ANNUAL REPORT 2017-18

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 excellence

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 and Custodians, on which all of our sites stand, the Wurundjeri and Boon Wurrung peoples of the Kulin Nation.

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Board Chair and CEO Message

A message from the Board Chair and the Chief Executive

It has been an exciting and productive year for Western Health. We are starting to see the results of our organisation's hard work and years of planning and community effort to have new hospitals built in Melbourne's west.

As the population of our region grows at unprecedented rates, our services and facilities continue to be stretched and we are determined to provide the Best Care that our community deserves.

Our reputation in healthcare research continues to grow, with many of our staff receiving state, national and international recognition for their work.

Most importantly, our initiatives to improve patient care are receiving positive feedback from those who matter most—our patients, our staff, our community.

REBUILDING FOOTSCRAY HOSPITAL

Footscray Hospital has been at the heart of our community for 65 years. We need a modern facility to match the excellent care provided by our staff and supported by our volunteers.

In May, our planning for a new Footscray Hospital reached a key milestone. We received welcome news in the 2018 State Budget that the Victorian Government has provided funds to purchase land for a new hospital. A decision about the chosen site will be made soon. Rebuilding Footscray Hospital has long been a top priority for our community and securing funding for its rebuild remains at the top of the Board and Executive team's agenda.

BETTER SERVICES AND ENVIRONMENTS FOR WOMEN AND CHILDREN

It has been wonderful to watch the new Joan Kirner Women's & Children's Hospital rise from the ground. Construction is due to be completed and the new facility opened in 2019.

Western Health's new drop-in immunisation service offering pregnant women free immunisations against the flu and whooping cough has been a great success, with more than 6,000 vaccinations administered since the service started in July 2017. Consumer feedback has been overwhelmingly positive, with many praising the convenience and accessibility of the service. Maternal immunisation is an increasingly important strategy to protect mothers and babies from developing serious illnesses.

IMPROVING TIMELY ACCESS TO CARE

Providing timely access to safe and effective patient care for a rapidly growing population with complex health needs, continues to present our health service with big challenges. Record numbers of patients are attending our emergency departments and using our maternity services. Record numbers of patients are being added to our elective surgery and outpatient service waiting lists. We are also seeing sicker patients seeking care, compared with previous years. This trend has led to an increase in patients arriving by ambulance and rising numbers of patients needing admission to our inpatient services.

We continue to implement patient access improvement plans to deal with these challenges. Western Health is also working with Better Care Victoria in projects to improve patient flow and patient wait times in high demand areas such as our emergency departments and outpatient services.

Sunshine Hospital's Emergency Department has reached capacity. We are therefore very pleased that the hospital will be getting a much bigger and better emergency department, thanks to a $29.6 million redevelopment funded by the State Government. The funding, announced in the May 2018 State Budget, means Sunshine Hospital's redeveloped emergency department, once completed by early 2021, will have capacity to treat an extra 59,000 emergency patients per year.

There has been significant demand from patients seeking mental health care in our emergency departments over the past year. Department of Health and Human Services personnel have visited our Footscray and Sunshine Hospital emergency departments to review and appreciate the challenges for patients and staff when patients experience long delays in accessing mental health beds. We continue to work closely with the Department and with the agencies that provide mental health services to our patients (Mercy Mental Health and North West Mental Health) to support the needs of this vulnerable patient group. The May 2018 State Budget has nominated Sunshine Hospital as one of six metropolitan sites to become emergency department mental health crisis hubs.

Board Chair and CEO Message (continued)

IMPROVING WILLIAMSTOWN HOSPITAL

The Heart of Williamstown Appeal, aimed at transforming the public spaces of the Williamstown Hospital, has received generous support from the community. Thanks to the leadership of local leaders, including the former Victorian premier and patron of the appeal, The Hon Steve Bracks, the fund has now reached the $2.2 million target to begin construction of the new spaces.

The project will significantly improve amenities for patients, visitors and staff. The Western Health Foundation generated the appeal and continues to manage it.

TACKLING CHRONIC DISEASE

Our pilot of the Western HealthLinks program is helping us to address the challenges posed by rapid growth in demand for our services. This innovative program, made possible through a new funding option provided by the Victorian Government, has allowed us to take a different approach on how we manage the needs of patients with complex illnesses. It aims to help these patients remain in their homes and avoid preventable hospital admissions.

At the 12-month mark of the pilot program, over three thousand patients have been identified for enrolment in the program, run in collaboration with the Silver Chain Group. Feedback from patients and their carers involved in the program has been consistently positive.

In December 2017 Western Health launched an important alliance to improve the early detection and management of chronic diseases such as chronic kidney disease, diabetes and cardiovascular disease.

The Western Health Chronic Disease Alliance is an evolving partnership between Western Health, the University of Melbourne's Health Economics Unit, Kidney Health Australia, Diabetes Victoria, Heart Foundation, Primary Healthcare Network and Victoria University's Department of Population Health.

The research from the Alliance complements the objectives and aims of the HealthLinks project and the wide range of Western Health's other work that supports tens of thousands of chronic disease patients every year.

DOING MORE TO HELP VULNERABLE MEMBERS OF OUR COMMUNITY

The vulnerability of many of our patients extends beyond their immediate healthcare needs to include issues such as family violence or sexual abuse. During the year we brought together a Health Equity Team to oversee Western Health's role in the Victorian Government's "10-year action plan" on family violence. Our team is leading a series of measures to tackle family violence, including strengthened screening and risk assessment procedures, greater workforce training and development, and better co-ordination and information sharing between different parts of the health-care system.

