancer diagnosis, on the catwalk, in a fundraising fashion parade.

The Heart of Williamstown Appeal, aimed at transforming the public spaces of the Williamstown Hospital, has received generous support from across the community in the past year. Through the leadership of a number of community leaders, including the former premier, The Hon Steve Bracks, who is patron of the appeal, the fund has now reached more than $2 million. A final push is now underway to secure an additional $200,000 to enable the construction of the new spaces to commence. The appeal was generated – and continues to be managed - by the Western Health Foundation.

The maternity wards and special care nursery at Sunshine Hospital were honoured to receive a special visit by The Honourable Linda Dessau AC, Governor of Victoria, on International Women's Day. The Governor had expressed her interest in visiting these services, where she also met a number of women and their newborn babies, as well as interacting with obstetricians, midwives and neonatal specialists.

STRIVING FOR SUSTAINABILITY

We continue to lead the hospital sector in Victoria with our successful implementation of sustainability measures. This culminated in Western Health hosting a statewide healthcare sustainability forum in June 2017, in collaboration with the Institute of Healthcare Engineering Australia and the Climate and Health Alliance, with support from the Australian Healthcare and Hospitals Association.

Our pharmacy departments have begun implementing an ambitious plan to reduce the vast quantity of packaging waste associated with hospital pharmacy provisions, while Western Health has also reinvigorated its Green Office Program and pioneered an extremely effective system to reduce the wastage associated with Single Use Medical Instruments.

More details on the extensive sustainability measures taken at Western Health, can be found in the Sustainability Report on our website.

With the extraordinary demands on our health service and as we continue to work to provide better facilities for our patients, the high value we place on Western Health remaining financially responsible is once again evident in our financial results. We have recorded a surplus of $0.6M in the 2016/17 year in a budget of over $700 million and we continue to have a strong cash position.

OUR CHIEF EXECUTIVE MAKES AN ANNOUNCEMENT

On 27 June 2017, Chief Executive, Associate Professor Alex Cockram, announced to the organisation that she had decided to step down from the role in August this year.

A/Prof Cockram commenced a three month secondment as Interim Chief Executive Officer at Barwon Health, in May, while they transitioned to a new CEO.

Alex has made the most incredible contribution throughout the five years she has been leading our organisation and her passion, intellect and vision will be greatly missed. She has taken Western Health to a new level of recognition and maturity as a health service of high quality, with strong clinical and executive leadership.

During her time here, Alex has driven and implemented some of the most significant changes to occur at Western Health since it commenced with the opening of Footscray Hospital in 1953. These include the establishment of intensive and coronary care services at Sunshine Hospital and the move of major acute specialties to that site.

Our staff, volunteers and community partners will have an opportunity to farewell Alex when she returns to Western for a short period in August.

THANKS

Finally, we would like to thank Western Health's staff; volunteers; our many community stakeholders, including our local members of parliament at both the State and Commonwealth levels; the Department of Health and Human Services and the Victorian Government; and financial donors, through the Western Health Foundation. Your support is greatly appreciated and makes an incredible difference to the care we are able to provide. We look forward to working with you over the next year.

In accordance with the Financial Management Act 1994, we are pleased to present the Report of Operations for Western Health for the year ending 30 June 2017.

The Hon Bronwyn Pike
Chair of the Board, Western Health
8 August 2017

Russell Harrison
Acting CEO, Western Health
8 August 2017

ABOUT WESTERN HEALTH

Western Health (WH) manages three acute public Hospitals: Footscray Hospital, Sunshine Hospital and the Williamstown Hospital. It also operates the Sunbury Day Hospital and a transition care program at Hazeldean in Williamstown. A wide range of community based services are also managed by Western Health, along with a large Drug Health and Addiction Medicine service.

Services are provided to the western region of Melbourne which has a population of approximately 800,000 people.

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 more than 6,200 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. We have academic partnerships with the University of Melbourne, Victoria University and Deakin University.

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 approximately 800,000 people
- is ageing, with frailty becoming an increasing challenge to independent healthy living
- 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 110 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.

OUR FACILITIES

Western Health provides services to residents of the following local government municipalities:

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

Western Health provides a range of higher level services to the patients who are also serviced by health services such as Werribee Mercy and Djerriwarrh at Bacchus Marsh.

FOOTSCRAY HOSPITAL

Footscray Hospital is an acute teaching hospital with approximately 300 beds. It provides acute elective and acute emergency services. 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.

SUNSHINE HOSPITAL

Sunshine Hospital is an acute teaching hospital with approximately 600 beds. The hospital provides acute elective and acute emergency services with a range of inpatient and outpatient services including intensive care and coronary care, acute medical and surgical services and sub-specialty medicine and surgical services.

Sunshine Hospital's emergency department, incorporating a paediatric service, is one of the busiest general emergency departments in the state.

Sunshine Hospital also has a comprehensive range of women's and children's services, with maternity services continuing to grow to meet the increasing demand within the community. Sunshine Hospital 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, 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.

WILLIAMSTOWN HOSPITAL

Williamstown Hospital is a 90 bed facility providing emergency services, surgical services, rehabilitation and geriatric evaluation and management services, renal dialysis services and community rehabilitation and transition care services.

SUNBURY DAY HOSPITAL

The Sunbury Day Hospital provides day medical, day surgical, day chemotherapy and haemodialysis treatment and a number of specialist clinics.

DRUG HEALTH AND ADDICTION MEDICINE

Drug Health Services provide a diverse range of services for individuals and their families affected by drug and alcohol related problems. Drug Health Services is a community based program of Western Health and offers innovative client centered recovery programs that include specialist programs for Adults, Women and their Children, Adolescents and their Families. We also provide Residential Withdrawal Services for both adults and adolescents. Services are both office based and outreach. Office based services are provided from the Footscray and Sunbury Campuses. Access to Addiction Medicine Consultants and Nurse Practitioners is available to support seamless service delivery. Drug Health Services liaises with Addiction Medicine Services within Western Health.

WESTERN CENTRE FOR HEALTH RESEARCH AND EDUCATION

Located at Sunshine Hospital, the Western Centre for Health Research and Education provides a range of purpose built, state-of-the-art teaching and research facilities. The Centre is the result of the partnerships with the University of Melbourne and Victoria University and plays a pivotal role in staff and student education and research activities. 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 enabled a number of collaborative projects and opportunities researching diseases that affect our local communities and has placed Western Health as a centre of excellence in academic and research fields.

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

HAZELDEAN TRANSITION CARE

Hazeldean Transition Care is located close to the Williamstown Hospital and 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.

STATEMENT OF PRIORITIES

Each year, Western Health identifies how it will contribute to Victorian Government policy directions and priorities. The following table lists outcomes against deliverables for 2016/17 agreed between our health service and the Minister for Health.

QUALITY AND SAFETY

ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home. Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection.	Improved reporting on advance care completions and alerts, and strategies agreed with the Primary Health Network to continue education on advance care planning in the community and with General Practitioners, as well as within Western Health.	**ACHIEVED** Opportunities have been actioned with the Primary Health Network for education to support completion of Advance Care Plans in community settings. A Western Health ICU consultant developed end of life education package has supported education of medical staff within Western Health. Advance Care alerts are now reported in our Monitoring and Performance (MaP) system and Western Health is involved in a working group looking at regional palliative care projects in the North West Region.
Progress implementation of a whole-of hospital model for responding to family violence.	Established health service family violence protocols, pathways and partnership programs maintained and enhanced in 2016-17 by engagement in the Department of Health and Human Services' pilot project on Family Violence.	**ACHIEVED** In accordance with the Strengthening Hospital Responses to Family Violence (SHRFV) project, a comprehensive program of work in response to family violence has been planned at Western Health. This work is being overseen by our *Health Equity Steering Group* and an established working group. Policy and procedure, data capture and reporting are being reviewed at multiple levels and awareness raising and training initiatives have commenced.
Establish a foetal surveillance competency policy and associated procedures for all staff providing maternity care that includes the minimum training requirements, safe staffing arrangements and ongoing compliance monitoring arrangements.	Clinical practice in line with the established Western Health procedure on Cardiotocography (CTG) Use, Interpretation and Response, with increased focus in 2016-17 on training to support clarity on expected standard of care and competency and compliance with the procedure.	**ACHIEVED** Western Health's foetal monitoring procedure has been refreshed, and we have implemented a competency action plan. This has supported level 3 CTG compliance for midwifery and medical staff. A continued focus in relation to competency attainment and compliance for all appropriate staff is progressing. A comprehensive monitoring system has been implemented.
Use patient feedback, including the Victorian Healthcare Experience Survey to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Use of an established Patient Experience Dashboard to focus patient feedback, with systems to explore and utilise feedback enhanced by the development in 2016-17 of a Patient Health Experience Roadmap (2016-20).	**ACHIEVED** The Western Health Patient Experience Dashboard has been utilised over 2016-17 to drive improvement activities across the organisation, The Dashboard has been evaluated with recommendations for enhancement to be actioned in the second half of 2017. A Western Health *'Moments that Matter'* Strategy has been developed to focus on and support compassionate and informed communication between staff and patients.
Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Point prevalence survey conducted, with results demonstrating the positive impact of 2015-16 initiatives to support staff compliance with the established Western Health procedure on mechanical restraint.	**ACHIEVED** A Point Prevalence Survey has been conducted, with results demonstrating the positive impact of 2016 initiatives to reduce the use of restrictive practices for patients. Mechanical restraint auditing has been incorporated into the Western Health Bedside Audit Program.

ACCESS AND TIMELINESS

ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Ensure the development and implementation of a plan in specialist clinics to: (1) optimise referral management processes and improve patient flow through to ensure patients are seen in turn and within time; and (2) ensure Victorian Integrated Non-admitted Health data accurately reflects the status of waiting patients.	Outpatient Roadmap 2016-20 launched, with Timely Care action plan for year one implemented and wait time data by category for all referred patients produced and published on the Western Health Internet as a community awareness and demand management strategy.	**PROGRESSED** The Outpatient Roadmap 2016-20 has been launched, with follow-up planning with senior clinicians to identify practical ways to improve patient flow. We have seen increased outpatient productivity of 3% from a number of public clinics that have been engaged in this work. Western Health submitted a successful expression of interest to be involved in a Better Care Victoria Collaborative on Outpatient redesign. A Waitlist Validation project has been undertaken, with external publication of waitlist data scoped and to be actioned in the second half of 2017.
Ensure the implementation of a range of strategies (including processes and service models) to improve patient flow, transfer times and efficiency in the emergency department, with particular focus on patients who did not wait for treatment and/or patients that re-presented within 48 hours.	Timely Care program in the emergency care setting progressed, with improved performance against emergency department waiting times achieved in 2015-16 sustained and enhanced.	**ACHIEVED** The Timely Care program in the Western Health emergency care setting progressed, with a refreshed program of work implemented. Despite increases in presentation volumes, the access performance gains achieved in the previous year have been maintained and slightly improved. Western Health has worked with Better Care Victoria as part of an Emergency Access Collaborative, as well as completing a collaborative project with Toyota to enhance the improvement initiative in the Fast Track area within the Sunshine Hospital Emergency Department.
Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Milestones for 2016-17 met for implementation of the HealthLinks innovative pilot to increase care outside hospital walls for patients in our community suffering from chronic disease.	**ACHIEVED** Milestones for 2016-17 met for implementation of the HealthLinks innovative pilot, with an implementation plan developed and the pilot commencing in late November 2016. A comprehensive review of the pilot was undertaken at the six month point and will inform the next six months of the pilot's implementation.
Increase the proportion of patients (locally and across the state) who receive treatment within the clinically recommended time for surgery and implement ongoing processes to ensure patients are treated in turn and within clinically recommended timeframes.	Number of category 1-3 patients admitted within clinically appropriate timeframes supported by a patient co-design informed review of pre-admission and elective booking processes	**ACHIEVED** Category 1-3 elective surgery patients were admitted within clinically appropriate times for 2016-17. This has been supported by a patient co-design informed review of pre-admission and elective booking process.
Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Pre-planning undertaken to ensure clients are appropriately identified for eligibility and supported to engage with appropriate external providers for National Disability Insurance Scheme services, with all relevant information (e.g. functional assessments available to relevant provider).	**ACHIEVED** Ongoing engagement with the Department of Education and Training (Early childhood) and NDIS continues in order to plan for the transition to NDIS in October 2018 for Western Health's Children's Allied Health Service – Outpatient stream. Work continues internally to also assist with this transition and is being incorporated into the Paediatric Service Plan for Western Health.
Develop and implement strategies within their organisation to ensure identification of potential organ and tissue donors and partner with DonateLife Victoria to ensure that all possible donations are achieved.	Established Organ and Tissue Donation process maintained and enhanced in 2016-17 with the commencement of a Donation after Cardiac Death (DCD) program at Sunshine Hospital.	**ACHIEVED** Organ and Tissue Donation processes have been maintained and enhanced in 2016-17 with the commencement of a Donation after Cardiac Death (DCD) program at Sunshine Hospital, supported by funded organ donation co-ordinator positions.

SUPPORTING HEALTHY POPULATIONS

ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	Continued involvement with the Better Health Plan for the West partnership, with key priorities for 2016-17 progressed as identified and endorsed by the Steering Committee, and support provided for a Primary Health Network led review of the partnership's governance.	**ACHIEVED** With the Primary Health Network (PHN), we continue to be involved in the Better Health Plan for the West partnership. Key priorities for the partnership in 2016-17 included a review of the partnership's governance. The PHN have assisted with a number of Western Health projects, including the quality of referrals, chronic kidney disease and diabetes management with general practices (GP), and the transition to a new GP e-messaging provider.
Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	Continued use of comprehensive psychosocial assessment and care plan development for Hospital Admission Risk Program (HARP) clients and application to the HealthLinks innovative pilot project.	**ACHIEVED** Comprehensive psychosocial assessment and care plan development continues to be utilised for Western Health's Admission Risk Program (HARP) clients. This has also been applied to clients in the HealthLinks innovative pilot, who are also receiving HARP intervention.
Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Newly introduced Patient Information Centres at Sunshine and Footscray Hospitals maintained and enhanced in 2016-17 by the dedicated recruitment of additional volunteers who speak languages other than English.	**ACHIEVED** The Patient Information Centres at Sunshine and Footscray Hospitals have been enhanced in 2016-17 by the dedicated recruitment of additional volunteers who speak languages other than English. There are currently a total of 22 volunteers across both sites, 12 of whom speak a language other than English. Languages covered include Italian, Greek, Vietnamese, Hindi, Arabic, Croatian, Russian and Macedonian. Volunteers will be issued with badges identifying the language they speak.
Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	2015-18 Aboriginal Health Roadmap progressed, with a 2016-17 focus on responsive models for maternity care, indigenous dental surgery provision, and guidance for clinically competent and culturally safe services	**ACHIEVED** Implementation of Western Health's 2015-18 Aboriginal Roadmap has progressed, with a number of initiatives completed over the past 12 months. These include scoping and implementation of dental services for Aboriginal patients through the Williamstown Dental Program in partnership with Dental Health Services Victoria, completion of a research program on continuity of midwife care for Aboriginal patients and recruitment to an Emergency Department Aboriginal Health Liaison Officer.
Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	Partnerships further developed to close gaps in the mental health patient journey in the West, with support provided in 2016-17 for the development of the Mental Health and Police Program and model of care proposals developed to improve responsiveness to mental health clients presenting for emergency care and women's and children's services.	**IN PROGRESS** Discussions with the Department of Health and Human Services (DHHS) and partners providing Mental Health Services at Western Health have been held to support the care of mental health presentations to our emergency departments. To support improved patient flow for mental health presentations at the Footscray Hospital, the Office of the Chief Psychiatrist and the DHHS Emergency Department Program have also undertaken a joint visit. A senior cross organisational Mental Health forum has been established and is strengthening joint working relationships. We also now have access to two programs for the Mental Health and Police Program (formerly PACER) for Sunhine and now Footscray via Werribee.
Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals and communities.	Change to Gay and Lesbian Health Victoria (GLHV) Audit tool used to assess Western Health's current level of LGBTI-inclusivity and identify gaps and areas requiring additional support and training.	**ACHIEVED** An LGBTI Rainbow Tick Audit was completed in 2017, with inclusive Western Health practices identified against 20 of the 26 standards. An LGBTI 2017-2020 Inclusive Strategy Plan has been developed, with implementation to be overseen by the our *Health Equity Steering Group*

GOVERNANCE AND LEADERSHIP

ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Further engagement with relevant academic institutions and other partners to increase participation in clinical trials.	Experts engaged from within the Melbourne Academic Centre for Health (MACH) partners and Melbourne Clinical and Translational Science platform (MCATS) to develop and deliver training and education programs to enhance Western Health's clinical trial capability and capacity.	**ACHIEVED** Experts were engaged from within the Melbourne Academic Centre for Health (MACH) partners and Melbourne Clinical and Translational Science platform (MCATS) to support the enhancement of Western Health's clinical trial capability and capacity. Clinical Trials Audit workshops have been undertaken for WH Research Coordinators to help with self-audits of clinical trials and a number of research coordinators from WH are on the MACH co-ordinators working group looking at the development of standardised educational tools to help facilitate best clinical trial practice. Through MCATS a number of WH Clinician Researchers attended the Health Economics in Clinical Trials workshop at the University of Melbourne's School of Population and Global Health.
Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Best Care Roadmap developed for 2016- 20 against the quality dimensions of person-centred care, co-ordinated care, right care and safe care, with strategies implemented in 2016-17 to develop a consistent methodology and implementation approach to quality improvement and redesign.	**ACHIEVED** A Western Health Best Care Roadmap has been developed against four dimensions of Best Care. Work has been undertaken to develop an organisation-wide Quality Improvement Framework, with a broader toolkit now being developed which will be supported through the Emergency Access Collaborative with Better Care Victoria. Western Health's patient Co-design Program has progressed.
Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016-17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	Western Health engaged in the development of the Western Growth Plan, with aligned collaborative projects progressed through the Strengthening Hospitals in the West working groups.	**ACHIEVED** Western Health has worked with the Department of Health and Human Services to finalise the Western Growth Corridor Plan. The *Strengthening Hospitals in Melbourne's West* Program has continued to facilitate collaborative and efficient regional action between the Partners, Western Health, Djerriwarrh Health Services, and Werribee Mercy Hospital. The set work plan for 2016/17 has been completed and focused on initiatives generated in the areas of elective surgery, emergency/urgent care, maternity and paediatric clinical streams.
Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Established anti-bullying and harassment procedure and processes maintained and enhanced in 2016-17 with implementation of Victorian Auditor-General's Office (VAGO) Bullying and Harassment recommendations and application of the Department of Health and Human Services' Pathway to Change Plan.	**ACHIEVED** Bullying and harassment policy and procedures have been reviewed and other strategies to address VAGO and Department of Health and Human Services recommendations have been incorporated into Western Health's Positive Workplace Strategy (launched in October 2016). The Western Health EMPOWIR (Employee Positive Workplace Issue Resolution) tool is now online to enable confidential reporting, issue raising, resolution, investigations and ongoing management and improvement. A "Positive Workplace Strategy" website has been developed and launched to provide all WH employees with resources to promote, manage and prevent bullying and harassment.