We have also secured funding from the Department of Health and Human Services for an Elder Abuse Project Officer to support the implementation of staff education, policy development and systems implementation to do more to combat elder abuse.

Western Health's specialist dental service, run in partnership with Dental Health Services Victoria, is the only service of its kind in the state to provide dental care for patients with an intellectual disability and other complex medical conditions. We were delighted that this unique service's important work was recognised at the 2017 Victorian Public Healthcare Awards when it won the Safer Care Victoria "Compassionate Care" Award.

THE GREATEST NEED PROJECT

We serve a region of Melbourne that includes some of Australia's most disadvantaged areas, where rates of many chronic diseases are well above the national average.

Many of our patients experience disadvantage so extreme that they cannot meet their most basic needs. This is why Western Health launched a new fundraising and story-sharing website, The Greatest Need Project. The initiative aims to raise funds to help patients suffering severe hardship, while also raising funds to support the health research we undertake at Western Health.

PROVIDING BEST CARE

Our vision of 'Best Care' is that we work together and in partnership with our patients to achieve high quality care that is safe, person-centred, right and co-ordinated. Therefore, it was pleasing that Western Health received a very positive report from the Australian Council on Healthcare Standards after taking part in a November 2017 accreditation survey on National Standards for safety and quality.

Listening and responding to concerns from patients and carers about clinical care is an integral part of the Best Care approach. In 2017 Western Health developed a "Call for Help" program. Attracting positive user feedback, it allows patients, families and carers to activate the system if they feel their concerns about clinical deterioration have not been adequately addressed by clinical staff.

Board Chair and CEO Message (continued)

IMPROVING OUR COMMUNICATION WITH PATIENTS

All adult inpatient wards will now be able to use a bespoke version of Western Health's award-winning CALD assist app that helps non-English speaking patients communicate with staff. The app was designed originally for allied health staff but has now been adapted for nursing staff. The app makes it easier for nurses to communicate with non-English speaking patients during basic care interactions.

To improve access to interpreters, Western Health has also begun a trial of video-interpreting in our Women's and Children's Services. An app has been developed in partnership with VITS, an external provider of interpreting services, which connects the interpreter with the care provider and patient.

From early November 2017, Western Health has been uploading discharge summaries to the My Health Record. This Australian Government Scheme (for patients who have registered) is a secure online summary of health information where the patient controls what goes into the summary and who is allowed to access it. About 200 discharge summaries of patients are currently being uploaded per month to the My Health Record.

GLOBAL ACCLAIM FOR OUR CANCER RESEARCHERS

Two Western Health Oncologists and hundreds of Western Health patients have contributed to a global breakthrough in cancer research. Professor Peter Gibbs and Associate Professor Jean Tie are part of an international team that has developed a blood test for eight common cancers. Their work received worldwide media coverage in January 2018 because of its potential to revolutionise the early detection and treatment of these common cancers.

Sunshine Hospital was one of five venues chosen to host the Victorian Comprehensive Care Centre's (VCCC) first international cancer research conference in September 2017. The conference featured a stellar line-up of 75 distinguished speakers from Australia and overseas. A committee of research leaders from all 10 VCCC partners, including Western Health, organised the conference.

Our roles as a VCCC Partner and conference host are indicative of our growing reputation in research. Further details about Western Health's broader research achievements can be found in our annual Research Report, located on our website.

AUSTRALIA'S FIRST CANCER POP-UP SHOP

We opened Australia's first cancer pop-up shop at Sunshine Plaza for four weeks over February-March 2018. The *Let's Talk About Cancer* pop-up shop was a great success. It provided a welcoming space for people to come in and talk to friendly, trained staff and volunteers about how to prevent and detect cancer. The shop was a partnership between Western Health, North Western Melbourne Primary Health Network, IPC Health, Cancer Council Victoria and the State Government.

OUR WONDERFUL VOLUNTEERS

Western Health is immensely grateful to the 650+ volunteers, as well as 12 local schools and eight community groups, who generously donate their time and resources to support our patients and staff. Jo Spence, our Community Engagement and Volunteers Manager, was honoured in December 2017 with a prestigious award from the Australasian Association for Managers of Volunteers, winning the 2017 Volunteer Manager Award of Excellence.

SUPPORTING A POSITIVE WORKPLACE

It is important that our staff and patients experience a positive workplace. We are continuing to implement our "Sustaining a Positive Workplace" Strategy. Our EMPOWIR tool was launched between June and August 2017. EMPOWIR is our Employee Positive Workplace Issue Resolution Tool that gives all employees and volunteers a no blame and non-disciplinary pathway to resolve workplace problems involving inappropriate behaviour that may affect them or their colleagues. Positive Workplace Contact and Issue Resolution Officers have been trained to support the use of EMPOWIR. Staff have responded positively to this initiative.

DEVELOPING OUR WORKFORCE

In January 2018, our Nursing and Midwifery Team began a "Target 150" project to recruit an additional 150 nurses to the supplementary workforce that covers vacant shifts on our inpatient wards. Since then, over 190 staff members have been added to our supplementary workforce. The additional staff have significantly decreased our reliance on external agency staff to care for our patients.

Work has also started on developing a new Nursing and Midwifery Strategic Workforce Plan. This plan will take into account changes in demand for services, workforce demographics, workforce patterns and trends across Australia to inform our decision making and planning.

Western Health welcomed its first Aboriginal school-based trainees in September 2017, as part of its commitment to *Closing the Gap.* Students who complete the 12-month traineeships will earn a Certificate Three in Business. The program aims to help students develop workplace skills, knowledge, confidence and opportunities to explore future careers in healthcare, while providing insight into the daily operation of a large and rapidly growing health service.

Board Chair and CEO Message (continued)

PREVENTING OCCUPATIONAL VIOLENCE

Western Health recognises the potential for occupational violence and aggression (OVA) to occur in a health care setting. We are committed to promoting a safe environment in our workplace for staff, patients and visitors. We have reviewed our OVA Action Plan, with the help of the Department of Health and Human Services ' strategies and guidelines.

We are implementing processes to prevent and effectively manage OVA. These cover such areas as security, identifying the risk of violence, engaging families in aggression management planning, learning from incidents of violence and raising staff awareness and education on OVA.

STRIVING FOR SUSTAINABILITY

We continue to be a leader in environmental sustainability among Victoria's hospitals. In October 2017, Western Health won the major health prize at the Victorian Premier's Sustainability Awards. The Single Use Metal Instruments (SUMI) recycling program, rolled out across all Western Health sites in 2016, was recognised as the best sustainability initiative developed by a public health organisation.

Our orthopaedic plastic technicians have developed an 'orthopaedic splint reuse program', in collaboration with suppliers and partner international aid organisation, Donations in Kind. This waste minimisation project collects casts and splints for re-use as part of Rotary International's Aid Program.

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

INTRODUCING AN ELECTRONIC MEDICAL RECORD

The past year saw Western Health continue 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.

A SUSTAINABLE APPROACH TO OUR FINANCES

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 $45 thousand in the 2017-18 year in a budget of over $800 million and we continue to have a strong cash position.

THANKS

Finally, we would like to thank Western Health's incredible staff, volunteers and board members, as well as our many community stakeholders, including our local members of parliament at both the State and Commonwealth levels.

Thank you to the Department of Health and Human Services and the Victorian Government. Thank you to our 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 2018.

The Hon Bronwyn Pike
Chair of the Board, Western Health
10 August 2018

Russell Harrison
Chief Executive, Western Health
10 August 2018

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 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 over 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 approximately 6,500 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 over 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.

SUNSHINE HOSPITAL

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

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, research and simulation laboratory 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. 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. Western Health is a Registered Training Organisation (RTO) that offers high quality training. Our training is aimed at professional development and offers innovative, valuable and accredited programs that are evaluated externally.

FOOTSCRAY HOSPITAL

Footscray Hospital is an acute and subacute teaching hospital with approximately 300 beds. It provides elective and emergency services. with a range of inpatient and outpatient services including acute general medical and surgical, intensive and coronary care, sub-specialty medicine, surgical services, rehabilitation and aged care and related clinical support.

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.

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.

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 SERVICES

Drug Health Services provide a diverse range of services for individuals and families affected by substance abuse related problems. As a community-based program of Western Health, Drug Health Services offers an innovative mix of inpatient and outpatient client-centred recovery programs. Our non-residential services include specialist programs for Adult, Women, Young People and their families, and are delivered in both office-based and outreach modes, depending on client need. Community-based Residential Withdrawal Services are available for both Adults and Young People. Services are currently offered from our Footscray based sites. A 20-bed Dual Diagnosis Residential Rehabilitation Centre will be open later in 2018 at Westside Lodge in St Albans. We also offer access to Addiction Medicine Consultants and Nurse Practitioners to support people with substance dependence issues.

Western Health Statement of Priorities 2017-18

Each year, Western Health identifies how it will contribute to Victorian Government policy directions and priorities. The following tables list outcomes against deliverables for 2017/18 agreed between our health service and the Minister for Health.

BETTER HEALTH

GOALS	STRATEGIES	WESTERN HEALTH DELIVERABLES	OUTCOME
A system geared to prevention as much as treatment Everyone understands their own health and risks Illness is detected and managed early Healthy neighborhoods and communities encourage healthy lifestyles	Reduce statewide risks Build healthy neighborhoods Help people to stay healthy Target health gaps	Progress implementation of Western Health's Health Equity Roadmap, with a focus in 2017-18 on organisation-wide roll-out of Family Violence and Child Safe Standards, including embedding a culture supporting recognition and response to vulnerable patients, delivering a manager training program, and redrafting of related Western Health policy and procedure.	**ACHIEVED** Implementation of the organisation's Health Equity Roadmap has progressed with a Project Team well established and overseeing the review of over 100 procedures across Western Health to ensure they align with Health Equity priorities. A Health Equity Advisor training module has been developed and is currently being rolled out across the organisation. Family Violence awareness training has been well attended, with compulsory family violence screening currently being implemented in our antenatal clinic. A Child Safeguarding Plan has been developed, with implementation underway. Western Health has also commenced an Elder Abuse management project with funding assistance from the Department of Health and Human Services.
		Engage with Health West to support implementation of the Prevention and Population Health Outcomes arm of the refreshed Better Health Plan for the West.	**ACHIEVED** Areas of common interest and work over the past 12 months have included prevention of violence against women, community participation, health literacy and smoking cessation.
		Implement year one of the five year vaccination program to improve women's and children's immunisation rates across the western catchment.	**ACHIEVED** The performance of the vaccination program has exceeded expectations. More than 6,000 immunisations have been administered to pregnant women in year one of the program.

Statement of Priorities 2017/18 (continued)

BETTER HEALTH continued

GOALS	STRATEGIES	WESTERN HEALTH DELIVERABLES	OUTCOME
A system geared to prevention as much as treatment Everyone understands their own health and risks Illness is detected and managed early Healthy neighborhoods and communities encourage healthy lifestyles	Reduce statewide risks Build healthy neighborhoods Help people to stay healthy Target health gaps	Progress the Western Health Chronic Disease Alliance, with a focus in 2017/18 on expansion of the chronic kidney disease detection program to other chronic conditions such as heart disease, stroke and diabetes.	**ACHIEVED** The Western Health Chronic Disease Alliance was officially launched in December 2017. Western Health was successful in an Expression of Interest for a Better Care Victoria Project on Chronic Disease early detection and improved management in primary care. The project involves improving the detection and management of chronic overlapping vascular diseases including Type 2 diabetes, Chronic kidney disease, Cardiovascular diseases and stroke. All project milestones have been met to-date.