GOVERNANCE AND LEADERSHIP

ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: (1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) Strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and (3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	2015-20 Occupational Health and Safety Roadmap progressed, with a 2016-17 focus on improving processes for assessment and management of patients at risk of escalating into challenging behaviours, and refresh of the Patient Back4Life Program training and data capture plan.	**ACHIEVED** Implementation of Western Health's 2015-20 Occupational Health and Safety Roadmap has progressed over 2016-17. A research based Occupational Violence (OV) management trial was undertaken at Sunshine Hospital. This trial addressed targeted areas of care such as new cognition/behavioural alerts, behaviour management planning processes, environmental audits and diversion for patients. Findings of the trial are being reviewed and will be further evaluated for suitability. We also developed an OV promotional campaign for staff and visitors based on myths and facts called *'What You Don't Know Can Hurt You'*. The Back4Life training program and data capture have been reviewed, with increased participation rates, compared to the previous year. A New Occupational Health and Safety Strategy is also in draft linking to new information published by the DHHS.
Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high quality and safe person centred care.	2016-20 Workforce Plan progressed, with a 2016-17 focus on the delivery of plans for the Joan Kirner Women's and Children's Hospital and the implementation of mandatory and priority Best Practice Clinical Learning Environment (BPCLE) indicators set by Department of Health and Human Services.	**ACHIEVED** Western Health's 2016-20 Workforce Plan has progressed over 2016-17, with planning for the Joan Kirner Women's and Children's Hospital delivering a draft workforce plan following several broad stakeholder consultations. Mandatory and priority Best Practice Clinical Learning Environment (BPCLE) indicators set by the Department of Health and Human Services have been implemented.
Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	Established workforce culture systems complemented in 2016-17 by development and initial implementation of a whole of health service Sustaining a Positive Workforce Culture Strategy (2016-20)	**ACHIEVED** *The Positive Workplace at Western Health* Strategy was initiated with medical professionals in August 2016. A Medical Advisory Group continues to monitor the implementation of the program. Organisation-wide launch of the strategy occurred on 20 October 2016 with an inaugural Positive Workplace Day. This will be an annual event. A Positive workplace at Western Health Website has been developed and launched and the education program "Don't Walk Past" continues.

FINANCIAL SUSTAINABILITY

ACTION	WESTERN HEALTH DELIVERABLES	OUTCOME
Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Organisation-wide Child Safe Standards gap analysis conducted, with recommendations used to implement changes to policy and procedures, staff recruitment, orientation, conduct and reporting, and staff training on Child Safe Standards compliance.	**ACHIEVED** An organisation-wide Child Safe Standards gap analysis has been conducted by the Australian Childhood Foundation (ACF), with recommendations used to inform an action plan to implement changes to policy and procedures, staff recruitment, orientation, conduct and reporting, and staff training on Child Safe Standards compliance. Action plan implementation has commenced with work being oversighted by A Child Safe Standards Working Group reporting into our newly established *Health Equity Steering Group*.
Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	Established systems supporting staff access to vaccination programs maintained and enhanced with the introduction of a Staff immunisation Clinic.	**ACHIEVED** Work has been undertaken to establish an Immunisation Clinic for Western Health staff. A Staff Immunisation Nurse has commenced and work is progressing on planned roll-out of new processes supporting immunisation of staff and immunisation data collection. Internal immunisation procedures have been updated and a staff communication plan completed. All staff continue to be offered Flu immunisation.
Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Established systems supporting Western Health's strong cash position maintained and strengthened by introduction of Australia Post 'Post Pay' services on all invoices.	**ACHIEVED** Western Health has worked with Australia Post to trial a new program called 'Pay by SMS'. The objective of this system is to provide a simple and convenient payment method for patients and to improve the overall patient experience when interacting with our Finance Services. The trial duration is three months, with evaluation planned for late 2017 to determine if the service will be continued beyond the trial period.
Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	2015-20 Environmental Sustainability Roadmap progressed, with a 2016/17 focus on roll out of LED lighting, installation of solar panels, hand dryer and pan sanitizer conversion, and reinvigoration of green office and single use medical instruments programs.	**ACHIEVED** Implementation of Western Health's 2015-20 Environmental Sustainability Roadmap has progressed over the past 12 months. Roll out of LED lighting is 95% complete and planning for installation of solar panels at Sunshine Hospital has been undertaken. Our green office and single use medical instruments programs have been reinvigorated and a program for hand dryer and pan sanitizer conversion undertaken.

KEY PERFORMANCE STATISTICS

QUALITY AND SAFETY

KEY PERFORMANCE INDICATOR	TARGET	2016-17 RESULT
Accreditation		
Compliance with NSQHS Standards accreditation	Full compliance	Achieved
Infection prevention and control		
Compliance with Cleaning standards (Overall)	Full compliance	Achieved
Compliance with Cleaning standards – very high risk (Category A)	90 points	Achieved
Compliance with Cleaning standards – high risk (Category B)	85 points	Achieved
Compliance with Cleaning standards – moderate risk (Category C)	85 points	Achieved
Compliance with the Hand Hygiene Australia program	80%	89%
Percentage of healthcare workers immunised for influenza	75%	77%
Patient experience		
Victorian Healthcare Experience Survey – data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	90%
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	94%
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	88%
Victorian Healthcare Experience Survey – discharge care Quarter 1	75% very positive experience	71%
Victorian Healthcare Experience Survey – discharge care Quarter 2	75% very positive experience	73%
Victorian Healthcare Experience Survey – discharge care Quarter 3	75% very positive experience	66%
Healthcare associated infections		
Number of patients with surgical site infection	No outliers	Achieved
ICU central line associated blood stream infection	No outliers	Not Achieved
SAB rate per occupied bed days	<2/10,000	0.8/10,000
Maternity and newborn		
Maternity – Percentage of women with prearranged postnatal home care	100%	100%
Rate of singleton term infants without birth anomalies with APGAR score <7 to 5 minutes	<1.6%	1.5%
Rate of severe foetal growth restriction in singleton pregnancy undelivered by 40 weeks	<28.6%	19.0%

KEY PERFORMANCE INDICATOR	TARGET	2016-17 RESULT
Continuing care		
Functional independence gain from admission to discharge, relative to length of stay (GEM)	≥0.39	0.55
Functional independence gain from admission to discharge, relative to length of stay (rehab)	≥0.645	1.06

GOVERNANCE AND LEADERSHIP

KEY PERFORMANCE INDICATOR	TARGET	2016-17 RESULT
Governance, Leadership and Culture		
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	90%

ACCESS AND TIMELINESS

KEY PERFORMANCE INDICATOR	TARGET	FOOTSCRAY	SUNSHINE	WILLIAMSTOWN
Emergency Care				
Percentage of ambulance patients transferred within 40 minutes	90%	83.2%	74.2%	90.1%
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	81%	56%	85%
Percentage of emergency patients with a length of stay less than four hours	81%	69%	63%	89%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	50	2	0

KEY PERFORMANCE INDICATOR	TARGET	2016-17 RESULT
Elective Surgery		
Percentage of urgency category 1 elective patients admitted within 30 days	100%	100%
Percentage of urgency category 1, 2 and 3 elective patients admitted within clinically recommended timeframes	94%	94.6%
20% longest waiting Category 2 and 3 removals from the elective surgery waiting list	100%	100%
Number of patients on the elective surgery waiting list	3,408	3234
Number of hospital initiated postponements per 100 scheduled admissions	<8/100	7.2%
Number of patients admitted from the elective surgery waiting list – annual total	14,548	15,081
Specialist clinics		
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	59%
Percentage of routine patients referred by a GP or external specialist who attended a first appointment within 30 days	90%	86%

KEY PERFORMANCE STATISTICS

FINANCIAL SUSTAINABILITY

KEY PERFORMANCE INDICATOR	TARGET	2016-17 RESULT
Finance		
Operating result ($m)	0.00	$0.6m
Trade creditors	60 days	53 days
Patient fee debtors	60 days	49 days
Public & private WIES performance to target	100%	101%
Adjusted current asset ratio	0.7	0.53
Number of days with available cash	14 days	21 days
Asset Management		
Basic asset management plan	Full compliance	Full compliance

ACTIVITY & FUNDING

FUNDING TYPE	2016-17 ACTIVITY ACHIEVEMENT
Acute Admitted	
WIES DVA	762
WIES Private	6,725
WIES Public*	80,567
WIES TAC	198
Acute Non-Admitted	
Home Renal Dialysis	88
Home Enteral Nutrition	554
Radiotherapy Non Admitted Shared Care	30
Aged Care	
Transition Care – Bed days	11,800
Transition Care – Home days	9,868
Subacute WIES – GEM Private	260

** This WIES figure excludes 2016–17 WIES for HealthLinks patients*

ACTIVITY & FUNDING

FUNDING TYPE	2016-17 RESULT
Aged Care	
Subacute WIES – GEM Public	1,951
Subacute WIES – Palliative Care Private	24
Subacute WIES – Palliative Care Public	313
Subacute WIES – Rehabilitation Private	126
Subacute WIES – Rehabilitation Public	859
Subacute WIES - DVA	89
Subacute non-admitted	
Health Independence Program – Public	91.785
Mental Health and Drug Services	
Drug Services	2,539
Primary Health	
Community Health / Primary Care Programs	2,500
Other	
Health Workforce	234

FINANCIAL SNAPSHOT

WORKFORCE FULL TIME EQUIVALENT (FTE) PER ANNUAL ACCOUNTS

LABOUR CATEGORY	JUNE CURRENT MONTH AVERAGE FTE		JUNE YTD AVERAGE FTE	
	2016	2017	2016	2017
Nursing	1987	2058	1966	2007
Administration and Clerical	640	673	618	653
Medical Support	359	315	357	370
Hotel and Allied Services	412	394	412	404
Medical Officers	121	117	116	120
Hospital Medical Officers	429	462	434	452
Sessional Clinicians	94	96	86	89
Ancillary Staff (Allied Health)	368	395	360	350
Total	**4410**	**4510**	**4350**	**4445**

FINANCIAL SNAPSHOT

$'000	2016/17	2015/16	2014/15	2013/14	2012/13
Total Revenue	757,595	686,303	644,174	607,881	571,686
Total Expenses	757,478	712,133	657,369	627,039	592,161
Net Result for the Year	**(117)**	**(25,830)**	**(13,195)**	**(19,158)**	**(20,475)**
Operating Result*	**590**	**320**	**1,408**	**4,229**	**4,226**
Total Assets	698,076	684,212	679,764	684,698	640,413
Total Liabilities	174,029	164,166	142,636	134,359	122,814
Net Assets	**524,047**	**520,046**	**537,128**	**550,339**	**517,599**
TOTAL EQUITY	**524,047**	**520,046**	**537,128**	**550,339**	**517,599**

** The Operating Result is the result for which the hospital is monitored in its Statement of Priorities also referred to as the Net Result before capital and specific items.*

FINANCIAL PERFORMANCE

OPERATING RESULT	TARGET	2016/17 ACTUALS
Annual Operating result ($'m)	$0	$0.6

CASH MANAGEMENT / LIQUIDITY	TARGET	2016/17 ACTUALS
Creditors (days)	<60	53
Debtors (days)	<60	49

ASSET MANAGEMENT	TARGET	2016/17 ACTUALS
Adjusted Current Asset Ratio	0.70	0.53
Days of Available Cash	14 days	22 days

DETAILS OF CONSULTANCIES (UNDER $10,000)

In 2016-17, there were 11 consultancies where the total fees payable to the consultants were less than $10,000.
The total expenditure incurred during 2016-17 in relation to these consultancies is $36,388 (excl. GST).

DETAILS OF CONSULTANCIES (VALUED AT $10,000 OR GREATER)

In 2016-17, there were 7 consultancies where the total fees payable to the consultants were $10,000 or greater.
The total expenditure incurred during 2016-17 in relation to these consultancies is $304,558 (excl. GST). Details of individual consultancies are as follows:

CONSULTANCIES

OVER $10,000

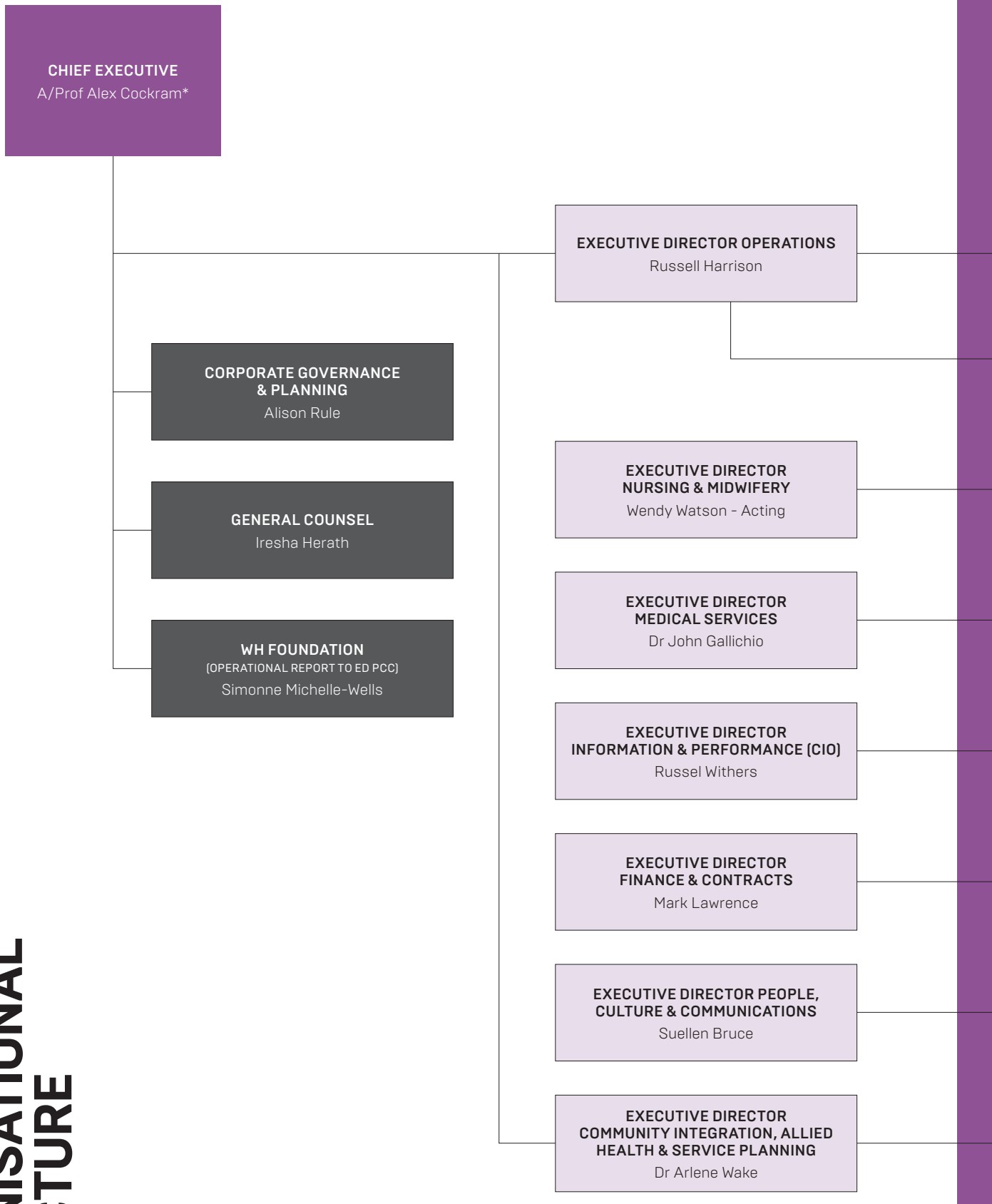
NAME	PARTICULARS	START DATE	END DATE	TOTAL PROJECT FEES (EXCL GST)	AMOUNT INCURRED (EXCL GST)	FUTURE COMMITMENTS (EXCL GST)
CSIRO	Designing technology to support timely nursing assessment of Culturally and Linguistically diverse patients	Feb-17	Jun-17	57,000	57,000	Nil
DARJACK PTY LTD	IPS configuration, training and implementation for AH Science Credentialing	Mar-17	Mar-17	12,800	12,800	Nil
ERNST & YOUNG	Application of Lean principal to reduce prescription dispensing times.	May-17	Jun-17	99,073	99,073	Nil
IHR AUSTRALIA	Workplace investigation services on complaint, documents, policies and preparing of reports	Jun-16	Jul-16	16,320	16,320	Nil
NATASHA LUDOWYK	Research, inforgraphics, presentation and findings to Executive	Sep-16	Sep-16	11,020	11,020	Nil
PHARMCONSULT PTY LTD	Review on Pharmacy inventory processes and evaluation of the wholesale tender	Oct-16	Apr-17	98,200	98,200	Nil
VICTORIAN GOVERNMENT SOLICITORS OFFICE	Consultancy and legal advice on NW Mental Health, use of WAVRS (Wearable Audio Video Recording System) and reviewing relevant legislation	Aug-16	Nov-16	10,145	10,145	Nil
	Totals			**304,558**	**304,558**	

DETAILS OF INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE

The total ICT expenditure incurred during 2016-17 is $20.6 million (excluding GST) with the details shown below.

BUSINESS AS USUAL (BAU) ICT EXPENDITURE (TOTAL) (EXCLUDING GST)	NON-BUSINESS AS USUAL (NON-BAU) ICT EXPENDITURE (TOTAL = OPERATIONAL EXPENDITURE AND CAPITAL EXPENDITURE) (EXCLUDING GST)	OPERATIONAL EXPENDITURE	CAPITAL EXPENDITURE (EXCLUDING GST)
$9.6 million	$11.0 million	$3.7 million	$7.3 million

ORGANISATIONAL STRUCTURE



**Alex Cockram on secondment as Chief Executive at Barwon Health from 1 May 2017; Acting Western Health Chief Executive: Russell Harrison*

Clinical Support & Specialist Clinics	Health Support
Sally Martin, Dr Andrew Jeffreys, Dr William Renwick	Christine Neumann

Emergency, Medicine & Cancer Services	Women's & Children's	Peri Operative & Critical Care Services	Sub Acute & Aged Care
Damian Gibney, A/Prof Garry Lane	Adele Mollo, A/Prof Glyn Teale	Claire Culley, Dr Andrew Jeffreys	Natasha Toohey, Dr Kris Ghosh

Director of Nursing & Midwifery Sunshine	Director of Nursing & Midwifery Footscray	Director of Nursing & Midwifery Sunbury	Director of Nursing & Midwifery Williamstown	Aboriginal Health
Vanessa Watkins - Acting	Joy Turner	Nicole Davies	Douglas Mill	Jacqueline Watkins

Medical Workforce	Medical Education	Quality, Safety, Patient Experience	Research & Development	Drug Health Services
Sue Truter	Dr Stephen Lew	Deborah Clark	Prof Edward Janus, Bill Karanatsios	Robyn Jackson - Acting

Information & Communications Technology	Electronic Medical Record	Health Information & Performance
Andrew Leong	Chris Chambers	Sean Downer

Finance	Capital Planning & Redevelopment	Contracts & Commercial Relationships
Nicholas Russell	Corinna Christensen	Arnold Roxas

Public Affairs & Stakeholder Relations	Organisational Learning & Education: WCHRE	People & Culture	Employee Relations & Org-Wellbeing	Community Engagement & Volunteers	OHS & Wellbeing
Cathy Sommerville	Michelle Noronha - Acting	Leonie Hall	Gillian Shedden	Jo Spence	Steve Parker

Allied Health	Community Services	GP Integration	Cultural Diversity & Community Participation	HealthLinks	Service Planning & Development
Julia Blackshaw	Lebe Malkoun	Bianca Bell	Assunta Morrone	Jason Plant	Robert Rothnie

WESTERN HEALTH SERVICES

EMERGENCY, MEDICINE AND CANCER SERVICES

Addiction Medicine
Dermatology
Endocrinology & Diabetes
Emergency Medicine
Gastroenterology
General Medicine
Haematology
Hospital In The Home
Immunology
Infectious Diseases
Medical Oncology
Nephrology
Neurology
Renal Dialysis
Respiratory and Sleep Disorders
Rheumatology
Palliative Care
Stroke Service

PERIOPERATIVE AND CRITICAL CARE SERVICES

Anaesthetics and Pain Management
Cardiology Services
Central Sterilising 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

Acute Aged Care
Cardio-Geriatric Service
Dementia Management Unit
Geriatric Evaluation and Management
Transition Care Program
Ortho-Geriatric Service
Palliative Care (inpatient service)
Rehabilitation
Subacute and Nonacute Assessment and Pathways Service
Wellcare Program

WOMEN'S AND CHILDREN'S SERVICES

Gynaecology
Obstetric Services
Maternal Fetal Medicine
Special Care Nursery
Paediatric Medicine

ALLIED HEALTH

Audiology
Exercise Physiology
Language Services
Neuropsychology
Nutrition and Dietetics
Occupational Therapy
Pastoral Care
Physiotherapy
Podiatry
Psychology
Social Work
Speech Pathology

CLINICAL SUPPORT AND SPECIALIST CLINIC SERVICES

Specialist Clinics (Adult)
Interventional Radiology
Medical Imaging
Pathology
Pharmacy

COMMUNITY SERVICES

Health Independence Programs (HIP)

- Post Acute Care Program
- Hospital Admission Risk Program
- Residential In-reach Program
- Subacute Ambulatory Care Services (community based rehabilitation and specialist clinics)

Aged Care Assessment Service
Immediate Response
Transition Care Program (Community)
Children's Allied Health Service

DRUG AND HEALTH SERVICES

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

OTHER

Aboriginal Health, Policy and Planning
GP Integration
Service Planning

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. Directors also have a role on Board Committees.

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 the 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

Over the period 1 July 2016 to 30 June 2017, the Board comprised of nine members, including the Chair.

THE HON BRONWYN PIKE

BA, GRAD DIP EDUCATION, GAICD

CHAIR

The Hon Bronwyn Pike is a former Victorian Minister for Housing, Aged Care, Community Services, Health, Education, Skills and Workforce Participation. Her 13 year parliamentary career included 11 as a Minister.

Prior to entering parliament in 1999, Bronwyn headed up the Uniting Church welfare program in Victoria, now known as Uniting Care, which provided children, youth, family and aged care services. She trained as a secondary school teacher and taught in Adelaide and Darwin and at RMIT.

Having left Parliament in 2012, Bronwyn chairs the Renewal SA Board and the Uniting Care Victorian/Tasmania Board, and is a board member of Uniting Care NSW/ACT. Bronwyn is also the President of the Australian College of Educators.

The Hon Bronwyn Pike is a member of Western Health's Finance Committee, Governance and Remuneration Committee, Quality and Safety Committee and the Audit and Risk Committee.

Appointed July 2014

DR ROBERT MITCHELL

LLB, MPHIL, GRAD DIP TAX, MTHST, PhD

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, The PwC Foundation, World Relief Australia, and the Global Health and Development Network.

Dr Mitchell has a strong interest in international development work and justice issues. He has served in senior executive roles with World Vision Australia and is the CEO of Anglican Overseas Aid.

Bob is also an ordained Anglican Minister, and has served as a member of the Federal Attorney-General's International Pro Bono Advisory Group.

Dr Mitchell is Chair of the Audit and Risk Committee and Chair of the Governance and Remuneration Committee

Appointed July 2010

PROFESSOR COLIN CLARK

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

Colin Clark is Dean of Business and Professor of Accounting at Victoria University.

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 range of research and consulting projects in Australia and overseas. His area of specialisation is public sector accounting and corporate governance.

Professor Clark is Chair of the Finance and Resources Committee.

Appointed July 2010

MRS ELLENI BEREDED-SAMUEL

MED, GRAD DIP COUNSELLING, GRAD CERT IN MANAGEMENT, BA (FOREIGN LANGUAGES AND LITERATURE AND ENGLISH AS A SECOND LANGUAGE)

Elleni Bereded-Samuel was born in Ethiopia. Mrs Bereded-Samuel has focused her life's work on strengthening education, training and employment for Culturally and Linguistically Diverse communities in Australia. Her dynamic leadership has resulted in new solutions for community to access and participate in society. Mrs Bereded-Samuel is currently employed with Australian Unity as Strategic Development Manager.

CORPORATE GOVERNANCE (CONTINUED)

For six years Mrs. Bereded–Samuel served as a Commissioner of Victorian Multicultural Commission and on the Board of Directors of The Women's Hospital and chaired the Community Advisory Committee. Mrs. Bereded-Samuel also served for three years as the inaugural member of the Australian Social Inclusion Board and for five years as a Director of the SBS Board.

Mrs Bereded-Samuel is one of 40 Australian champions independently selected as the People of Australia Ambassadors appointed by the Prime Minster. Mrs. Bereded-Samuel has been recognized as one of the hundred most influential African Australians and inducted into the Hall of Fame for her exceptional work in assisting the Australian community. In 2014 Mrs Bereded- Samuel was inducted into Westpac & Financial Review Award as one of 100 Women of Influence in Australia.

Mrs Bereded-Samuel is Chair of the Cultural Diversity and Community Advisory Committee and a Member of the Governance & Remuneration Committee

Appointed July 2011

MRS PATRICIA CAROLYN VEJBY

JP, CMC

Patricia (Trish) Vejby is a Full Member of Heritage Victoria and has previously held Board positions which include a member of the Board of Directors, 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 a long-time resident of the western suburbs and 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 Trish is involved in various community activities.

Mrs Vejby enjoys her role as a Civil Celebrant/ Commonwealth Authorised Marriage Celebrant and has undertaken the AICD Company Director's Course to support her role as a Board Director.

Mrs Vejby is Chair of the Primary Care and Population Health Advisory Committee and a Member of the Quality and Safety Committee.

Appointed July 2011 – Term Completed June 2017

DR PHUONG PHAM

DPhil, MA, BA, BSc

The son of Vietnamese immigrants, Dr Phuong Pham feels a strong connection to the community in the West.

Dr Pham has a background of public policy and financial governance with a wealth of experience in senior roles for the Commonwealth Government Department of Health and Department of Prime Minister and Cabinet.

In his current position as General Manager, Strategic Bids, for Telstra Health, Dr Pham leads the development of strategies in telehealth and telemedicine, electronic medications management, and ehealth applications for the health, community and aged care sectors.

Dr Pham is a member of the Quality and Safety Committee.

Appointed July 2015

MR KELVYN LAVELLE

Dip.YA, Grad.Dip.Urban Research and Policy, MA by Research, GAICD

Born and raised in the Western suburbs, Mr Lavelle sees being a Director of Western Health as an opportunity to contribute to the long-term development of health services in the West, including improving the environment for patient care.

Over the past 15 years, Mr Lavelle has had a distinguished career as a corporate and public affairs professional based in Melbourne. Firstly as a strategic advisor to senior executives at some of the nation's best known companies and now, as an Executive Director at leading international infrastructure company Plenary Group.

Mr Lavelle is a Director of Plenary Conventions Pty Ltd and a member of the Advisory Board for the McKell Institute Victoria.

Highly collaborative by nature, Mr Lavelle places great value on strategic and effective communications and has applied this focus to his positions on Boards and advisory committees.

Mr Lavelle is a member of the Finance and Resources Committee.

Appointed September 2015

MS COLLEEN GATES

BA Chemical Engineering, GAICD

Initially raised in Geelong, Ms Colleen Gates has resided in and been passionate about Melbourne's west for the last 20+ years. She has been an active participant on various State, Local Government and not-for-profit committees and stakeholder groups during this time, advocating for improvements to public transport and infrastructure, disability services/ access, mental health, environmental sustainability and affordable housing.

Ms Gates is currently the Deputy Mayor at Hobsons Bay, Chairperson of the Metropolitan Waste and Resource Recovery Board and a former Board Member of LeadWest. Combined with a long standing professional career in environmental compliance and management, currently within the food manufacturing sector, Ms Gates' diverse background and knowledge has been of great benefit with respect to driving strategic focus, encouraging innovation and supporting community capacity building.

Ms Gates is a member of the Audit and Risk Committee and a member of the Cultural Diversity and Community Advisory Committee.

Appointed July 2016

DR CATHERINE HUTTON

MBBS, DRCOG, FRACGP, MPH, GAICD

Dr Cathy Hutton has worked as a general practitioner for over 30 years where her work includes general family medicine, women's health and antenatal care, chronic disease management, health prevention, and care of disadvantaged people.

Dr Hutton is an experienced board member specialising in clinical governance, strategy and GP-hospital integration. She has held health service Board Director positions at both Peter MacCallum Cancer Centre and the Royal Women's Hospital.

Additionally, Dr Hutton has experience as a Director of North West Melbourne Division of General Practice from 2002 to 2008, Inner North West Medicare Local 2013 to 2015, and the AMA Victoria Board for 3 years. She is currently a Director for North West Melbourne Primary Health Network.

Dr Hutton has a Fellowship of the College of General Practitioners, has a Masters of Public Health from Melbourne University and is a Graduate member of the Australian Institute of Company Directors.

Dr Hutton has a broad working knowledge of the health system, both primary and secondary, state and federal, and private and public and she holds positions in the Australian Medical Association (AMA) Victoria Section of General Practice and the AMA Federal Council of General Practice and has a Fellowship Awarded by the Australian Medical association.

Dr Hutton is a member of the Quality and Safety Committee and a member of the Primary Care and Population Health Advisory Committee.

Appointed July 2016

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.

2016/17 Committee Members:

- Dr Robert Mitchell (Chair)
- The Hon Bronwyn Pike
- Ms Colleen Gates

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.

CORPORATE GOVERNANCE (CONTINUED)

BOARD MEETING ATTENDANCE 2016-17

DIRECTORS	MEETINGS ATTENDED/ MEETINGS HELD
Hon Bronwyn Pike	10/11
Dr Robert Mitchell	10/11
Professor Colin Clark	9/11
Patricia Vejby	11/11
Elleni Bereded-Samuel	11/11
Dr Phuong Pham	10/11
Kelvyn Lavelle	10/11
Dr Catherine Hutton	9/11
Colleen Gates	10/11

ATTESTATION FOR COMPLIANCE WITH MINISTERIAL STANDING DIRECTION 3.7.1 – RISK MANAGEMENT FRAMEWORK AND PROCESSES

I, Russell Harrison, Acting Chief Executive certify that Western Health has complied with Ministerial Direction 3.7.1 - Risk Management Framework and Processes. The Western Health Audit & Risk Committee has verified this.

Russell Harrison, Acting Chief Executive 8 August 2017

ATTESTATION ON COMPLIANCE WITH HEALTH PURCHASING VICTORIA (HPV) HEALTH PURCHASING POLICIES

I, Russell Harrison, Acting Chief Executive certify that Western Health has put in place appropriate internal controls and processes to ensure that it has complied with the requirements as set out in the HPV Purchasing Policies including mandatory HPV collective agreements as required by the Health Services Act 1988 (Vic) and has critically reviewed these controls and processes during the year.

Russell Harrison, Acting Chief Executive 8 August 2017

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 2016/17	1417
Full Access	692
Partial Access	11
Access Denied	11
Applications Withdrawn	64
No Documents	14
Applications Not Processed	613
VCAT Appeal	0
Appeal Withdrawn	0
Transfers received	1
Time of Births	10
Attendance letter	1

OCCUPATIONAL HEALTH AND SAFETY 2016/17

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, Executive and the Occupational Health and Safety Committee detailing OH&S and WorkCover performance.
- OH&S training courses for managers and supervisors - Manage Workplace Health and Safety (WHS) Processes.
- Efficient and effective staff rehabilitation and return to work processes embedded into organisational standard practice.

- Education and training is provided to staff in relation to managing risks i.e. patient handling, general manual handling, occupational violence management, workstation ergonomics, gas cylinder storage and handling, hospital danger tags, chemical handling storage, ChemAlert chemical data base, and Hazstop chemical information.
- The ongoing maintenance and 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 (HSR Engagement Program) including initial and annual refresher training and the use of a resource package to support newly elected representatives.
- Scheduled worksite inspections developed for the year for work areas and conducted monthly.
- The use 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 and revision of OH&S related policies and procedures to ensure systematic standardised and effective processes.
- Annual OH&S Awards which acknowledge significant contributions in improving the health, safety or well-being by Health and Safety Representatives (HSR's), staff members, Back 4 Life trainers, management and groups.
- Psychological support made available to staff offering critical incident stress management, employee assistance programs and counselling services.
- Promotion of staff health, fitness and wellbeing.
- Psychological support made available to staff offering critical incident stress management, employee assistance programs and counselling services.

WORKCOVER CLAIMS AND WORKSAFE NOTIFIABLE INCIDENTS

Twenty three (23) accepted standard WorkCover claims (8 - Footscray Hospital, 13 - Sunshine Hospital, 2 - Williamstown Hospital) and two (2) minor claims (Footscray Hospital) were recorded for the year.

Eight (8) standard claims were rejected, however some of these may undergo an appeal process which could affect the liability outcome.

There were thirteen (13) 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 no (0) Improvement Notices issued by WorkSafe Victoria.

OCCUPATIONAL VIOLENCE STATISTICS

MEASURE	2016/17 ACTUALS
1. Workcover accepted claims with an occupational violence cause per 100 FTE	0.045
2. Number of accepted claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0.296
3. Number of occupational violence incidents reported	240
4. Number of occupational violence incidents reported per 100 FTE	5.34
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	10.83%

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.

BUILDING ACT 1993

Western Health fully complied with the building and maintenance provisions of the Building Act 1993 for the period 1 July 2016 to 30 June 2017. Where applicable, the appropriate Building Permits and Certificates of Occupancy were obtained in line with the requirements of the Building Act 1993.

CAR PARKING FEES

Western Health complies with the DHHS hospital circular on car parking fees effective 1 February 2016 and details of car parking fees and concession benefits can be viewed at www.westernhealth.org.au/OurSites (transport and parking options under each of our listed hospitals).

CORPORATE GOVERNANCE (CONTINUED)

PROTECTED DISCLOSURE ACT

In accordance with Part 9 of the Protected Disclosure Act (Vic) 2012, Western Health has developed procedures and guidelines to facilitate the handling of a disclosure, the making a disclosure and to ensure that the person making such disclosure is protected from detrimental action. To ensure awareness, the procedure and guidelines are available on the Western Health intranet.

In accordance with the provisions of section 21 (2) of the Act, no disclosures were received and notified to IBAC during the 2016/17 financial year.

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.

2016-17 – New/Completed Victorian Industry Participation Projects

PROCUREMENT NAME AND TENDER NO.	SUNSHINE HOSPITAL STAFF CARPARK EXTENSION
Value of Procurement	$3.47m excl GST
Project Location	Sunshine Hospital
VIPP plan with ICN acknowledgement letter	Certification ref: 2016/ICN39608
Commencement and Completion Date	27/05/2016 to 19/12/2016
AEE jobs committed (new and retained)	12No. (4 created & 8 retained)
AEE jobs achieved (new and retained)	12No. (4 created & 8 retained)
AEE apprenticeships/ traineeships committed (new and retained)	3No. (1 created & 3 retained)
AEE apprenticeships/ traineeships achieved (new and retained)	4No. (1 created & 3 retained)
Local content (%)committed	98.89%
Local content (%)achieved	92.5%
Industry sector as per the ANZSIC codes	

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.

ADDITIONAL INFORMATION

Consistent with the requirements of FRD 22H Standard Disclosures in the Report of Operations, 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. Declarations of pecuniary interests have been duly 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 itself, and how these 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 statements 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 Western Health 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;

L. Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

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.