BETTER ACCESS

GOALS	STRATEGIES	WESTERN HEALTH DELIVERABLES	OUTCOME
Care is always there when people need it More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	Plan and invest Unlock innovation Provide easier access Ensure fair access	Develop the Model of Care for the New Footscray Hospital as part of Master Planning and business case development, including investigation and attention on advanced technology solutions for patient care and staff support.	**ACHIEVED** The Model of Care for a new Footscray Hospital was completed, with Western Health working with the Department of Health and Human Services and consultants to finalise and submit a business case for the new Hospital. Funding has been provided in the 2018-19 State Budget to purchase land for the new Footscray Hospital, with a site selection to be made in coming months.
		Continue the HealthLinks Innovative Pilot to increase care outside hospital walls for patients in our community suffering from chronic disease, and evaluate pilot activity, cost, patient outcomes and satisfaction.	**ACHIEVED** The HealthLinks model of care continues to be piloted, with a review at the end of year one revealing that the program is supporting patients with chronic and complex conditions to remain at home, with consistent positive feedback from patients and families and a reduction in healthcare costs.

Statement of Priorities 2017/18 (continued)

BETTER ACCESS continued

GOALS	STRATEGIES	WESTERN HEALTH DELIVERABLES	OUTCOME
Care is always there when people need it More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	Plan and invest Unlock innovation Provide easier access Ensure fair access	Engage in the Better Care Victoria Emergency and Specialist Clinic Access Improvement Partnerships to support the redesign and improvement of patient flow.	**ACHIEVED** Western Health has been supported by Better Care Victoria to participate in a Patient Flow Partnership Project, with improvement initiatives including standardisation of admission and discharge planning, and implementation of a Western Health version of a Daily Operating System (DOS) as advocated by the Department of Health and Human Services. Western Health is also participating in the Better Care Victoria Outpatient Collaborative project. The Collaborative has identified six services to develop and apply access criteria and advanced discharge processes.
		Further develop partner relationships to close gaps in the mental health patient journey in the west, and undertake forward thinking for the provision of mental health services supporting patients presenting to Western Health.	**ACHIEVED** Flow management of mental health patients has been supported over the past year by initiatives such as the implementation of a Mental Health Service Development and Operational Manager position, recommencement and refocusing of liaison meetings with North West Mental Health and Mercy Mental Health, and opening of additional mental health beds at Werribee Mercy. While mental health patient times in our emergency departments are still excessive, the frequency of 24-hour breaches significantly reduced within the second half of 2017-18. Western Health continues to report breaches to the Department of Health and Human Services who have visited our emergency departments to review and appreciate the challenges for patients and staff when they experience long delays accessing mental health beds.

Statement of Priorities 2017/18 (continued)

BETTER ACCESS continued

GOALS	STRATEGIES	WESTERN HEALTH DELIVERABLES	OUTCOME
Care is always there when people need it More access to care in the home and community People are connected to the full range of care and support they need There is equal access to care	Plan and invest Unlock innovation Provide easier access Ensure fair access	Progress construction of the Joan Kirner Women's and Children's Hospital (JKWCH) and models of care that mitigate the challenges of demand, patient acuity and physical facilities.	**ACHIEVED** Construction has progressed on the Joan Kirner Women's and Children's Hospital, with completion scheduled for 2019. Work has been undertaken to develop models of care for women's and children's services to be provided within the new facility.

BETTER CARE

GOALS	STRATEGIES	WESTERN HEALTH DELIVERABLES	OUTCOME
Target zero avoidable harm Healthcare that focusses on outcomes Patients and carers are active partners in care Care fits together around people's needs	Put quality first Join up care Partner with patients Strengthen the workforce Embed evidence Ensure equal care	Enhance co-ordinated clinical workflow practices and support safe care through the implementation and ongoing support of the Western Health Electronic Medical Record (EMR) Project.	**IN PROGRESS** Electronic Medical Record Design and Testing has been the major focus over the past 12 months, with EMR implementation to commence in late 2018.
		Develop a new Western Health Organisational Development and Education Roadmap that reflects the Western Health Best Care principles, builds culture, grows care competencies and capabilities for agile leaders and managers, and has outcome measures of improved quality care.	**ACHIEVED** Western Health's 'Best People' Roadmap 2018-20 has been developed. It reflects the organisation's Best Care principles of person-centred care, right care, co-ordinated care and safe care, and aims to build culture and grow care competencies and capabilities for agile leaders and managers.