LEGISLATION	REQUIREMENT	PAGE
MINISTERIAL DIRECTIONS		
Report of Operations		
Charter and purpose		
FRD 22H	Manner of establishment and the relevant Ministers	25
FRD 22H	Purpose, functions, powers and duties	25
FRD 22H	Initiatives and key achievements	2-7
FRD 22H	Nature and range of services provided	8-9, 24
Management and structure		
FRD 22H	Organisational Structure	22-23
Financial and other information		
FRD 10A	Disclosure index	31
FRD 11A	Disclosure of ex-gratia payments	N/A
FRD 21C	Responsible person and executive officer disclosures	99-100
FRD 22H	Application and operation of *Protected Disclosure Act 2012*	30
FRD 22H	Application and operation of *Freedom of Information Act 1982*	28
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	29
FRD 22H	Details of consultancies over $10,000	21
FRD 22H	Details of consultancies under $10,000	21
FRD 22H	Employment and Conduct Principles	29
FRD 22H	Information and Communication Technology Expenditure	21
FRD 22H	Major changes or factors affecting performance	2-7
FRD 22H	Occupational health and safety	28-29
FRD 22H	Occupational violence	29
FRD 22H	Operational and budgetary objectives and performance against objectives	16-21
FRD 24C	Reporting of office-based environmental impacts	6
FRD 22H	Significant changes in financial position during the year	20-21

DISCLOSURE INDEX (CONTINUED)

LEGISLATION	REQUIREMENT	PAGE
FRD 22H	Statement on National Competition Policy	30
FRD 22H	Subsequent events	105
FRD 22H	Summary of the financial results for the year	20
FRD 22H	Additional information available on request	30
FRD 22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	20, 29
FRD 25C	Victorian Industry Participation Policy disclosures	30
FRD 29B	Workforce Data disclosures	20
FRD 103F	Non-Financial Physical Assets	58-70
FRD 110A	Cash Flow Statements	38
FRD 112D	Defined Benefit Superannuation Obligations	53
SD 5.2.3	Declaration in report of operations	7
SD 3.7.1	Risk management framework and processes	28
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statements	34
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	40
SD 5.2.1(a)	Compliance with Ministerial Directions	40
Legislation		
Freedom of Information Act 1982		28
Protected Disclosure Act 2012		30
Carers Recognition Act 2012		N/A
Victorian Industry Participation Policy Act 2003		30
Building Act 1993		29
Financial Management Act 1994		7, 40
Safe Patient Care Act 2015		N/A

FINANCIAL STATEMENTS & ACCOMPANYING NOTES

For the Year Ended 30th June 2017

APPENDIX TO THE WESTERN HEALTH ANNUAL REPORT

BOARD MEMBER'S, ACCOUNTABLE OFFICER'S AND CHIEF FINANCIAL OFFICER'S DECLARATION

The attached consolidated financial statements for Western Health have been prepared in accordance with Direction 5.2 of the Standing Directions of the Minister for Finance under the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards, including 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 accompanying notes, presents fairly the financial transactions during the year ended 30th June 2017 and the financial position of Western Health as at 30th June 2017.

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

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

The Honourable Bronwyn Pike
Board Chairperson

Melbourne
8th August 2017

Russell Harrison
Acting Chief Executive Officer

Melbourne
8th August 2017

Mark Lawrence
Chief Financial Officer

Melbourne
8th August 2017

COMPREHENSIVE OPERATING STATEMENT

For the Year Ended 30th June 2017

	NOTE	2017 $'000	2016 $'000
Revenue from Operating Activities	2.1	714,722	669,468
Revenue from Non-operating Activities	2.1	2,436	2,072
Employee Expenses	3.1	(522,731)	(495,405)
Non Salary Labour Expenses	3.1	(11,566)	(10,216)
Supplies & Consumables	3.1	(109,829)	(101,698)
Other Expenses	3.1	(72,442)	(63,901)
Net Result Before Capital and Specific Items		**590**	**320**
Capital Purpose Income	2.1	35,651	14,767
Gain on Disposal of Available-For-Sale Investment	8.1	108	-
Expenditure for Capital Purpose	3.1	(298)	(443)
Depreciation and Amortisation	4.4	(40,568)	(40,470)
Net Result After Capital and Specific Items		**(4,517)**	**(25,826)**
Other Economic Flows Included in Net Result			
Net Gain/(Loss) on Non-Financial Assets	7.2	(44)	(4)
Revaluation of Long Service Leave		4,678	-
Total Other Economic Flows Included in Net Result		**4,634**	**(4)**
NET RESULT FOR THE YEAR		**117**	**(25,830)**
Other Comprehensive Income			
Items that will not be reclassified to net result			
Changes in Physical Asset Revaluation Surplus	2.2 & 8.1	3,464	8,663
Items that may be reclassified subsequently to net result			
Changes to Financial Assets Available-For-Sale Revaluation Surplus	8.1	420	101
Total Other Comprehensive Income		**3,884**	**8,764**
COMPREHENSIVE RESULT FOR THE YEAR		**4,001**	**(17,066)**

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

BALANCE SHEET

For the Year Ended 30th June 2017

	NOTE	2017 $'000	2016 $'000
Current Assets			
Cash and Cash Equivalents	6.2	17,597	16,679
Receivables	5.1	11,576	13,895
Investments and Other Financial Assets	4.1	46,928	45,101
Inventories	5.2	2,440	2,105
Prepayments and Other Assets	5.3	1,822	404
Total Current Assets		**80,363**	**78,184**
Non-Current Assets			
Receivables	5.1	24,283	21,917
Investments and Other Financial Assets	4.1	1	1
Property, Plant and Equipment	4.3	592,541	582,479
Intangible Assets	4.5	888	1,631
Total Non-Current Assets		**617,713**	**606,028**
TOTAL ASSETS		**698,076**	**684,212**
Current Liabilities			
Payables	5.4	36,648	33,504
Provisions	3.3	114,260	107,047
Total Current Liabilities		**150,908**	**140,551**
Non-Current Liabilities			
Provisions	3.3	23,121	23,615
Total Non-Current Liabilities		**23,121**	**23,615**
TOTAL LIABILITIES		**174,029**	**164,166**
NET ASSETS		**524,047**	**520,046**
EQUITY			
Property, Plant & Equipment Revaluation Surplus	8.1	306,241	302,777
Financial Asset Available for Sale Revaluation Surplus	8.1	521	101
Restricted Specific Purpose Surplus	8.1	4,279	2,892
Contributed Capital	8.1	202,980	202,980
Accumulated Surplus	8.1	10,026	11,296
TOTAL EQUITY	**8.1**	**524,047**	**520,046**
Commitments For Expenditures	6.3		
Contingent Assets and Contingent Liabilities	7.3		

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

STATEMENT OF CHANGES IN EQUITY

For the Year Ended 30th June 2017

	NOTE	PROPERTY, PLANT & EQUIPMENT REVAL-UATION SURPLUS	FINANCIAL ASSET AVAILABLE FOR SALE REVAL-UATION SURPLUS	RESTRICTED SPECIFIC PURPOSE SURPLUS	CONTRIB-UTED BY OWNERS	ACCUMU-LATED SUR-PLUSES/ (DEFICITS)	TOTAL
		$'000	$'000	$'000	$'000	$'000	$'000
Balance at July 1st 2015		**294,114**	**-**	**2,398**	**202,980**	**37,636**	**537,128**
Net result for the year	8.1	-	-	-	-	(25,830)	(25,830)
Other comprehensive income for the year	8.1	8,663	101	-	-	-	8,764
Share of decrements in surplus attributed to joint venture	8.1	-	-	(16)	-	-	(16)
Transfer from accumulated surplus	8.1	-	-	510	-	(510)	-
Balance at June 30th 2016		**302,777**	**101**	**2,892**	**202,980**	**11,296**	**520,046**
Net result for the year	8.1	-	-	-	-	117	117
Other comprehensive income for the year	8.1	3,464	420	1,387	-	(1,387)	3,884
Share of decrements in surplus attributed to joint venture	8.1	-	-	-	-	-	-
Transfer from accumulated surplus	8.1	-	-	-	-	-	-
Balance at June 30th 2017		**306,241**	**521**	**4,279**	**202,980**	**10,026**	**524,047**

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

CASH FLOW STATEMENT

For the Year Ended 30 June 2017

	NOTE	2017 $'000	2016 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		640,256	586,527
Capital grants from government		35,562	14,514
Patient and resident fees received		25,045	19,454
Private practice fees received		24,695	20,991
Donations and bequests received		1,526	1,427
GST received from ATO		7,617	9,031
Recoupment from private practice for use of hospital facilities		794	726
Interest received		2,478	1,977
Other receipts		27,098	28,714
Total receipts		**765,071**	**683,361**
Employee expenses paid		(510,675)	(477,229)
Non salary labour costs		(12,275)	(10,788)
Payments for supplies & consumables		(118,600)	(102,505)
Other payments		(74,835)	(65,676)
Total payments		**(716,385)**	**(656,198)**
NET CASH INFLOW FROM/(USED IN) OPERATING ACTIVITIES	**8.2**	**48,686**	**27,163**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of non-financial assets		(46,471)	(21,932)
Purchase of investments		(1,300)	(45,000)
Proceeds from sale of non-financial assets		3	-
NET CASH OUTFLOW FROM/(USED IN) INVESTING ACTIVITIES		**(47,768)**	**(66,932)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**918**	**(39,769)**
Cash and cash equivalents at beginning of financial year		16,679	56,448
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	**6.2**	**17,597**	**16,679**

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

BASIS OF PRESENTATION

These financial statements are presented in Australian dollars and the historical cost convention is used unless a different measurement basis is specifically disclosed in the note associated with the item measured on a different basis.

The accrual basis of accounting has been applied in the preparation of these financial statements whereby assets, liabilities, equity, income and expenses are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

Consistent with the requirements of AASB 1004 Contributions, (that is contributed capital and its repayment), are treated as equity transactions and therefore do not form part of the income and expenses of the Health Service.

Additions to net assets which have been designated as contributions by owners are recognised as contributed capital. Other transfers that are in the nature of contributions to or distributions by owners have also been designated as contributions by owners.

Transfers of net assets arising from administrative restructurings are treated as distributions to or contributions by owners. Transfer of net liabilities arising from administrative restructurings are treated as distribution to owners.

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements are disclosed. 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.

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also future periods that are affected by the revision. Judgements and assumptions made by management in applying the application of AASB that have significant effect on the financial statements and estimates are disclosed in the notes under the heading: “Significant judgement or estimates”.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Notes to the Financial Statements

These annual financial statements represent the audited general purpose financial statements for Western Health, (the "Health Service"), for the period ending 30th June 2017. The report provides users with information about the Health Service's stewardship of the resources entrusted to it.

(A) STATEMENT OF COMPLIANCE

These financial statements are general purpose financial statements, which have been prepared in accordance with the Financial Management Act 1994 and applicable Australian Accounting Standards (AASs) and include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 *Presentation of Financial Statements*.

These 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.

The Health Service is a not-for profit entity and applies the additional Aus paragraphs applicable to "not-for-profit" Health Services under the AASBs.

The annual financial statements were authorised for issue by the Board of Western Health on the 8th August 2017.

(B) REPORTING ENTITY

The financial statements include all the controlled entities of the Health Service. The only controlled entity is the Western Health Foundation Limited.

The principle address of Western Health is:

130 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.

Objectives and Funding

The Health Service's overall objective is the provision of health services, as well as to improve the quality of life of Victorians.

The Health Service is predominantly funded by accrual based grant funding for the provision of outputs.

(C) 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 events are reported.

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30th June 2017 and the comparative information presented in these financial statements for the year ended 30th June 2016.

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

These financial statements are presented in Australian dollars, the functional and presentation currency of the Health Service. All amounts shown in the financial statements are expressed to the nearest $1,000.

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:

- non-current physical assets which, subsequent to acquisition, are measured at the revalued amount being their fair value at the date of revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are reassessed when new indices are published by the Valuer-General to ensure that the carrying amounts do not materially differ from their fair values;
- available-for-sale investments are measured at fair value with movements reflected in equity until the asset is derecognised, i.e. other comprehensive income - items that may be reclassified subsequent to net result; and
- the fair value of assets, other than land, is based on their depreciated acquisition cost.

Judgements, estimates and assumptions are required to be made about the carrying amounts 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.

(D) PRINCIPLES OF CONSOLIDATION

These statements are presented on a consolidated basis in accordance with AASB 10 *Consolidated Financial Statements:*

- The consolidated financial statements of the Health Service include all reporting entities controlled by the Health Service as at 30th June 2017.
- The consolidated financial statements exclude bodies of the Health Service that are not controlled by the Health Service.
- Control exists when the Health Service has the power to govern the financial and operating policies of a health service so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable are taken into account. The consolidated financial statements include the audited financial statements of the controlled entities listed in note 8.9.
- The parent entity is not shown separately in the notes.

Where control of an entity is obtained during the financial period, its results are included in the comprehensive operating statement from the date on which control commenced. Where control ceases during a financial period, the entity's results are included for that part of the period in which control existed. Where entities adopt dissimilar accounting policies and their effect is considered material, adjustments are made to ensure consistent policies are adopted in these financial statements.

The only entity consolidated into the Health Service reports is the Western Health Foundation.

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.

Jointly Controlled Assets and Operations

Interests in jointly controlled assets or operations are not consolidated by the Health Service, but are accounted for in accordance with the policy outlined in Note 4 Financial Assets. The Victorian Comprehensive Cancer Care Centre (VCCC) is the only jointly controlled asset or operation.

(E) OTHER COMPREHENSIVE INCOME

Other comprehensive income measures the change in the volume or value of assets or liabilities that do not result from transactions.

Net Gain/(Loss) on Non-Financial Assets

Net gain/(loss) on non-financial assets and liabilities includes realised and unrealised gains and losses as follows:

- **Revaluation gains/(losses) of non-financial physical assets**

Refer to Note 4.3 Property Plant and Equipment.

- **Net gain/(loss) on disposal of non-financial assets**

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal and is the difference between the proceeds and the carrying amount of the asset at the time.

- **Net gain/(loss) on financial instruments**

Net gain/(loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- impairment and reversal of impairment for financial instruments at amortised cost refer to Note 4.1 Investments and other financial assets; and
- disposals of financial assets and derecognition of financial liabilities.

- **Revaluation of Financial Instrument at Fair Value**

Refer to Note 7.1 Financial Instruments.

Other Gains/(Losses) from Other Economic Flows

Other gains/(losses) include:

A. the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors.

B. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

NOTE 2: FUNDING FOR DELIVERY OF SERVICES

Notes to the Financial Statements

The Health Service overall objective is to deliver programs and services that support and enhance the wellbeing of all Victorians.

To enable the Health Service to fulfill its objective it receives income based on parliamentary appropriations. The Health Service also receives income from the supply of services.

STRUCTURE

2.1 Analysis of revenue by source

2.2 Specific income

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE

2017	ADMITTED PATIENTS $'000	NON ADMITTED $'000	EDS[1] $'000	AGED CARE $'000	OTHERS $'000	TOTAL $'000
Government Grants	515,775	48,392	55,069	10,620	7,813	637,669
Indirect contributions by Department of Health and Human Services	2,772	-	-	-	-	2,772
Patient Fees	20,452	505	1,840	423	-	23,220
Private Practice Fees	2,267	6,748	856	9	12,182	22,062
Commercial Activities	7,352	773	772	-	412	9,309
Other Revenue from Operating Activities	7,069	311	724	56	11,530	19,690
Total Revenue from Operating Activities	**555,687**	**56,729**	**59,261**	**11,108**	**31,937**	**714,722**
Interest	1,872	240	240	12	72	2,436
Other Revenue from Non-Operating Activities	-	-	-	-	-	-
Total Revenue from Non-Operating Activities	**1,872**	**240**	**240**	**12**	**72**	**2,436**
Capital Purpose Income	-	-	-	-	35,587	35,587
Capital Interest	-	64	-	-	-	64
Total Capital Purpose Income	**-**	**64**	**-**	**-**	**35,587**	**35,651**
Available-For-Sale Revaluation surplus	-	-	-	-	108	108
Total Revenue	**557,559**	**57,033**	**59,501**	**11,120**	**67,704**	**752,917**

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE (CONTINUED)

2016	ADMITTED PATIENTS $'000	NON ADMITTED $'000	EDS[1] $'000	AGED CARE $'000	OTHERS $'000	TOTAL $'000
Government Grants	467,997	46,057	56,053	10,101	7,258	587,466
Indirect contributions by Department of Health and Human Services	11,493	-	-	-	-	11,493
Patient Fees	18,938	93	1,300	395	-	20,726
Private Practice Fees	1,878	6,027	446	9	12,362	20,722
Commercial Activities	4,647	479	535	95	273	6,029
Other Revenue from Operating Activities	11,069	535	1,021	-	10,407	23,032
Total Revenue from Operating Activities	**516,022**	**53,191**	**59,355**	**10,600**	**30,300**	**669,468**
Interest	1,615	166	186	33	72	2,072
Other Revenue from Non-Operating Activities	-	-	-	-	-	-
Total Revenue from Non-Operating Activities	**1,615**	**166**	**186**	**33**	**72**	**2,072**
Capital Purpose Income	-	-	-	-	14,706	14,706
Capital Interest	-	61	-	-	-	61
Total Capital Purpose Income	**-**	**61**	**-**	**-**	**14,706**	**14,767**
Available-For-Sale Revaluation surplus	-	-	-	-	-	-
Total Revenue	**517,637**	**53,418**	**59,541**	**10,633**	**45,078**	**686,307**

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

(i) Emergency Department Services

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

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

NOTE 2: FUNDING FOR DELIVERY OF SERVICES (CONTINUED)

Notes to the Financial Statements

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 received are treated as income in advance 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 and Human Services (DHHS)

- Insurance premiums paid by DHHS on behalf of the Health Service are recognised as revenue following advice from the DHHS.
- Long Service Leave (LSL) grants are 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 04/2017 (update for 2016-17). The grant is intended to partly reimburse the health service for LSL expenditure.

Patient Fees

Patient fee revenue is calculated by adding unbilled fees for patients not discharged at year end to fees billed to date less accrued fees in the previous year.

Private Practice Fees

Private practice fees are recognised by adding unbilled fees for patients not discharged at year end to fees billed to date less accrued fees in the previous year.

Revenue from Commercial Activities

Revenue from commercial activities is recognised 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 fund, such as a restricted 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, which allocates interest over the relevant period.

Sale of Investments

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

Other Income

Other income includes non-property rental, provision of services and usage of facilities by external health and community service organisations.

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 acute and subacute admitted patient services, where services are delivered in public hospitals.

Non Admitted Services comprises acute and subacute non admitted services, where services are delivered in public hospital clinics and provide models of integrated community care, which significantly reduces the demand for hospital beds and supports the transition from hospital to home in a safe and timely manner.

Emergency Department Services (EDS) comprises all emergency department services.

Aged Care comprises a range of in home, specialist geriatric and community based programs and support services, such as Home and Community Care (HACC) that are targeted at older people, people with a disability and their carers.

Primary and Community Health comprises a range of home based, community based and primary health, including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy.

Other Services not reported elsewhere - (Other) comprises 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, 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 2.2: SPECIFIC INCOME

	2017 $'000	2016 $'000
Specific Income		
Revaluation Increment on Non Current Assets:		
- Land	3,464	8,663
Total	**3,464**	**8,663**

NOTE 3: THE COST OF DELIVERING OUR SERVICES

Notes to the Financial Statements

This section provides an account of the expenses incurred by the Health Service in delivering services and outputs. In Note 2, the funds that enable the provision of services were disclosed and in this note the cost associated with provision of services are recorded.