Statement of Priorities 2017/18 (continued)

BETTER CARE continued

GOALS	STRATEGIES	WESTERN HEALTH DELIVERABLES	STATUS
Target zero avoidable harm Healthcare that focusses on outcomes Patients and carers are active partners in care Care fits together around people's needs	Mandatory actions against the 'Target zero avoidable harm' goal: Develop and implement a plan to educate staff about obligations to report patient safety concerns.	Undertake a comprehensive review of the Western Health Incident Report and Investigation Framework and procedure and provide a communication and education platform to support staff awareness and capability to operate effectively in this area.	**ACHIEVED** Following review of Western Health's Incident Reporting and Investigation Framework, a 'How to Guide' has been developed to assist managers with documenting incident investigation, and clinical areas have received additional Incident Management training from the Department of Health and Human Services. In addition, work has commenced with medical staff on optimal morbidity and mortality review documentation processes.
	Mandatory actions against the 'Target zero avoidable harm' goal: In partnership with consumers, identify 3 priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every 6 months to reflect new areas for improvement in patient experience.	To support staff communication and discussion with patients and carers, implement year one actions of the Western Health Best Care Roadmap for Person Centred Care	**ACHIEVED** The following actions have been undertaken over the past 12 months to support staff communication and discussion with patients and carers: The Advisory Board has delivered two sessions organisationally on 'Teach back, engaging patients in their care'. Positive feedback was received on these sessions, with a plan developed for a pilot of this methodology in the second half of 2018. 'Communicating with CARES' (Compassion, Accountability, Respect, Excellence & Safety) was trialled in outpatients and has been reviewed and redesigned. The redesigned program has been developed into an e-learning module and launched on our We-Learn education system. 'Hello my name is' has been rolled out across the organisation. The Program has been included as a standing item in the orientation and education program for all new staff. The Quiet Hospital Working Party has used co-design methodology to obtain information from patients and staff on noise and whether it bothers them and strategies to address identified issues. Relevant stakeholders have reviewed what is possible to change in the environment and an implementation strategy has been developed for launch in September 2018.

Statement of Priorities 2017/18 (continued)

BETTER CARE continued

GOALS	STRATEGIES	WESTERN HEALTH DELIVERABLES	STATUS
Target zero avoidable harm Healthcare that focusses on outcomes Patients and carers are active partners in care Care fits together around people's needs	Mandatory actions against the 'Target zero avoidable harm' goal: In partnership with consumers, identify 3 priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every 6 months to reflect new areas for improvement in patient experience.	To support information needs of patients on discharge, progress patient and General Practitioner access to discharge information within My Health Record	**ACHIEVED** From early November 2017, Western Health has been uploading discharge summaries to the My Health Record, for those patients who have a My Health Record and who haven't requested to opt-out of a discharge summary being sent. Approximately 200 discharge summaries are currently being uploaded per month to the My Health Record.
		To support patient and carers to raise worries or fears about their condition or treatment, evaluate and refine Western Health's "Call for Help" program as indicated based on patient, carer and staff feedback	**ACHIEVED** There have been 40 'Calls for Help' in the first 12 months of the service. Feedback from the patients, families and carers who have used the program has been positive, as has the feedback from staff. Following a review of the program, enhancements have been undertaken to increase language diversity and improve promotion. The program will now continue as an ongoing part of patient care.

Key Performance Statistics[1]

QUALITY AND SAFETY

KEY PERFORMANCE INDICATOR	TARGET	2017-18 RESULT
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Full compliance	Achieved
Infection Prevention and control		
Compliance with the Hand Hygiene Australia program	80%	90%
Percentage of healthcare workers immunised for influenza	75%	78%
Patient experience		
Victorian Healthcare Experience Survey (VHES) —data submission	Full Compliance	Achieved
VHES —patient experience Quarter 1	95% positive experience	89.1%
VHES —patient experience Quarter 2	95% positive experience	85.2%
VHES —patient experience Quarter 3	95% positive experience	87.7%
VHES —discharge care Quarter 1	75% very positive experience	69.3%
VHES —discharge care Quarter 2	75% very positive experience	71.3%
VHES —discharge care Quarter 3	75% very positive experience	71.1%
VHES —patient perception of cleanliness Quarter 1	70%	59.0%
VHES —patient perception of cleanliness Quarter 2	70%	57.7%
VHES —patient perception of cleanliness Quarter 3	70%	55.9%
Healthcare associated infections (HAI's)		
Number of patients with surgical site infection	No outliers	Achieved
ICU central line associated blood stream infection (CLABSI)	Nil	Not Achieved
Rate of patients with SAB[2] per occupied bed days	≤1/10,000	0.56/10,000
Adverse events		
Number of sentinel events	Nil	Not Achieved
Mortality—number of deaths in low mortality DRGs[3]	Nil	n/a[3]
Maternity and Newborn		
Singleton term infants without birth anomalies with Apgar score <7 to 5 minutes	≤1.6%	0.9%
Severe foetal growth restriction in singleton pregnancy undelivered by 40 weeks	≤28.6%	23.8%
Continuing Care		
Functional Independence gain from an episode of GEM[4] admission to discharge	≥0.39	0.597
Functional Independence gain from an episode of rehabilitation admission to discharge relative to length of stay	≥0.645	1.15

[1]Results are as at June 30 2018
[2]SAB is Staphylococcus Aureus Bacteraemia
[3] This indicator was withdrawn during 2017-18 and is currently under review by the Victorian Agency for Health Information
[4] GEM is Geriatric Evaluation and Management

Key Performance Statistics (continued)

TIMELY ACCESS TO CARE

KEY PERFORMANCE INDICATOR	TARGET	FOOTSCRAY	SUNSHINE	W'TOWN
Emergency Care				
Percentage of ambulance patients transferred within 40 minutes	90%	73.3%	72.3%	91.1%
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 time	80%	67.0%	48.2%	83.2%
Percentage of emergency patients with a length of stay in the emergency department of less than four hours	81%	58.2%	56.9%	88.0%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	58	4	0

KEY PERFORMANCE INDICATOR	TARGET	2017-18 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 surgery patients admitted within clinically recommended timeframes	94%	93.3%
Percentage of patients on the waiting list who have waited longer than clinically recommended time for their respective triage category	15% proportional improvement from prior year	16.9%
Number of patients on the elective surgery waiting list[5]	3,150	2,957
Number of hospital initiated postponements per 100 scheduled elective surgery	≤ 8/100	6.6/100
Number of patients admitted from the elective surgery waiting list	15,598	15,555
Specialist Clinics		
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	58.6%
Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%	90%