STRUCTURE

3.1 Analysis of expenses by source

3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds

3.3 Employee benefits in the balance sheet

3.4 Superannuation

NOTE 3.1: ANALYSIS OF EXPENSES BY SOURCE

2017	ADMITTED PATIENTS $'000	NON ADMITTED $'000	EDS[1] $'000	AGED CARE $'000	OTHER $'000	TOTAL $'000
Employee Expenses	374,392	51,992	70,312	11,323	14,712	522,731
Other Operating Expenses						
- Non Salary Labour Expenses	9,539	1,029	805	99	94	11,566
- Supplies & Consumables	88,760	9,506	9,792	1,049	722	109,829
- Other Expenses	46,530	12,434	9,257	1,531	2,690	72,442
Total Expenditures from Operating Activities	**519,221**	**74,961**	**90,166**	**14,002**	**18,218**	**716,568**
Other Non-Operating Expenses						
- Expenditure for Capital Purposes	-	-	-	-	298	298
Depreciation & Amortisation (refer note 4.4)	29,395	4,244	5,105	793	1,031	40,568
Total Other Expenses	**29,395**	**4,244**	**5,105**	**793**	**1,329**	**40,866**
Total Expenses	**548,616**	**79,205**	**95,271**	**14,795**	**19,547**	**757,434**

NOTE 3.1: ANALYSIS OF EXPENSES BY SOURCE (CONTINUED)

2016	ADMITTED PATIENTS $'000	NON ADMITTED $'000	EDS[1] $'000	AGED CARE $'000	OTHER $'000	TOTAL $'000
Employee Expenses	352,438	51,933	66,254	10,975	13,805	495,405
Other Operating Expenses						
- Non Salary Labour Expenses	8,296	977	716	94	133	10,216
- Supplies & Consumables	78,711	9,692	11,404	1,034	857	101,698
- Other Expenses	43,459	9,596	7,124	1,481	2,241	63,901
Total Expenditures from Operating Activities	**482,904**	**72,198**	**85,498**	**13,584**	**17,036**	**671,220**
Other Non-Operating Expenses						
- Expenditure for Capital Purposes	-	-	-	-	443	443
Depreciation & Amortisation (refer note 4.4)	29,116	4,353	5,155	819	1,027	40,470
Total Other Expenses	**29,116**	**4,353**	**5,155**	**819**	**1,470**	**40,913**
Total Expenses	**512,020**	**76,551**	**90,653**	**14,403**	**18,506**	**712,133**

(i) Emergency Department Services

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;
- fringe benefits tax;
- leave entitlements;
- termination payments;
- workcover premiums; and
- superannuation expenses which is reported differently depending upon whether employees are members of defined benefits or defined contribution plans.

NOTE 3: THE COST OF DELIVERING OUR SERVICES (CONTINUED)

Notes to the Financial Statements

Other Operating Expenses

Other operating expenses generally represent the day-to-day running costs incurred in normal operations and include:

- **Supplies and Consumables**

Supplies and service costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.

- **Bad and Doubtful Debts**

Refer to Note 5.1 Receivables.

- **Fair Value of Assets, Services and Resources Provided Free of Charge or for Nominal Consideration**

Contributions of 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 agency as a consequence of a restructuring or administrative arrangements. In the latter case, such a transfer will be recognised at its carrying amount.

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.

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 acute and subacute admitted patient services, where services are delivered in public hospitals.

Non Admitted Services comprises acute and subacute non admitted services, where services are delivered in public hospital clinics and provide models of integrated community care, which significantly reduces the demand for hospital beds and supports the transition from hospital to home in a safe and timely manner.

Emergency Department Services (EDS) comprises all emergency department services.

Aged Care comprises a range of in home, specialist geriatric and community based programs and support services, such as Home and Community Care (HACC) that are targeted at older people, people with a disability and their carers.

Primary and Community Health comprises a range of home based, community based, primary health, including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy.

Other Services not reported elsewhere - (Other) comprises 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, 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 3.2: ANALYSIS OF EXPENSE AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS

	EXPENSE		REVENUE	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000
Commercial Activities				
Diagnostic Imaging	6,082	6,126	12,189	12,508
Car Parking	591	647	4,380	3,772
Property	-	6	96	181
Internal and Specific Purpose Funds	761	462	746	1,832
Other	146	145	1,199	245
Other Activities				
Fundraising and Community Support	500	460	1,612	1,427
Research	2,949	3,008	3,492	3,162
TOTAL	**11,029**	**10,854**	**23,714**	**23,127**

NOTE 3: THE COST OF DELIVERING OUR SERVICES (CONTINUED)

Notes to the Financial Statements

NOTE 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET

	2017 $'000	2016 $'000
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- Unconditional and expected to be settled wholly within 12 months(ii)	31,654	30,560
- Unconditional and expected to be settled wholly after 12 months(iii)	5,186	5,023
Long Service Leave		
- Unconditional and expected to be settled wholly within 12 months(ii)	7,397	6,649
- Unconditional and expected to be settled wholly after 12 months(iii)	44,349	43,189
Accrued salaries and wages	15,318	10,853
Other	1,263	1,894
	105,167	**98,168**
Provisions Related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months(ii)	3,989	3,911
- Unconditional and expected to be settled after 12 months(iii)	5,104	4,968
Total Current Provisions	**114,260**	**107,047**
Non-Current Provisions		
Employee Benefits (iii)	20,961	21,408
Provisions related to Employee Benefit On-Costs	2,160	2,207
Total Non-Current Provisions	**23,121**	**23,615**
Total Provisions	**137,381**	**130,662**

NOTE 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET (CONTINUED)

	2017 $'000	2016 $'000
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional Long Service Leave Entitlements	57,081	54,974
Annual Leave Entitlements	40,598	39,216
Accrued Wages and Salaries	14,286	10,853
Accrued Days Off	995	913
Superannuation	1,031	812
Other	269	279
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements(iii)	23,121	23,615
Total Employee Benefits and Related On-Costs	**137,381**	**130,662**
(b) Movements in provisions		
Movement in Long Service Leave:		
Balance at start of year	**78,589**	**64,039**
Provision made during the year		
- Revaluations	(4,678)	9,754
- Expense recognising Employee Service	13,390	11,294
Settlement made during the year	(7,098)	(6,498)
Balance at end of year	**80,203**	**78,589**

Notes:

(i) Provision 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 3: THE COST OF DELIVERING OUR SERVICES (CONTINUED)

Notes to the Financial Statements

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

This provision arises for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered up to the reporting date.

Wages and Salaries, Annual Leave and Accrued Days Off

Liabilities for wages and salaries, including non-monetary benefits, accrued days off and annual leave are all recognised in the provision for employee benefits as "current liabilities" because the Health Service does not have an unconditional right to defer settlements of these liabilities.

Depending on the expectation of the timing of settlement, liabilities for wages and salaries, accrued days off and annual leave are measured at:

- undiscounted value - if the Health Service expects to wholly settle within 12 months; or
- present value - if the Health Service does not expect to wholly settle within 12 months.

Long Service Leave (LSL)

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

Unconditional LSL 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. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- undiscounted value - if the Health Service expects to wholly settle within 12 months; and
- present value - where the Health Service does not expect to settle a component of this current liability within 12 months.

Conditional LSL 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. This non-current LSL liability is measured at present value.

Any gain or loss followed revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in estimations, e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flow.

On-Costs Related to Employee Expense

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

NOTE 3.4: SUPERANNUATION

	PAID CONTRIBUTION FOR THE YEAR		CONTRIBUTION OUTSTANDING AT YEAR END	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000
Defined benefit plans(i):				
State Superannuation Fund - revised and new	464	511	12	12
Defined contribution plans:				
First State Super	24,695	22,991	598	523
Hesta	12,731	11,410	298	249
Choice of Funds (various)	1,242	1,349	123	29
	39,132	**36,261**	**1,031**	**813**

(i) The basis for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

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

The Health Service does not recognise any defined benefit liability in respect of the plan(s) because the entity 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 discloses the State's defined benefits liabilities in its disclosure for administered items.

However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Health Service. The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Service are as follows:

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 employees during the reporting period. 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 defined benefit and defined contribution plans. The defined benefit plan(s) provides 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 disclosed in Note 3.4 Superannuation.

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

Derecognition of Financial Liabilities

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

When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified, such an exchange or modification is treated as a derecognition of the original liability and the recognition of a new liability. The difference in the respective carrying amounts is recognised as an expense in the consolidated comprehensive operating statement.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

Notes to the Financial Statements

The Health Service controls infrastructure and other investments that are utilised in fulfilling its objectives and conducting its activities. They represent the key resources that have been entrusted to the Health Service to be utilised for delivery of those outputs.

STRUCTURE

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS

	OPERATING FUND		SPECIFIC PURPOSE FUND		CAPITAL FUND		TOTAL	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000
CURRENT								
Loans and Receivables								
Term Deposit								
- Term deposit more than 3 months	-	-	300	-	-	-	300	-
Available for sale								
Managed Investment								
- VFMC Multi Strategy Funds	25,555	36,934	14,450	8,167	6,623	-	46,628	45,101
Total Current	**25,555**	**36,934**	**14,750**	**8,167**	**6,623**	**-**	**46,928**	**45,101**
NON CURRENT								
Investment								
- Cancer Therapeutics CRC	-	-	1	1	-	-	1	1
Total Non Current	**-**	**-**	**1**	**1**	**-**	**-**	**1**	**1**
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**25,555**	**36,934**	**14,751**	**8,168**	**6,623**	**-**	**46,929**	**45,102**
Represented by:								
Health Service Investments	25,555	36,934	14,751	8,168	6,623	-	46,929	45,102
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**25,555**	**36,934**	**14,751**	**8,168**	**6,623**	**-**	**46,929**	**45,102**

(A) AGEING ANALYSIS OF INVESTMENTS AND OTHER FINANCIAL ASSETS

Refer to Note 7.1 for the ageing analysis of investments and other financial assets

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

Refer to Note 7.1 for the nature and extent of credit risk arising from investments and other financial assets

Investments and Other Financial Assets

Hospital investments are made in accordance with Standing Direction 3.7.2 - Treasury and Investment Risk Management. Investments are recognised and derecognised on 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:

- available-for-sale financial assets; and
- loans and receivables.

The Health Service classifies its other financial assets between current and non-current assets based on the purpose for which the assets were acquired. Management determines the classification of its other financial assets at initial recognition.

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.

Derecognition of Financial Assets

A financial asset, (or where applicable, a part of a financial asset or part of a group of similar financial assets), 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.

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.

Doubtful Debts

Receivables are assessed for bad and doubtful debts on a regular basis.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY (CONTINUED)

Notes to the Financial Statements

NOTE 4.2: INVESTMENTS IN JOINT OPERATIONS

NAME OF ENTITY	PRINCIPAL ACTIVITY	OWNERSHIP INTEREST	
		2017 %	2016 %
Victorian Comprehensive Cancer Centre Joint Venture (VCCC)	Cancer research, education and training and patient care	10%	10%

Summarised financial information of the jointly controlled operations has been set out below.

	2017 $'000	2016 $'000
Current Assets	5,722	2,642
Non-Current Assets	37	48
Current Liabilities	337	959
Non-Current Liabilities	61	53
NET ASSETS	**5,361**	**1,678**
The following amounts have been included in the amounts above:		
Cash and cash equivalents	4,664	2,565
Current financial liabilities	229	155

	2017 $'000	2016 $'000
Revenue	6,882	3,166
Net Result From Continuing Operations	3,682	238
Other Comprehensive Income	-	-
Total Comprehensive Income	3,682	238
The following amounts have been included in the amounts above:		
Interest income	92	51
Depreciation	14	14
Commitments for Expenditure (inclusive of GST)	342	199
Contingent Assets and Contingent Liabilities	-	-

Note: Figures obtained from the unaudited VCCC joint venture annual report.

Jointly controlled assets and operations

Interests in jointly controlled assets or operations are not consolidated by the Health Service but are accounted for in accordance with the policy outlined below.

In respect of any interest in joint operations, the Health Service recognises in the financial statements:

- its assets, including its share of any assets held jointly;
- any liabilities, including its share of liabilities that it had incurred;
- its revenue from the sale of its share of the output from the joint operation;
- its share of the revenue from the sale of the output by the operation; and
- its expenses, including its share of any expenses incurred jointly.

The Health Service as a member of the VCCC joint operation retains joint control over the arrangement which it has classified as a joint operation. The vision of the VCCC is to save lives through the integration of cancer research, education and patient care. The VCCC is a not-for-profit organisation and has been recognised by the Australian Taxation Office as a Health Promotion Charity.

All members of the VCCC hold an equal 10 percent (2016: 10 percent) share in the assets, liabilities, revenue and expenses of the VCCC. The members own the VCCC assets as tenants in common and are severally responsible for the joint operation costs in the same proportions as their interests. Accordingly, assets, liabilities, income and expenses are consolidated in proportion to the Health Service's contractually specified share.

Interests in the VCCC are not transferable and are forfeited on withdrawal from the joint operation. Distributions are not able to be paid to members and excess property, on winding up, will be distributed to other charitable organisations with objectives similar to those of the VCCC.

The VCCC member entities have created a company to conduct the affairs of the joint operation. The member entities have specifically, in their agreement, stated that they do not indemnify the company against any liabilities beyond their contribution to the joint assets of the joint operation. The member entities do not therefore bear any financial risk beyond their contribution to the joint assets. "Their contribution" means their share of the net assets. Reputational risk through membership is addressed through the appointment of representatives to the governing bodies of the VCCC. The risks associated with the VCCC have not changed from previous reporting periods.

The principal place of business for the VCCC is Level 10, 305 Grattan Street, Melbourne, Victoria.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY (CONTINUED)

Notes to the Financial Statements

NOTE 4.3: PROPERTY, PLANT & EQUIPMENT

	2017 $'000	2016 $'000
Land		
Land at Fair Value	78,552	75,088
Total Land	**78,552**	**75,088**
Buildings		
Buildings under Construction at Cost	24,040	13,573
Buildings at Fair Value	498,895	494,203
- Less Accumulated Depreciation	(84,593)	(56,129)
Total Buildings	**438,342**	**451,647**
Plant and Equipment		
Plant and Equipment at Fair Value	45,674	26,902
- Less Accumulated Depreciation	(12,223)	(10,665)
Total Plant and Equipment	**33,451**	**16,237**
Medical Equipment		
Medical Equipment at Fair Value	101,616	90,674
- Less Accumulated Depreciation	(65,774)	(58,643)
Total Medical Equipment	**35,842**	**32,031**
Non Medical Equipment		
Non Medical Equipment at Fair Value	6,534	6,254
- Less Accumulated Depreciation	(4,167)	(3,681)
Total Non Medical Equipment	**2,367**	**2,573**

NOTE 4.3: PROPERTY, PLANT & EQUIPMENT (CONTINUED)

	2017 $'000	2016 $'000
Computers and Communication		
Computers and Communication at Fair Value	17,119	16,736
- Less Accumulated Depreciation	(16,502)	(15,726)
Total Computers and Communications	**617**	**1,010**
Furniture and Fittings		
Furniture and Fittings at Fair Value	7,551	7,377
- Less Accumulated Depreciation	(4,181)	(3,484)
Total Furniture and Fittings	**3,370**	**3,893**
Motor Vehicles		
Motor Vehicles at Fair Value	93	93
- Less Accumulated Depreciation	(93)	(93)
Total Motor Vehicles	**-**	**-**
TOTAL PROPERTY, PLANT & EQUIPMENT	**592,541**	**582,479**

Share of jointly controlled assets included in property, plant and equipment are separately disclosed in Note 4.2 jointly controlled operations and assets.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY (CONTINUED)

Notes to the Financial Statements

(B) RECONCILIATIONS OF THE CARRYING AMOUNTS OF EACH CLASS OF ASSET

	LAND	BUILD-INGS	BUILD-INGS UNDER CONSTR	PLANT AND EQUIP-MENT	MEDICAL EQUIP-MENT	NON MEDICAL EQUIP-MENT	COMPUT-ER AND COMM	FURNI-TURE AND FITTINGS	TOTAL
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2015	**66,425**	**441,989**	**36,831**	**13,305**	**29,491**	**2,115**	**1,480**	**3,654**	**595,290**
Additions	-	1,357	6,438	4,077	4,854	404	367	212	17,709
Disposals	-	-	-	-	(4)	-	-	-	(4)
Revaluation increments/ (decrements)	8,663	-	-	-	-	-	-	-	8,663
Net transfer between classes	-	23,161	(29,696)	556	4,400	536	329	714	-
Depreciation and Amortisation (note 4.4)	-	(28,433)	-	(1,701)	(6,710)	(482)	(1,166)	(687)	(39,179)
Balance at 1 July 2016	**75,088**	**438,074**	**13,573**	**16,237**	**32,031**	**2,573**	**1,010**	**3,893**	**582,479**
Additions	-	980	21,407	19,888	3,522	77	121	50	46,045
Disposals	-	-	-	-	(44)	(3)	-	-	(47)
Revaluation increments/ (decrements)	3,464	-	-	-	-	-	-	-	3,464
Net transfer between classes	-	3,712	(10,940)	(1,117)	7,747	209	264	125	-
Depreciation and Amortisation (note 4.4)	-	(28,464)	-	(1,557)	(7,414)	(489)	(778)	(698)	(39,400)
Balance at 30 June 2017	**78,552**	**414,302**	**24,040**	**33,451**	**35,842**	**2,367**	**617**	**3,370**	**592,541**

Land and buildings carried at valuation

An independent valuation of the Health Service's land and buildings was performed by 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 **30th June 2014**. Subsequent to this valuation, the Health Service assessed the carrying amounts of land and buildings based on indices (compounded) made available by the Valuer-General Victoria (VGV) to establish whether they materially approximate fair value at 30th June 2017.

Fair Value measurement of Land – Past practice has always been that health services use the commercial index issued by the Valuer General Victoria (VGV) for the managerial revaluation of specialised land. The use of Commercial index reflects actual usage of the land. In early 2017, the DHHS directed the Health service that revaluation should adopt the appropriate indices depending on the zoning of the land, rather than the usage. As a result the "Englobo" index became the index all health services were directed to use for the revaluation of land in the 2016-17 accounts. Englobo is defined as an undeveloped parcel of land that is zoned to allow for, and capable of significant subdivision into smaller parcels under existing land use provisions. The rationale is that any prospective buyer will not be purchasing the buildings to use as a hospital but will instead be buying the land to use as the zoning allows. If used in the prior year the Health Service land value would have been $4.2 million lower in the 2015-16 accounts. From that figure, using Englobo, the value would have increased by $7.7 million in 2016-17. However this becomes a movement of only $3.5 million in the 2016/17 accounts since Englobo was not used in the prior year.