[5]the target shown is the number of patients on the elective surgery waiting list as at 30 June 2018

Key Performance Statistics (continued)

STRONG GOVERNANCE, LEADERSHIP AND CULTURE

KEY PERFORMANCE INDICATOR	TARGET	2017-18 RESULT
Organisational Culture		
People matter survey - percentage of staff with an overall positive response to safety and culture questions	80%	91%
People matter survey - percentage of staff with a positive response to the question, "I am encouraged by my colleagues to report any patient safety concerns I may have"	80%	95%
People matter survey - percentage of staff with a positive response to the question, "Patient care errors are handled appropriately in my work area"	80%	94%
People matter survey - percentage of staff with a positive response to the question, "My suggestions about patient safety would be acted upon if I expressed them to my manager"	80%	93%
People matter survey - percentage of staff with a positive response to the question, "The culture in my work area makes it easy to learn from the errors of others"	80%	89%
People matter survey - percentage of staff with a positive response to the question, "Management is driving us to be a safety-centred organisation"	80%	94%
People matter survey - percentage of staff with a positive response to the question, "This health service does a good job of training new and existing staff"	80%	86%
People matter survey - percentage of staff with a positive response to the question, "Trainees in my discipline are adequately supervised"	80%	86%
People matter survey - percentage of staff with a positive response to the question, "I would recommend a friend or relative to be treated as a patient here"	80%	89%

EFFECTIVE FINANCIAL MANAGEMENT

KEY PERFORMANCE INDICATOR	TARGET	2017-18 RESULT
Finance		
Operating result ($m)	0.00	1.158*
Average number of days to paying trade creditors	60 days	52 days
Average number of days to receiving patient fee debtors	60 days	44 days
Public and Private WIES[6] activity performance to target	100%	99%
Number of days of available cash	14 days	22 days
Adjusted current asset ratio	0.7	0.53

[6]WIES is a Weighted Inlier Equivalent Separation

* $45K = WH Operational Performance; $1.113M = Jointly Controlled Operations with the Victorian Comprehensive Cancer Centre (VCCC)

Key Performance Statistics (continued)

ACTIVITY & FUNDING

FUNDING TYPE	2017-18 ACTIVITY ACHIEVEMENT
Acute Admitted	
WIES Public*	75,662
WIES Private	6,059
WIES DVA	526
WIES TAC	241
Acute Non-Admitted	
Home Enteral Nutrition	563
Home Renal Dialysis	84
Radiotherapy Non Admitted Shared Care	30
Specialist Clinics—Public	154,834
Subacute & Non-Acute Admitted	
Subacute WIES—Rehabilitation Public	780
Subacute WIES—Rehabilitation Private	171
Subacute WIES—GEM Public	2,011
Subacute WIES—GEM Private	259
Subacute WIES—Palliative Care Public	305
Subacute WIES—Palliative Care Private	40
Subacute WIES—DVA	76
Transition Care—Bed Days	11,407
Transition Care—Home days	9,451
Subacute Non-Admitted	
Health Independence Program—Public	98,390
Mental Health and Drug Services	
Drug Services	3,283
Primary Health	
Community Health / Primary Care Programs	2,500
Other	
Health Workforce	216

* This WIES figure excludes 2017-18 WIES for HealthLinks patients

Financial Snapshot

WORKFORCE FULL TIME EQUIVALENT (FTE) PER ANNUAL ACCOUNTS

HOSPITALS LABOUR CATEGORY	JUNE CURRENT MONTH FTE		JUNE YTD FTE	
	2017	2018	2017	2018
Nursing	2066	2131	2014	2098
Administration & Clerical	655	699	642	673
Medical Support	370	388	367	380
Hotel and Allied Services	414	430	419	425
Medical Officers	119	119	122	119
Hospital Medical Officers	467	476	456	476
Sessional Clinicians	103	108	92	104
Ancillary Staff (Allied Health)	368	376	361	360
Total	**4562**	**4728**	**4475**	**4634**

FINANCIAL SNAPSHOT

$'000	2017/18	2016/17	2015/16	2014/15	2013/14
Total Revenue	854,829	757,595	686,303	644,174	607,881
Total Expenses	791,422	757,478	712,133	657,369	627,039
Net Result for the Year (inc. Capital and Specific Items)	**63,407**	**(117)**	**(25,830)**	**(13,195)**	**(19,158)**
Operating Result (net result before capital & specific items)	**1,158**	**590**	**320**	**1,408**	**4,229**
Total Assets	840,333	698,076	684,212	679,764	684,698
Total Liabilities	199,289	174,029	164,166	142,636	134,359
Net Assets	**641,044**	**524,047**	**520,046**	**537,128**	**550,339**
TOTAL EQUITY	**641,044**	**524,047**	**520,046**	**537,128**	**550,339**

* $45K = WH Operational Performance; $1.113M = Jointly Controlled Operations with the Victorian Comprehensive Cancer Centre (VCCC)

Financial Snapshot (continued)

FINANCIAL PERFORMANCE

OPERATING RESULT	TARGET	2017-18 RESULT
Annual Operating Result ($m)	0.00	1.158*
CASH MANAGEMENT / LIQUIDITY	**TARGET**	**2017-18 RESULT**
Creditors (days)	<60	52
Debtors (days)	<60	44
ASSET MANAGEMENT	**TARGET**	**2017-18 RESULT**
Adjusted Current Asset Ratio	0.70	0.53
Days of Available Cash	14 days	22 days