Indices applied to buildings value remained relatively unchanged and approximate fair value.

Plant and equipment

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 30th June 2017. The outcome indicated that the carrying amount of plant and equipment does approximate fair value.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY (CONTINUED)

Notes to the Financial Statements

(C) FAIR VALUE MEASUREMENT HIERARCHY FOR ASSETS

	CARRYING AMOUNT AS AT 30TH JUNE 2017	FAIR VALUE MEASUREMENT AT END OF REPORTING PERIOD USING:		
	$'000	LEVEL 1 $'000	LEVEL 2 $'000	LEVEL 3 $'000
Land at fair value				
Land	78,552	-	7,498	71,054
Total Land at fair value	**78,552**	**-**	**7,498**	**71,054**
Buildings at fair value				
Buildings under Construction at fair value	24,040	-	-	24,040
Buildings at Fair Value	498,895	-	484	498,411
- Less Accumulated Depreciation	(84,593)	-	(100)	(84,493)
Total Buildings at fair value	**438,342**	**-**	**384**	**437,958**
Plant and Equipment				
Plant and Equipment at Fair Value	45,674	-	-	45,674
- Less Accumulated Depreciation	(12,223)	-	-	(12,223)
Total Plant and Equipment at fair value	**33,451**	**-**	**-**	**33,451**
Medical Equipment				
Medical Equipment at Fair Value	101,616	-	-	101,616
- Less Accumulated Depreciation	(65,774)	-	-	(65,774)
Total Medical Equipment ar fair value	**35,842**	**-**	**-**	**35,842**
Non Medical Equipment				
Non Medical Equipment at Fair Value	6,534	-	6,534	-
- Less Accumulated Depreciation	(4,167)	-	(4,167)	-
Total Non Medical Equipment at fair value	**2,367**	**-**	**2,367**	**-**

(C) FAIR VALUE MEASUREMENT HIERARCHY FOR ASSETS (CONTINUED)

	CARRYING AMOUNT AS AT 30TH JUNE 2017	FAIR VALUE MEASUREMENT AT END OF REPORTING PERIOD USING:		
	$'000	LEVEL 1 $'000	LEVEL 2 $'000	LEVEL 3 $'000
Computers and Communication				
Computers and Communication at Fair Value	17,119	-	17,119	-
- Less Accumulated Depreciation	(16,502)	-	(16,502)	-
Total Computers and Communications at fair value	**617**	**-**	**617**	**-**
Furniture and Fittings				
Furniture and Fittings at Fair Value	7,551	-	7,551	-
- Less Accumulated Depreciation	(4,181)	-	(4,181)	-
Total Furniture and Fittings at fair value	**3,370**	**-**	**3,370**	**-**
Motor Vehicles				
Motor Vehicles at Fair Value	93	-	93	-
- Less Accumulated Depreciation	(93)	-	(93)	-
Total Motor Vehicles at fair value	**-**	**-**	**-**	**-**
TOTAL PROPERTY, PLANT & EQUIPMENT	**592,541**	**-**	**14,236**	**578,305**

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY (CONTINUED)

Notes to the Financial Statements

(C) FAIR VALUE MEASUREMENT HIERARCHY FOR ASSETS (CONTINUED)

	CARRYING AMOUNT AS AT 30TH JUNE 2016	FAIR VALUE MEASUREMENT AT END OF REPORTING PERIOD USING:		
	$'000	LEVEL 1 $'000	LEVEL 2 $'000	LEVEL 3 $'000
Land at fair value				
Land	75,088	-	6,159	68,929
Total Land at fair value	**75,088**	**-**	**6,159**	**68,929**
Buildings at fair value				
Buildings under Construction at Cost	13,573	-	-	13,573
Buildings at Fair Value	494,203	-	484	493,719
- Less Accumulated Depreciation	(56,129)	-	(33)	(56,096)
Total Buildings	**451,647**	**-**	**451**	**451,196**
Plant and Equipment				
Plant and Equipment at Fair Value	26,902	-	-	26,902
- Less Accumulated Depreciation	(10,665)	-	-	(10,665)
Total Plant and Equipment	**16,237**	**-**	**-**	**16,237**
Medical Equipment				
Medical Equipment at Fair Value	90,674	-	-	90,674
- Less Accumulated Depreciation	(58,643)	-	-	(58,643)
Total Medical Equipment	**32,031**	**-**	**-**	**32,031**
Non Medical Equipment				
Non Medical Equipment at Fair Value	6,254	-	6,254	-
- Less Accumulated Depreciation	(3,681)	-	(3,681)	-
Total Non Medical Equipment	**2,573**	**-**	**2,573**	**-**

(C) FAIR VALUE MEASUREMENT HIERARCHY FOR ASSETS (CONTINUED)

	CARRYING AMOUNT AS AT 30TH JUNE 2016	FAIR VALUE MEASUREMENT AT END OF REPORTING PERIOD USING:		
	$'000	LEVEL 1 $'000	LEVEL 2 $'000	LEVEL 3 $'000
Computers and Communication				
Computers and Communication at Fair Value	16,736	-	16,736	-
- Less Accumulated Depreciation	(15,726)	-	(15,726)	-
Total Computers and Communications	**1,010**	**-**	**1,010**	**-**
Furniture and Fittings				
Furniture and Fittings at Fair Value	7,377	-	7,377	-
- Less Accumulated Depreciation	(3,484)	-	(3,484)	-
Total Furniture and Fittings	**3,893**	**-**	**3,893**	**-**
Motor Vehicles				
Motor Vehicles at Fair Value	93	-	93	-
- Less Accumulated Depreciation	(93)	-	(93)	-
Total Motor Vehicles	**-**	**-**	**-**	**-**
TOTAL PROPERTY, PLANT & EQUIPMENT	**582,479**	**-**	**14,086**	**568,393**

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY (CONTINUED)

Notes to the Financial Statements

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision. Judgements and assumptions made by management in the application of AASBs that have significant effects on the financial statements and estimates relate to:

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 7.4);
- superannuation expense (refer to Note 3.4);
- actuarial assumptions for employee benefit provisions based on likely tenure of existing employees, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3); and
- equities and management investment schemes classified at level 3 of the fair value hierarchy.

Consistent with AASB 13 Fair Value Measurement, the Health Service determines the policies and procedures for recurring fair value measurements such as property, plant and equipment and financial instruments in accordance with the requirements of AASB 13 and the relevant FRDs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, described as follows, based on the lowest level input that is significant to the fair value measurement as a whole:

- Level 1 - Quoted (unadjusted) market prices in active markets for identical assets or liabilities
- Level 2 - Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable
- Level 3 - Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable

For the purpose of fair value disclosures, the Health Service has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

In addition, the Health Service determines whether transfers have occurred between levels in the hierarchy by re-assessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period.

The Valuer-General Victoria (VGV) is the Health Service's independent valuation agency.

The Health Service, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required. VGV supply land and buildings indices which the Health Service uses for fair value assessment, with adjustments made where applicable.

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 and assumptions made by management in the application of AASBs that have significant effects on the financial statements and estimates, with a risk of material adjustments in the subsequent period, relate to:

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 7.4);
- superannuation expense (refer to Note 3.4); and
- actuarial assumptions for employee benefit provisions based on likely tenure of existing employees, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3).

Fair Value Measurement

The fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

The fair value measurement is based on the following assumptions:

- that the transaction to sell the asset or transfer the liability takes place either in the principal market (or the most advantageous market, in the absence of the principal market), either of which must be accessible to the Health Service at the measurement date; and
- that the Health Service uses the same valuation assumptions that market participants would use when pricing the asset or liability, assuming that market participants act in their economic best interest.

The fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefits by using the asset in its highest and best use or by selling it to another market participant that would use the asset in its highest and best use.

(D) RECONCILIATION OF LEVEL 3 FAIR VALUE

2017	LAND $'000	BUILDINGS $'000	ASSETS UNDER CONSTR $'000	PLANT AND EQUIPMENT $'000	MEDICAL EQUIPMENT $'000	TOTAL $'000
Opening Balance	**68,929**	**437,623**	**13,573**	**16,237**	**32,031**	**568,393**
Purchases (sales)	**-**	**980**	**21,407**	**19,888**	**3,522**	**45,797**
Transfers in (out) of Level 3		**3,712**	**(10,940)**	**(1,117)**	**7,703**	**(642)**
Gains/(losses) recognised in net result						
- Depreciation	-	(28,397)	-	(1,557)	(7,414)	(37,368)
- Impairment loss	-	-	-	-	-	-
	68,929	**413,918**	**24,040**	**33,451**	**35,842**	**576,180**
Items recognised in other comprehensive income						
- Revaluation	2,125	-	-	-	-	2,125
Balance at 30th June 2017	**71,054**	**413,918**	**24,040**	**33,451**	**35,842**	**578,305**

2016	LAND $'000	BUILDINGS $'000	ASSETS UNDER CONSTR $'000	PLANT AND EQUIPMENT $'000	MEDICAL EQUIPMENT $'000	TOTAL $'000
Opening Balance	**60,603**	**441,538**	**36,831**	**13,305**	**29,491**	**581,768**
Purchases (sales)	**-**	**1,357**	**6,438**	**4,077**	**4,854**	**16,726**
Transfers in (out) of Level 3		**23,161**	**(29,696)**	**556**	**4,396**	**(1,583)**
Gains/(losses) recognised in net result						
- Depreciation	-	(28,433)	-	(1,701)	(6,710)	(36,844)
- Impairment loss	-	-	-	-	-	-
	60,603	**437,623**	**13,573**	**16,237**	**32,031**	**560,067**
Items recognised in other comprehensive income						
- Revaluation	8,326	-	-	-	-	8,326
Balance at 30th June 2016	**68,929**	**437,623**	**13,573**	**16,237**	**32,031**	**568,393**

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY (CONTINUED)

Notes to the Financial Statements

Non-Specialised Land and Non-Specialised Buildings

Non-specialised land and non-specialised buildings are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.

For non-specialised land and non-specialised buildings, an independent valuation was performed by VGV to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, appropriate size, topography, location and other factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30th June 2014.

To the extent that non-specialised land and non-specialised buildings do not contain significant, unobservable adjustments, these assets are classified as Level 2 under the market approach.

Specialised Land and Specialised Buildings

The market approach is also used for specialised land and specialised buildings although it is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued. Specialised assets contain significant, unobservable adjustments; therefore these assets are classified as Level 3 under the market based direct comparison approach.

The CSO adjustment is a reflection of the Valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement and takes into account the use of the asset that is physically possible, legally permissible and financially feasible. As adjustments of CSO are considered as significant unobservable inputs, specialised land is classified as a Level 3 asset.

For the health services, the depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

An independent valuation of the Health Service's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30th June 2014. Subsequent to scheduled revaluation, land and buildings fair value assessment were carried out using VGV published indices.

Plant and Equipment

Plant and equipment is held at carrying value (depreciated cost). When plant and equipment is specialised in use, such that it is rarely sold other than as part of a going concern, the depreciated replacement cost is used to estimate the fair value. Unless there is market evidence that current replacement costs are significantly different from the original acquisition cost, it is considered unlikely that depreciated replacement cost will be materially different from the existing carrying value.

There were no changes in valuation techniques throughout the period to 30th June 2017.

For all assets measured at fair value, the current use is considered the highest and best use.

(E) DESCRIPTION OF SIGNIFICANT UNOBSERVABLE INPUTS TO LEVEL 3 VALUATIONS:

	VALUATION TECHNIQUE	SIGNIFICANT UNOBSERVABLE INPUTS
Specialised land		
- Western Hospital, Footscray - Sunshine Hospital - Williamstown Hospital - Sunbury Day Hospital	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings		
- Western Hospital, Footscray - Sunshine Hospital - Williamstown Hospital - Sunbury Day Hospital - Hazeldean Transition Care, Williamstown	Depreciated replacement cost	Direct Cost per square metre
- Western Hospital, Footscray - Sunshine Hospital - Williamstown Hospital - Sunbury Day Hospital - Hazeldean Transition Care, Williamstown		Useful life of specialised buildings
Assets under construction at fair value	Depreciated replacement cost	Cost per unit
Plant and equipment at fair value	Depreciated replacement cost	Useful life of plant and equipment
Medical equipment at fair value	Depreciated replacement cost	Useful life of medical equipment

The significant unobservable inputs have remain unchanged from 2016.

Refer to Note 7.4 for guidance on fair value measurement indicative expectations.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY (CONTINUED)

Notes to the Financial Statements

Property, Plant and Equipment

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 4.3 Property, Plant and Equipment.

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

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

Revaluations of Non-Financial Physical Assets

Non-financial physical assets are measured at fair value and are revalued in accordance with FRD 103F Non-Current Physical Assets. This revaluation process for land and buildings 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 of land and buildings 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 amount and fair value.

Revaluation increments are recognised in "other comprehensive income" and are added directly in equity 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 recognised as an expense in net result, the increment is recognised as income in the net result.

Revaluation decrements are recognised in "other comprehensive income" to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of property, plant and equipment.

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 103F, the Health Service's non-financial physical assets were assessed to determine whether revaluation of the non-financial physical assets was required.

NOTE 4.4: DEPRECIATION AND AMORTISATION

	2017 $'000	2016 $'000
Depreciation		
Buildings	28,464	28,433
Plant and Equipment	1,557	1,701
Medical Equipment	7,414	6,710
Computers and Communication	778	1,166
Furniture and Fittings	698	687
Non Medical Equipment	489	482
Total Depreciation	**39,400**	**39,179**
Amortisation		
Intangibles Assets	1,168	1,291
Total Amortisation	**1,168**	**1,291**
Total Depreciation and Amortisation	**40,568**	**40,470**

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (this excludes land). 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.

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, residual value 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 and Human Services. 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.

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

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY (CONTINUED)

Notes to the Financial Statements

NOTE 4.4: DEPRECIATION AND AMORTISATION (CONTINUED)

	2017	2016
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	7-10 Years	7-10 Years
Non Medical Equipment	10 Years	10 Years
Furniture and Fittings	10 Years	10 Years
Motor Vehicles	4 Years	4 Years
Computers and Communication	3 Years	3 Years

As part of the buildings valuation, building values were separated into components and each component assessed for its useful life which is represented above.

NOTE 4.5: INTANGIBLE ASSETS

	2017	2016
Software	12,879	12,455
- Less Accumulated Amortisation	(11,991)	(10,824)
Total Intangible Assets	**888**	**1,631**

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

	SOFTWARE $'000	TOTAL $'000
Balance at 1st July 2015	**1,626**	**1,626**
Additions	1,296	1,296
Disposals	-	-
Amortisation	(1,291)	(1,291)
Balance at 1st July 2016	**1,631**	**1,631**
Additions	425	425
Disposals	-	-
Amortisation	(1,168)	(1,168)
Balance at 30th June 2017	**888**	**888**

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.

Expenditure on research activities is recognised as an expense in the period on which it is incurred.

When the recognition criteria in AASB 138 Intangible Assets are met, internally generated intangible assets are recognised and measured at cost less accumulated depreciation/amortisation and impairment.

An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

1. the technical feasibility of completing the intangible asset so that it will be available for use or sale;
2. an intention to complete the intangible asset and use or sell it;
3. the ability to use or sell the intangible asset;
4. the intangible asset will generate probable future economic benefits;
5. the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and
6. the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Amortisation

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 is reviewed annually. 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 asset concerned is 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 produced assets with finite useful lives are depreciated as an expense from transactions on a systemic basis over the asset's useful life.

Intangible assets with finite useful lives are amortised over a 3 year period (2016: 3 years).

NOTE 5: OTHER ASSETS AND LIABILITIES

Notes to the Financial Statements

This section sets out those assets and liabilities that arose from the Health Service's operations.

STRUCTURE

5.1 Receivables

5.2 Inventories

5.3 Prepayments

5.4 Payables

NOTE 5.1: RECEIVABLES

	2017 $'000	2016 $'000
CURRENT		
Contractual		
Inter Hospital Debtors	1,038	1,187
Trade Debtors	1,825	977
Patient Fees	6,259	5,742
Accrued Investment Income	183	161
Accrued Revenue	4,448	6,790
less Allowance for Doubtful Debts		
- Inter Hospital Debtors	-	-
- Trade Debtors	(160)	(146)
- Patient Fees	(3,824)	(2,326)
	9,769	**12,385**
Statutory		
GST Receivable	1,358	865
Accrued Revenue - Department of Health and Human Services	449	645
	1,807	**1,510**
TOTAL CURRENT RECEIVABLES	**11,576**	**13,895**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	24,283	21,917
TOTAL NON CURRENT RECEIVABLES	**24,283**	**21,917**
TOTAL RECEIVABLES	**35,859**	**35,812**

(A) MOVEMENT IN THE ALLOWANCE FOR DOUBTFUL DEBTS

	2017 $'000	2016 $'000
Balance at beginning of year	2,472	1,960
Amounts written off during the year	(1,085)	(1,315)
Increase/(decrease) in allowance recognised in net result	2,597	1,827
Balance at end of year	**3,984**	**2,472**

(B) AGEING ANALYSIS OF RECEIVABLES

Refer to Note 7.1 for the ageing analysis of contractual receivables.

(C) NATURE AND EXTENT OF RISK ARISING FROM RECEIVABLES

Refer to Note 7.1 for the nature and extent of credit risk arising from contractual 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 are 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. For the Health Service, GST receivables and certain DHHS Grants fall into this category.

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 not to be collectible 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.

NOTE 5: OTHER ASSETS AND LIABILITIES (CONTINUED)

Notes to the Financial Statements

NOTE 5.2: INVENTORIES

	2017 $'000	2016 $'000
Pharmaceuticals		
- At cost	2,221	1,884
Radiology		
- At cost	219	221
TOTAL INVENTORIES	**2,440**	**2,105**

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.

Inventories acquired for no cost or nominal considerations are measured at current replacement cost at the date of acquisition.

The basis used in assessing loss of service potential for inventories held for distribution includes 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.

NOTE 5.3: PREPAYMENTS

	2017 $'000	2016 $'000
CURRENT		
Prepayments	1,822	404
TOTAL OTHER ASSETS	**1,822**	**404**

NOTE 5.4: PAYABLES

	2017 $'000	2016 $'000
CURRENT		
Contractual		
Trade Creditors	12,106	13,410
Accrued Expenses	14,360	10,911
Salary Packaging	2,544	2,776
Amounts payable to Governments and Agencies:		
- Melbourne Health	5,416	5,335
Other	2,222	1,072
TOTAL PAYABLES	**36,648**	**33,504**

(A) MATURITY ANALYSIS OF PAYABLES

Refer to Note 7.1 for the ageing analysis of payables

(B) NATURE AND EXTENT OF RISK ARISING FROM PAYABLES

Refer to Note 7.1 for the nature and extent of risk arising from contractual 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 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 classified as financial instruments and 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.