* $45K = WH Operational Performance; $1.113M = Jointly Controlled Operations with the Victorian Comprehensive Cancer Centre (VCCC)

DETAILS OF CONSULTANCIES [UNDER $10,000]
In 2017-18, there was one (1) consultancy where the total fees payable to the consultant were less than $10,000.
The total expenditure incurred during 2017-18 in relation to this consultancy is $6,978 (excl. GST)

DETAILS OF CONSULTANCIES [VALUED AT $10,000 OR GREATER]
In 2017-18, there was one (1) consultancy where the total fees payable to the consultant were $10,000 or greater.
The total expenditure incurred during 2017-18 in relation to the consultancy is $17,911 (excl. GST). Details of individual consultancy are as follows:

CONSULTANCIES

OVER 10,000

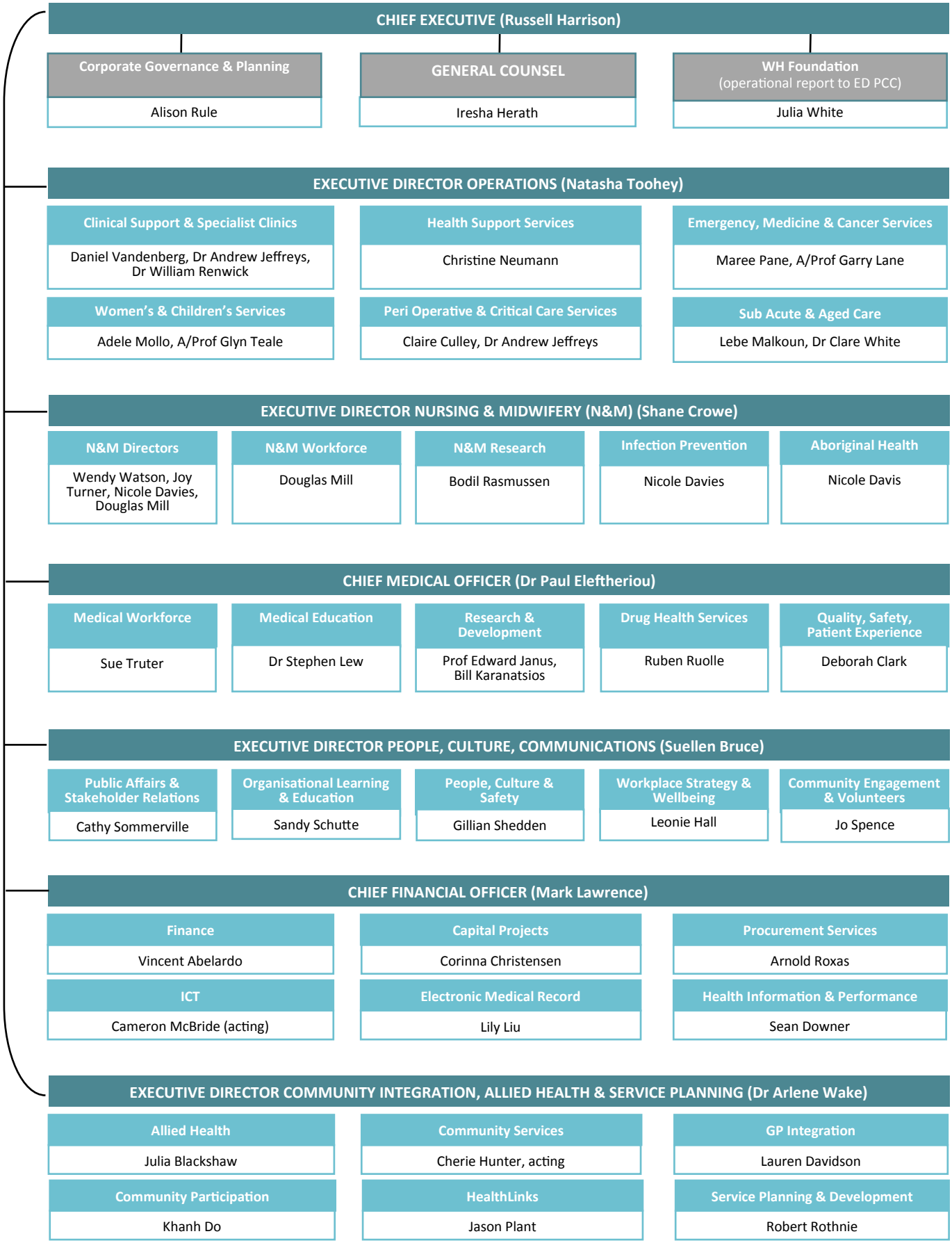
Consultant	Purpose of consultancy	Start Date	End Date	Total approved project fee (excluding GST)	Expenditure 2017-18 (excluding GST)	Future expenditure (excluding GST)
Loss Prevention Group of Australia (LPGA)	Review of security, including benchmarking, executives and stakeholders engagement and preparation of reports	Jul-17	Jul-17	$17,911	$17,911	Nil
	TOTALS			**$17,911**	**$17,911**	

DETAILS OF INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE

The total ICT expenditure incurred during 2017-18 is $27.7 million (excluding GST) with the details shown below:

Business As Usual (BAU) ICT expenditure	Non-Business As Usual (non-BAU) ICT expenditure		
Total (excluding GST)	**Total = Operational expenditure and Capital Expenditure (excluding GST) (a) + (b)**	**Operational expenditure (excluding GST) (a)**	**Capital expenditure (excluding GST) (b)**
$9 million	$18.7 million	$7.7 million	$11 million

Organisational Structure (as at June 2018)