NOTE 6: FUNDING FOR OPERATIONS

Notes to the Financial Statements

This section provides information on the sources of finance utilised by the Health Service during its operations, along with other information related to financing activities of the Health Service.

This section includes disclosures of balances that are financial instruments (such as cash balances). Note 7.1 provides additional specific financial instrument disclosures.

STRUCTURE

6.1 Leasing arrangements

6.2 Cash and cash equivalents

6.3 Commitments for expenditure

NOTE 6.1: LEASING ARRANGEMENTS

A lease is a right to use an asset for an agreed period of time in exchange for payment. 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 the ownership.

Leases of property, plant and equipment are classified as finance lease 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.

Operating Leases

	2017 $'000	2016 $'000
Non-cancellable operating lease		
Not longer than one year	426	538
Longer than one year but not longer than five years	788	2,471
Longer than five years	-	-
	1,214	**3,009**

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. The leased asset is not recognised in the balance sheet.

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.

NOTE 6.2: 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.

	2017 $'000	2016 $'000
Cash on Hand	16	13
Cash at Bank	17,581	14,507
Deposits at Call	-	2,159
Total Cash and Cash Equivalents	**17,597**	**16,679**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	17,597	16,679
Total Cash and Cash Equivalents	**17,597**	**16,679**

Cash and cash equivalents recognised on the balance sheet 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.

NOTE 6: FUNDING FOR OPERATIONS (CONTINUED)

Notes to the Financial Statements

NOTE 6.3: COMMITMENTS FOR EXPENDITURE

(A) COMMITMENTS

	2017 $'000	2016 $'000
Capital Expenditure Commitments		
Payable:		
Buildings	145,465	40,348
Plant and equipment	3,997	2,982
Medical equipment	2,120	9,331
Computer equipment	7,623	2,900
Furniture and fittings	913	662
Intangible assets	12,673	20,686
Total capital expenditure commitments	**172,791**	**76,909**
Other Expenditure Commitments		
Payable:		
Supplies and consumables	143,006	131,167
Service agreements	39,033	37,888
Maintenance contracts	6,808	16,393
Total other expenditure commitments	**188,847**	**185,448**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating leases	1,214	3,009
Total lease commitments	**1,214**	**3,009**
Operating Leases		
Cancellable	-	-
Sub-Total	**-**	**-**
Non-cancellable	1,214	3,009
Total operating lease commitments	**1,214**	**3,009**
Total lease commitments	**1,214**	**3,009**
Total Commitments (inclusive of GST)	**362,852**	**265,366**

Note: All amounts shown in the commitments note are nominal amounts inclusive of GST, where applicable.

(B) COMMITMENTS PAYABLE

NOMINAL VALUES	2017 $'000	2016 $'000
Capital expenditure commitments payable		
Less than 1 year	172,110	65,003
Longer than 1 year but not longer than 5 years	681	11,906
5 years or more	-	-
Total capital expenditure commitments	**172,791**	**76,909**
Other expenditure commitments payable		
Less than 1 year	70,131	48,992
Longer than 1 year but not longer than 5 years	104,154	69,852
5 years or more	14,562	66,604
Total other expenditure commitments	**188,847**	**185,448**
Lease commitments payable		
Less than 1 year	426	538
Longer than 1 year but not longer than 5 years	788	2,471
5 years or more	-	-
Total lease commitments	**1,214**	**3,009**
Total commitments (inclusive of GST)	**362,852**	**265,366**
Less GST recoverable from the Australian Tax Office [(i)]	26,843	11,985
Total commitments (exclusive of GST)	**336,009**	**253,381**

(i) Supply of medical items, including drugs and diagnostic services, such as radiology and pathology are GST free

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note at their nominal value and are inclusive of the 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.

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES

Notes to the Financial Statements

The Health Service is exposed to risk from its activities and outside factors. In addition, it is often necessary to make judgements and estimates associated with recognition and measurement of items in the financial statements. This section sets out the financial instrument specific information, including exposures to financial risks, as well as those items that are contingent in nature or require a higher level of judgement to be applied, which for the Health Service is related mainly to fair value determination.

STRUCTURE

NOTE 7.1: 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)
- Investment in equities and managed investment schemes
- 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 Health Service's main financial risks include credit risk, liquidity risk, interest rate risk and equity price risk. The Health Service manages these financial risks in accordance with its financial risk management policy.

The Health Service uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the financial risk management committee of the Health Service.

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

Categorisation of financial instruments

2017	CONTRACTUAL FINANCIAL ASSETS - RECEIVABLES $'000	CONTRACTUAL FINANCIAL ASSETS - AVAILABLE FOR SALE $'000	CONTRACTUAL FINANCIAL LIABILITIES AT AMORTISED COST $'000	TOTAL $'000
Financial Assets				
Cash and Cash Equivalents	17,597	-	-	17,597
Receivables				
- Trade Debtors	2,863	-	-	2,863
- Patient Fees	6,259	-	-	6,259
- Other Receivables	4,631	-	-	4,631
Other Financial Assets				
- Term Deposit	300	-	-	300
- Managed Funds	-	46,628	-	46,628
- Shares in Other Entities	-	1	-	1
Total Financial Assets[i]	**31,650**	**46,629**	**-**	**78,279**
Financial Liabilities				
Payables	-	-	34,426	34,426
Other Financial Liabilities	-	-	2,222	2,222
Total Financial Liabilities[ii]	**-**	**-**	**36,648**	**36,648**

2016	CONTRACTUAL FINANCIAL ASSETS - RECEIVABLES $'000	CONTRACTUAL FINANCIAL ASSETS - AVAILABLE FOR SALE $'000	CONTRACTUAL FINANCIAL LIABILITIES AT AMORTISED COST $'000	TOTAL $'000
Financial Assets				
Cash and Cash Equivalents	16,679	-	-	16,679
Receivables				
- Trade Debtors	2,164	-	-	2,164
- Patient Fees	5,742	-	-	5,742
- Other Receivables	6,951	-	-	6,951
Other Financial Assets				
- Managed Funds	-	45,101	-	45,101
- Shares in Other Entities	-	1	-	1
Total Financial Assets[i]	**31,536**	**45,102**	**-**	**76,638**
Financial Liabilities				
Payables	-	-	32,432	32,432
Other Financial Liabilities	-	-	1,072	1,072
Total Financial Liabilities[ii]	**-**	**-**	**33,504**	**33,504**

(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)

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES (CONTINUED)

Notes to the Financial Statements

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

(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 and patients, 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 financial institutions 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

2017	FINANCIAL INSTITUTIONS (AA CREDIT RATING) $'000	GOVERNMENT AGENCIES (AA CREDIT RATING) $'000	OTHER $'000	TOTAL $'000
Financial Assets				
Cash and Cash Equivalents	17,597	-	-	17,597
Receivables				
- Trade Debtors	-	1,038	1,825	2,863
- Patient Fees	-	-	6,259	6,259
- Other Receivables[1]	-	-	4,631	4,631
Other Financial Assets				
- Term Deposit	300	-	-	300
- Managed Funds	-	46,628	-	46,628
- Shares in Other Entities	-	-	1	1
Total Financial Assets	**17,897**	**47,666**	**12,716**	**78,279**

2016	FINANCIAL INSTITUTIONS (AA CREDIT RATING) $'000	GOVERNEMENT AGENCIES (AA CREDIT RATING) $'000	OTHER $'000	TOTAL $'000
Financial Assets				
Cash and Cash Equivalents	16,679	-	-	16,679
Receivables				
Trade Debtors	-	1,187	977	2,164
Patient Fees	-	-	5,742	5,742
Other Receivables[1]	-	-	6,951	6,951
Other Financial Assets				
Managed Funds	-	45,101	-	45,101
Shares in Other Entities	-	-	1	1
Total Financial Assets	**16,679**	**46,288**	**13,671**	**76,638**

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

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES (CONTINUED)

Notes to the Financial Statements

Ageing analysis of financial assets as at 30 June

2017	CARRYING AMOUNT $'000	NOT PAST DUE AND NOT IMPAIRED $'000	PAST DUE BUT NOT IMPAIRED				IMPAIRED FINANCIAL ASSETS $'000
			LESS THAN 1 MONTH $'000	1-3 MONTHS $'000	3 MONTHS - 1 YEAR $'000	1-5 YEARS $'000	
Financial Assets							
Cash and Cash Equivalents	17,597	17,597	-	-	-	-	-
Receivables[1]							
Trade Debtors	2,863	1,812	566	308	17	-	160
Patient Fees	6,259	1,752	581	99	3	-	3,824
Other Receivables	4,631	4,631	-	-	-	-	-
Other Financial Assets							
Term Deposit	300	300	-	-	-	-	-
Managed Funds	46,628	46,628	-	-	-	-	-
Shares in Other Entities	1	1	-	-	-	-	-
Total Financial Assets	**78,279**	**72,721**	**1,147**	**407**	**20**	**-**	**3,984**

2016							
Financial Assets							
Cash and Cash Equivalents	16,679	16,679	-	-	-	-	-
Receivables[1]							
Trade Debtors	2,164	1,118	518	259	123	-	146
Patient Fees	5,742	1,384	936	790	306	-	2,326
Other Receivables	6,951	6,951	-	-	-	-	-
Other Financial Assets							
Managed Funds	45,101	45,101	-	-	-	-	-
Shares in Other Entities	1	1	-	-	-	-	-
Total Financial Assets	**76,638**	**71,234**	**1,454**	**1,049**	**429**	**-**	**2,472**

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

Contractual financial assets that are either past due or impaired

There are no material financial assets which are individually determined to be impaired. Currently the Health Service does not hold any collateral as security nor credit enhancements relating to 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 operates under the Government's fair payments policy of settling financial obligations within 30 days and in the event of a dispute, making payments within 30 days from the date of resolution.

The Health Service's maximum exposure to liquidity risk is the carrying amounts 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 30th June

	CARRYING AMOUNT	NOMINAL AMOUNT	MATURITY DATES			
2017	$'000	$'000	LESS THAN 1 MONTH $'000	1-3 MONTHS $'000	3 MONTHS-1 YEAR $'000	1-5 YEARS $'000
Financial Liabilities						
At amortised cost						
Payables	34,426	34,426	30,267	4,145	14	-
Other Financial Liabilities[(i)]	2,222	2,222	2,222	-	-	-
Total Financial Liabilities	**36,648**	**36,648**	**32,489**	**4,145**	**14**	**-**
2016						
Financial Liabilities						
At amortised cost						
Payables	32,432	32,432	31,020	1,278	134	-
Other Financial Liabilities[(i)]	1,072	1,072	1,072	-	-	-
Total Financial Liabilities	**33,504**	**33,504**	**32,092**	**1,278**	**134**	**-**

(i) Ageing analysis of financial liabilities excludes the types of statutory financial liabilities (i.e. GST payable)

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES (CONTINUED)

Notes to the Financial Statements

(D) MARKET RISK

The Health Service's exposures to market risk is primarily through interest rate risk with only insignificant exposure to foreign currency and other 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.

Interest Rate Risk

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

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

The Health Service has minimal exposure to cash flow interest rate risks through its cash and term deposits.

The Health Service manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded that cash at bank is a financial asset that can be left at floating rate without necessarily exposing the Health Service to significant risk.

In compliance with the requirements of the Victorian Public Sector Financial Management Compliance Framework, the Health Service invested with the Victorian Funds Management Corporation (VFMC) where interest rate risk is managed primarily in the physical market by observing the target portfolio composition.

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 amounts of the financial assets or liabilities.

Interest Rate exposure of financial assets and liabilities as at 30 June

2017	WEIGHTED AVERAGE EFFECTIVE INTEREST RATE 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	2.0	17,597	-	17,581	16
Receivables					
Trade Debtors	-	2,863	-	-	2,863
Patient Fees	-	6,259	-	-	6,259
Other Receivables[1]	-	4,631	-	-	4,631
Other Financial Assets					
Term Deposit	2.7	300	300	-	-
Managed Funds	3.0	46,628	-	46,628	-
Shares in Other Entities	-	1	-	-	1
Total Financial Assets		**78,279**	**300**	**64,209**	**13,770**
Financial Liabilities					
At amortised cost					
Payables	-	34,426	-	-	34,426
Other Financial Liabilities[1]	-	2,222	-	-	2,222
Total Financial Liabilities	**-**	**36,648**	**-**	**-**	**36,648**
Net Financial Asset/Liabilities	**-**	**41,631**	**300**	**64,209**	**(22,878)**

2016					
Financial Assets					
Cash and Cash Equivalents	2.6	16,679	-	16,666	13
Receivables					
Trade Debtors	-	2,164	-	-	2,164
Patient Fees	-	5,742	-	-	5,742
Other Receivables[1]	-	6,951	-	-	6,951
Other Financial Assets					
Managed Funds	2.4	45,101	-	45,101	-
Shares in Other Entities	-	1	-	-	1
Total Financial Assets		**76,638**	**-**	**61,767**	**14,871**
Financial Liabilities					
At amortised cost					
Payables	-	32,432	-	-	32,432
Other Financial Liabilities[1]	-	1,072	-	-	1,072
Total Financial Liabilities	**-**	**33,504**	**-**	**-**	**33,504**
Net Financial Asset/Liabilities	**-**	**43,134**	**-**	**61,767**	**(18,633)**

(i) The carrying amount exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable)

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES (CONTINUED)

Notes to the Financial Statements

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 100 basis points up and down in market interest rates (AUD) from year-end rates
- A parallel shift of +1% and -1% in inflation rate from year-end rates
- A movement of 15% up and down (2016: 15%) for the top ASX 200 index

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.

2017	CARRYING AMOUNT	INTEREST RATE RISK				OTHER PRICE RISK			
		-1%		+1%		-15%		+15%	
		PROFIT $'000	EQUITY $'000	PROFIT $'000	EQUITY $'000	PROFIT $'000	EQUITY $'000	PROFIT $'000	EQUITY $'000
Financial Assets									
Cash and Cash Equivalents	17,581	(176)	(176)	176	176	-	-	-	-
Receivables[(i)]									
- Trade Debtors	2,863	-	-	-	-	-	-	-	-
- Patient Fees	6,259	-	-	-	-	-	-	-	-
- Other Receivables[(i)]	4,631	-	-	-	-	-	-	-	-
Other Financial Assets									
- Term Deposit	300	(3)	(3)	3	3				
- Managed Funds	46,628	-	-	-	-	(6,994)	(6,994)	6,994	6,994
- Shares in Other Entities	1	-	-	-	-	-	-	-	-
Total Financial Assets	**78,263**	**(179)**	**(179)**	**179**	**179**	**(6,994)**	**(6,994)**	**6,994**	**6,994**
Financial Liabilities									
Payables	34,426	-	-	-	-	-	-	-	-
Other Financial Liabilities[(i)]	2,222	-	-	-	-	-	-	-	-
Total Financial Liabilities	**36,648**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net Financial Asset/Liabilities	**41,615**	**(179)**	**(179)**	**179**	**179**	**(6,994)**	**(6,994)**	**6,994**	**6,994**
2016									
Financial Assets									
Cash and Cash Equivalents	16,666	(167)	(167)	167	167	-	-	-	-
Receivables[(i)]									
- Trade Debtors	2,164	-	-	-	-	-	-	-	-
- Patient Fees	5,742	-	-	-	-	-	-	-	-
- Other Receivables[(i)]	6,951	-	-	-	-	-	-	-	-
Other Financial Assets									
- Managed Funds	45,101	-	-	-	-	(6,765)	(6,765)	6,765	6,765
- Shares in Other Entities	1	-	-	-	-	-	-	-	-
Total Financial Assets	**76,625**	**(167)**	**(167)**	**167**	**167**	**(6,765)**	**(6,765)**	**6,765**	**6,765**
Financial Liabilities									
Payables	32,432	-	-	-	-	-	-	-	-
Other Financial Liabilities[(i)]	1,072	-	-	-	-	-	-	-	-
Total Financial Liabilities	**33,504**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net Financial Asset/Liabilities	**43,121**	**(167)**	**(167)**	**167**	**167**	**(6,765)**	**(6,765)**	**6,765**	**6,765**

(i) The carrying amount exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable)

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES (CONTINUED)

Notes to the Financial Statements

(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 financial assets include holdings in unlisted shares. Fair value of these is determined by projecting future cash inflows from expected future dividends and subsequent disposal of the securities. These cash flows are then discounted back to their present value.

The Health Service considers that the carrying amount of financial instrument 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 2017 $'000	FAIR VALUE 2017 $'000	CARRYING AMOUNT 2016 $'000	FAIR VALUE 2016 $'000
Financial Assets				
Cash and Cash Equivalents	17,597	17,597	16,679	16,679
Receivables[(i)]				
- Trade Debtors	2,863	2,863	2,164	2,164
- Patient Fees	6,259	6,259	5,742	5,742
- Other Receivables[(i)]	4,631	4,631	6,951	6,951
Other Financial Assets				
- Term Deposit	300	300	-	-
- Managed Funds	46,628	46,628	45,101	45,101
- Shares in Other Entities	1	1	1	1
Total Financial Assets	**78,279**	**78,279**	**76,638**	**76,638**
Financial Liabilities				
Payables	34,426	34,426	32,432	32,432
Other Financial Liabilities[(i)]	2,222	2,222	1,072	1,072
Total Financial Liabilities	**36,648**	**36,648**	**33,504**	**33,504**

(i) The carrying amount exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable)

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 the Health Service, Goods and Services Tax ("GST") receivables and DHHS grants 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 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

Financial assets and liabilities at fair value through profit or loss

Financial assets are categorised as fair value thorugh profit or loss at trade date if they are classified as held for trading or designated as such upon initial recognition. Financial instrument assets are designated at fair value through profit or loss on the basis that the financial assets form part of a group of financial assets that are managed by the entity concerned based on their fair value, and have their performance evaluated in accordance with documented risk management and investment strategies.

Financial instruments at fair value through profit or loss are initially measured at fair value and attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net results.

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 includes cash and deposits (refer to Note 6.2), trade receivables, loans and other receivables, but not statutory receivables.

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. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised in "other comprehensive income" 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. Fair value is determined in the manner described in Note 7.1.

Financial liabilities at amortised 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 interest rate method.

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.

Offsetting financial instruments

Financial instrument assets and liabilities are offset and the net amount presented in the balance sheet when, and only when, the Health Service has a legal right to offset the amounts and intend to settle on a net basis or to realise the asset and settle the liability simultaneously.

Net gain/(loss) on financial instruments

Net gain/(loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through profit or loss;
- impairment and reversal of impairment for financial instruments at amortised cost; and
- disposals of financial assets and derecognition of financial liabilities.

Revaluation of financial instrument at fair value

The revaluation gain/(loss) on financial instruments at fair value excludes interest earned on financial assets.

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES (CONTINUED)

Notes to the Financial Statements

NOTE 7.2: NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS

	2017 $'000	2016 $'000
Proceeds from Disposal of Non-Current Assets		
Medical Equipment	-	-
Non-Medical Equipment	3	-
Total Proceeds from Disposal of Non-Current Assets	**3**	**-**
Less: Written Down Value of Non-Current Assets Sold		
Medical Equipment	44	-
Non-Medical Equipment	3	4
Total Written Down Value of Non-Current Assets Sold	**47**	**4**
Net loss on Disposal of Non-Financial Assets	**(44)**	**(4)**

Disposal of Non-Financial Assets

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to Note 1 - "comprehensive income".

Impairment of Non-Financial Assets

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 amount exceeds their possible recoverable amount. Where an asset's carrying amount exceeds its recoverable amount, the difference is written-off as an expense except to the extent that the write-down can be deducted from an asset revaluation surplus amount applicable to that same class of asset.

If there is an indication that there has been a reversal 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.

In the event of the loss or destruction of an asset, it is deemed that 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 less costs of disposal. The 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 costs of disposal.

NOTE 7.3: CONTINGENT ASSETS & CONTINGENT LIABILITIES

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

	2017 $'000	2016 $'000
Contingent Assets		
The Directors are not aware of any quantifiable or non-quantifiable contingent assets	-	-
	-	**-**
Contingent Liabilities		
Quantifiable		
Recallable capital grant - Car Park System	260	520
Total Quantifiable Contingent Liabilities	**260**	**520**
Non-Quantifiable	**-**	**-**

All amounts shown in contingents note are nominal amounts inclusive of GST, where applicable.

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, where applicable.

NOTE 7.4: FAIR VALUE DETERMINATION

ASSET CLASS	EXAMPLES OF TYPES OF ASSETS	EXPECTED FAIR VALUE LEVEL	LIKELY VALUATION APPROACH	SIGNIFICANT INPUTS (LEVEL 3 ONLY)
Non-Specialised Land	In areas where there is an active market: - vacant land - land not subject to restrictions as to use or sale	Level 2	Market approach	N/A
Specialised Land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market approach	CSO adjustments
Non-Specialised Buildings	For general/commercial buildings that are just built	Level 2	Market approach	N/A
Specialised Buildings	Specialised buildings with limited alternative uses and/or substantial customisation, e.g. hospitals	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Infrastructure	Any type	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and Equipment	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Useful life
Vehicles	If there is an active resale market available; If there is no active resale market available	Level 2 Level 3	Market approach Depreciated replacement cost approach	N/A Useful life

NOTE 8: OTHER DISCLOSURES

Notes to the Financial Statements

This section includes additional material disclosures required by accounting standards or otherwise, for the understanding of this financial report.

STRUCTURE

NOTE 8.1: EQUITY

	2017 $'000	2016 $'000
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus[i]		
Balance at the beginning of the reporting period	302,777	294,114
Revaluation Increment/(Decrement)		
- Land	3,464	8,663
- Buildings	-	-
Balance at the end of the reporting period	**306,241**	**302,777**
Represented by:		
- Land	66,377	62,913
- Buildings	239,864	239,864
	306,241	**302,777**
Financial Assets Available-for-Sale Revaluation Surplus [ii]		
Balance at the beginning of the reporting period	101	-
Valuation gain recognised	528	101
Cumulative gain transferred to Operating Statement on sale of financial asset	(108)	-
Balance at the end of the reporting period	**521**	**101**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	2,892	2,398
Transfer from Accumulated Surplus	1,387	510
Share of decrements in surplus attributed to joint venture	-	(16)
Balance at the end of the reporting period	**4,279**	**2,892**
Total Surpluses	**311,041**	**305,770**
(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	11,296	37,636
Net Result for the Year	117	(25,830)
Transfers to Restricted Specific Purpose Surplus	(1,387)	(510)
Balance at the end of the reporting period	**10,026**	**11,296**
Total Equity at end of financial year	**524,047**	**520,046**

(i) The property, plant and equipment asset revaluation surplus arises on the revaluation of land and buildings.

(ii) The financial assets available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets.

NOTE 8: OTHER DISCLOSURES (CONTINUED)

Notes to the Financial Statements

Contributed Capital

Consistent with Australian Accounting Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public Sector Entities and FRD 119A 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 to or distributions by owners that have been designated as contributed capital are also treated as contributed capital. Contributed capital consists of grants received from the owners i.e. the DHHS, no contributed capital was received in the 2016/17 financial year.

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.

NOTE 8.2: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES

	2017 $'000	2016 $'000
Net Result For The Year	**117**	**(25,830)**
Non-cash movements:		
Depreciation and Amortisation	40,568	40,470
Revaluation of Long Service Leave	(4,678)	9,754
Provision for Doubtful Debts	1,512	1,827
Movements included in investing and financing activities:		
Net (Gain)/Loss from Disposal of Non Financial Physical Assets	44	4
Net (Gain)/Loss from Disposal of Financial Assets	(108)	-
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/Decrease in Receivables	1,101	(2,041)
(Increase)/Decrease in Other Assets	(2,662)	(10,977)
(Increase)/Decrease in Prepayments	(1,417)	719
Increase/(Decrease) in Payables	1,997	13,198
Increase/(Decrease) in Provisions	11,397	(262)
Increase/(Decrease) in Other Liabilities	1,151	-
Change in Inventories	(336)	301
NET CASH INFLOW FROM OPERATING ACTIVITIES	**48,686**	**27,163**

NOTE 8.3: 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 Jill Hennessy, Minister for Health, Minister for Ambulance Services	1/07/2016 - 30/06/2017
Governing Board	
The Honourable Bronwyn Pike (Chair)	1/07/2016 - 30/06/2017
Professor Colin Clark	1/07/2016 - 30/06/2017
Mrs Elleni Bereded-Samuel	1/07/2016 - 30/06/2017
Mrs Patricia Carolyn Vejby	1/07/2016 - 30/06/2017
Dr Robert Mitchell	1/07/2016 - 30/06/2017
Dr Phuong Pham	1/07/2016 - 30/06/2017
Mr Kelvyn Lavelle	1/07/2016 - 30/06/2017
Dr Catherine Hutton	1/07/2016 - 30/06/2017
Ms Colleen Gates	1/07/2016 - 30/06/2017
Accountable Officers	
Associate Professor Alex Cockram	1/07/2016 - 30/04/2017
Mr Russell Harrison	1/05/2017 - 30/06/2017

	2017 NO.	2016 NO.
Remuneration of Responsible Persons		
The number of Responsible Persons are shown in their relevant income bands:		
Income Band		
$0 - $9,999	3	2
$10,000 - $19,999	0	1
$20,000 - $29,999	0	1
$30,000 - $39,999	1	7
$40,000 - $49,999	7	0
$50,000 - $59,999	1	0
$60,000 - $69,999	0	1
$70,000 - $79,999	1	0
$480,000 - $489,999	1	0
$490,000 - $499,999	0	1
Total Numbers	**14**	**13**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$982,146**	**$836,461**

Note: Remuneration includes payments made up to 30 June 2017 to Directors that have resigned as at 30 June 2016

NOTE 8: OTHER DISCLOSURES (CONTINUED)

Notes to the Financial Statements

NOTE 8.4: EXECUTIVE OFFICER DISCLOSURES

Remuneration of Executives

The numbers of executive officers, other than Ministers and Accountable Officer, and their total remuneration during the reporting period are shown in the table below. Total annualised employee equivalent provides a measure of full time equivalent executive officers over the reporting period.

Remuneration comprises employee benefits in all form of consideration paid, payable or provided in exchange for services rendered, and is disclosed in the following categories.

Short-term employee benefits include amounts such as wages, salaries, annual leave or sick leave that are usually paid or payable on a regular basis, as well as non-monetary benefits such as allowances and free or subsidised goods or services.

Post-employment benefits include pensions and other retirement benefits paid or payable on a discrete basis when employment has ceased.

Other long-term benefits include long service leave, other long service benefit or deferred compensation.

Termination benefits include termination of employment payments, such as severance packages.

Share-based payments are cash or other assets paid or payable as agreed between the Health Service and the employee, provided specific vesting conditions, if any, are met.

Several factors affected total remuneration payable to executives over the year. A number of employment contracts were completed during the year and negotiated and a number of executives received bonus payments during the year. These bonus payments depend on the terms of individual employment contracts. Some contracts provide for an annual bonus payment whereas other contracts only include the payment of bonuses on the successful completion of the full term of the contract. A number of these contract completion bonuses became payable during the year.

A number of executive officers retired, resigned or were retrenched in the past year. This has had an impact on total remuneration figures due to the inclusion of annual leave, long-service leave and retrenchment payments.

REMUNERATION OF EXECUTIVE OFFICERS (INCLUDING KEY MANAGEMENT PERSONNEL DISCLOSED IN NOTE 8.5)	TOTAL REMUNERATION	
	2017 $'000	2016 $'000
Short-term employee benefits	$6,840	
Post-employment benefits	$619	
Other long-term benefits	$224	
Total remuneration[i][ii]	**$7,683**	
Total number of executives	**41**	**40**
Total annualised employee equivalent (AEE)[iii]	**37**	**33**

Notes:

(i) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD 21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-16 reporting period.

(ii) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the Health Service under AASB 124 Related Party Disclosures and are also reported within the related parties note disclosure (8.5).

(iii) Annualised employee equivalent is based on the time fraction worked over the reporting period.

NOTE 8.5: RELATED PARTIES

The Health Service is a wholly owned and controlled entity of the State of Victoria. Related parties of the Health Service include:

- all key management personnel and their close family members;
- all cabinet ministers and their close family members; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of State Consolidated Financial Statements.

All related party transactions have been entered into on an arm's length basis.

Significant Transactions with Government-Related Entities

The Health Service received funding (direct and indirect) from the Department of Health and Human Services of $639 million (2016: $584 million).

During the year, the Health Service had the following government-related entity transactions:

- received funding of $1 million (2016: $1 million) from the Department of Early Education and Childhood Development for Paediatric Allied Health.
- invested $46 million (2016: $45 million) with Victorian Funds Management Corporation.

Key management personnel (KMP) of the Health Service include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the Health Service. The Minister's remuneration and allowances is set by the *Parliamentary Salaries and Superannuation Act 1968*, and is reported within the Department of Parliamentary Services' Financial Report.

COMPENSATION	2017 $'000
Short-term employee benefits	3,135
Post-employment benefits	219
Other long-term benefits	77
Total	**3,431**

Transactions with Key Management Personnel and Other Related Parties

Given the breadth and depth of State Government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public, such as stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the *Public Administration Act 2004* and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with the Department of Health and Human Services, there were no related party transactions that involved key management personnel, their close family members and their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

All other transactions that have occurred with KMP and their related parties have been trivial or domestic in nature. In this context, transactions are only disclosed when they are considered of interest to users of the financial report in making and evaluating decisions about the allocation of scare resources.

NOTE 8.6: REMUNERATION OF AUDITORS

	2017 $'000	2016 $'000
Victorian Auditor-General's Office		
Audit of financial statement	117	131
Acquittal audit - WHCRE and Cultural Key Phrases Project	-	7
Other Providers		
Internal Audit	210	198
	327	**336**

NOTE 8: OTHER DISCLOSURES (CONTINUED)

Notes to the Financial Statements

NOTE 8.7: AASBS ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards have been published that are not mandatory for the 30th June 2017 reporting period. The Department of Treasury and Finance assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30th June 2017, 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 OR ENDING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 9 Financial instruments	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 Jan 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. While there will be no significant impact arising from AASB 9, there will be a change to the way financial instruments are disclosed.
AASB 10-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: – The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and – Other fair value changes are presented in profit or loss. If this approach creates or enlarges an accounting mismatch in the profit and loss, the effect of the changes in credit risk are also presented in profit or loss."	1 Jan 2018	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 Jan 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 Jan 2018	The assessment has indicated that there will be no impact for the public sector.

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING OR ENDING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.
AASB 2016-7 Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit Entities	This Standard defers the mandatory effective date of AASB 15 for not-fot-profit entities from 1 January 2018 to 1 January 2019	1 Jan 2018	This assessment has indicated that there will be no significant impact for the public sector, other than the impact identified in AASB 15.
AASB 2016-3 Amendments to Australian Accounting Standards - Clarifications to AASB 15	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: - a promise to transfer to a customer a good or service that is "distinct" to be recognised as a separate performance obligation; - for items purchased online, the entity is a principal if it obtains control of the good or service prior to the transferring to the customer; and - for licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right of use) or at a point in time (right of access).	1 Jan 2018	This assessment has indicated that there will be no significant impact for the public sector, other than the impact identified in AASB 15 above.
AASB 2016-7 Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit Entities	This Standard defers the mandatory effective date of AASB 15 for not-fot-profit entities from 1 January 2018 to 1 January 2019	1 Jan 2019	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 Amendments to Australian Accounting Standards - Australian Implementation Guidance for Not-for-Profit Entities	This Standard amends AASB 9 and 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments: - require non-contractual receivables arising from statutory requirements (i.e. taxes, rates and fines) to be initially measured and recognised in accordance with AASB 9 as if those receivables are financial instruments; and - clarifies circumstances when a contract with a customer is within the scope of AASB 15.	1 Jan 2019	The assessment has indicated that there will be no significant impact for the public sector, other than the impacts identified for AASB 9 and AASB 15 above.

NOTE 8: OTHER DISCLOSURES (CONTINUED)

Notes to the Financial Statements

STANDARD / INTERPRETATION	SUMMARY	APPLICABLE FOR ANNUAL REPORTING PERIODS BEGINNING OR ENDING ON	IMPACT ON FINANCIAL STATEMENTS
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 Jan 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of-use assets and lease liabilities will cause net debt to increase. Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. No change for lessors.
AASB 2016-4 Amendments to Australian Accounting Standards - Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities	The Standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	1 Jan 2017	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136.
AASB 1058 Income of Not-for-Profit Entities	This Standard replaces AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entity to further its objectives.	1 Jan 2019	This assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change.

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2016-17 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

- AASB 2016-2 *Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107*
- AASB 2016-5 *Amendments to Australian Accounting Standards – Classifications and Measurement of Share-based Payment Transactions*
- AASB 2016-6 *Amendments to Australian Accounting Standards – Applying AASB 9 Financial Instruments with AASB 4 Insurance Contracts*
- AASB 2017-1 *Amendments to Australian Accounting Standards – Transfers of Investment Property, Annual Improvements 2014–2016 Cycle and Other Amendments*
- AASB 2017-2 *Amendments to Australian Accounting Standards – Further Annual Improvements 2014–16 Cycle*

NOTE 8.8: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

Assets, liabilities, income or expenses arise from past transactions or other past events. Where the transactions result from an agreement between the Health Service and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reproting period.

Adjustments are made to amounts recognised in the financial statements for events which occur between the end of the reporting period and the date when the financial statements are authorised for issue, where those events provide information about conditions which existed at the reporting date. Note disclosure is made about events between the end of the reproting period and the date the financial statements are authorised for issue where the events relate to conditions which arose after the end of the reporting period that are considered to be of material interest.

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

NOTE 8.9: CONTROLLED ENTITY

Controlled Entity in 2017

NAME OF ENTITY	PRINCIPAL ACTIVITY	COUNTRY OF INCORPORATION	EQUITY HOLDING
Western Health Foundation Limited	Managing fundraising and philanthropic activities on behalf of the Health Service	Australia	Limited by Guarantee

Controlled Entity in 2016

NAME OF ENTITY	PRINCIPAL ACTIVITY	COUNTRY OF INCORPORATION	EQUITY HOLDING
Western Health Foundation Limited	Managing fundraising and philanthropic activities on behalf of the Health Service	Australia	Limited by Guarantee

AUDITOR-GENERAL'S REPORT

Independent Auditor's Report

VAGO
Victorian Auditor-General's Office

To the Board of Western Health

Opinion

I have audited the consolidated financial report of Western Health (the health service) and its controlled entities (together the consolidated entity), which comprises the:

- consolidated balance sheet as at 30 June 2017
- consolidated comprehensive operating statement for the year then ended
- consolidated statement of changes in equity for the year then ended
- consolidated cash flow statement for the year then ended
- notes to the financial statements, including a summary of significant accounting policies
- board member's, accountable officer's and chief financial officer's declaration.

In my opinion, the financial report presents fairly, in all material respects, the financial position of the consolidated entity as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.

Basis for Opinion

I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. My responsibilities under that Act and those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

My independence is established by the *Constitution Act 1975*. My staff and I are independent of the consolidated entity in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.

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

Board's responsibilities for the financial report

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

In preparing the financial report, the Board is responsible for assessing the consolidated entity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

Level 31 / 35 Collins Street, Melbourne Vic 3000
T 03 8601 7000 enquiries@audit.vic.gov.au www.audit.vic.gov.au

Auditor's responsibilities for the audit of the financial report

As required by the *Audit Act 1994,* my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

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

- identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the consolidated entity's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board
- conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the consolidated entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the consolidated entity to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation
- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the consolidated entity to express an opinion on the financial report. I remain responsible for the direction, supervision and performance of the audit of the consolidated entity. I remain solely responsible for my audit opinion.

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

MELBOURNE
21 August 2017

Charlotte Jeffries
as delegate for the Auditor-General of Victoria

NOTES

TOGETHER, CARING FOR THE WEST

FOOTSCRAY HOSPITAL

Gordon Street
Footscray VIC 3011
Locked Bag 2
Footscray VIC 3011
8345 6666

SUNSHINE HOSPITAL

Furlong Road
St Albans VIC 3021
PO Box 294
St Albans VIC 3021
8345 1333

SUNSHINE HOSPITAL RADIATION THERAPY CENTRE

176 Furlong Road
St Albans VIC 3021
8395 9999

WESTERN CENTRE FOR HEALTH RESEARCH AND EDUCATION

Sunshine Hospital
Furlong Road
St Albans VIC 3021
8345 1333

SUNBURY DAY HOSPITAL

7 Macedon Road
Sunbury VIC 3429
9732 8600

WILLIAMSTOWN HOSPITAL

Railway Crescent
Williamstown VIC 3016
9393 0100

DRUG HEALTH SERVICES

3-7 Eleanor Street
Footscray VIC 3011
8345 6682

HAZELDEAN TRANSITION CARE

211-215 Osborne Street
Williamstown VIC 3016
9397 3167

Western Health

www.westernhealth.org.au