Western Health Services

EMERGENCY, MEDICINE AND CANCER SERVICES

- Addiction Medicine
- Dermatology
- Endocrinology and 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

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)
- Inpatient Rehabilitation
- Subacute and Non acute Access and Pathways Service
- Wellcare Program

WOMEN'S AND CHILDREN'S SERVICES

- Gynaecology
- Obstetric Services
- Maternal Fetal Medicine
- Special Care Nursery
- Paediatric Medicine

PERIOPERATIVE AND CRITICAL CARE SERVICES

- Anaesthetics and Pain Management
- Cardiology Services
- Central Sterilising Services
- General and Colorectal Surgery
- Elective Booking Service
- Preadmission Service
- General and Endocrine Surgery
- General and Breast Surgery
- Intensive Care Services (incorporating ICU liaison and Organ Donation Services)
- Neurosurgery
- Ophthalmology
- Orthopaedic Surgery
- Otolaryngology, Head, Neck Surgery
- Paediatric Surgery
- Plastic and Reconstructive Surgery
- Facio-Maxillary Surgery
- Thoracic Surgery
- General & Upper Gastrointestinal Surgery
- Urology Surgery
- Vascular Surgery

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)

- Hospital Admission Risk Program
- Subacute Ambulatory Care Services (community based rehabilitation and specialist clinics)
- Aged Care Assessment Service
- ACE (Advice, Co-ordination and Expertise)
- Transition Care Program (Community)
- Children's Allied Health Service
- Central Access Unit (CAU)
- HIP Community Services

DRUG HEALTH SERVICES

- Adolescent Community Programs
- Women's Therapeutic Day Rehabilitation Program
- Adult and Specialist Services
- Nurse Practitioner Clinics
- Psychology Clinics
- Community Residential Drug Withdrawal Units
- Dual Diagnosis Residential Rehabilitation Centre (Westside Lodge)

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). Established in 2000, 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 performance targets

Over the period 1 July 2017 to 30 June 2018, 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. Bronwyn's 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. Bronwyn 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, the Uniting Victorian/ Tasmania Board, and the Uniting Care Australia Board. Bronwyn is also a board member of Uniting NSW/ACT, LeapIn and the Australian Health Policy Collaborative.

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

Dr Robert (Bob) Mitchell has been a solicitor for 30 years, and was a Tax Partner at Pricewaterhouse Coopers 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.

Bob has a strong interest in international development work and justice issues and has served in senior executive roles with World Vision Australia. Bob is the CEO of Anglican Overseas Aid and serves on the global board of The ACT Alliance, one of the largest humanitarian networks in the world.

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

Appointed July 2010

Corporate Governance (continued)

PROFESSOR COLIN CLARK

BBus, Dip Ed, MBA, PhD, FCPA, FCA, FIPAA, FAICD

Professor Colin Clark is Professor of Accounting at Victoria University; and until recently was Dean of Business until being appointed as Dean International.

Colin 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.

Colin has undertaken a range of research and consulting projects in Australia and overseas. Colin's area of specialisation is public sector accounting and corporate governance.

Professor Colin Clark is Chair of the Finance and Resources Committee.

Appointed July 2010

MRS ELLENI BEREDED-SAMUEL

MEd, Grad Dip Counselling, Grad Cert Management, BA (foreign languages and literature and english as a second language)

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

For six years Elleni served as a Commissioner of the Victorian Multicultural Commission and on the Board of Directors of The Women's Hospital and chaired the Community Advisory Committee.

Elleni 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.

Elleni is one of 40 Australian champions independently selected as the People of Australia Ambassadors appointed by the Prime Minister. Elleni 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 Elleni was inducted into Westpac & Financial Review Award as one of 100 Women of Influence in Australia.

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

Appointed July 2011

DR PHUONG PHAM

DPhil, MA, BA, BSc

The son of Vietnamese immigrants, Phuong 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. Phuong is currently Head of Strategy and Policy for Telstra Health, the largest Australian-based provider of software products, solutions and platforms for healthcare providers and funders.

Dr Phuong Pham is Chair 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 Kelvyn 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, Kelvyn 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. Kelvyn is a Director of Plenary Conventions Pty Ltd and a member of the Advisory Board for the McKell Institute Victoria.

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

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

Appointed September 2015

Corporate Governance (continued)

MS COLLEEN GATES

BA Chemical Engineering, GAICD

Ms Colleen Gates has resided in and been passionate about Melbourne's west for the last 20+ years. Colleen 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, community wellbeing, and environmental sustainability.

In addition to a Board role at Western Health, Colleen also serves as a Councillor at Hobsons Bay City Council and Chairperson of the Metropolitan Waste and Resource Recovery Board. Combined with a long standing professional career in environmental compliance and management, currently within the food manufacturing sector, Colleen's diverse background and knowledge has been of great benefit with respect to driving strategic focus, encouraging innovation and supporting community capacity building.

Ms Colleen Gates is a member of the Primary Care and Population Health Advisory Committee and a member of the Cultural Diversity and Community Advisory Committee.

Appointed July 2016

DR CATHERINE HUTTON

MBBS, DRCOG, FRACGP, MPH, GAICD

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

Cathy is an experienced board member specialising in clinical governance, strategy and GP-hospital integration, and has held health service Board Director positions at both Peter MacCallum Cancer Centre and the Royal Women's Hospital. Additionally, Cathy 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. Cathy is currently a Director for North West Melbourne Primary Health Network. Cathy 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.

Cathy has a broad working knowledge of the health system, both primary and secondary, state and federal, and private and public and 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 Catherine Hutton is the Chair of the Primary Care and Population Health Advisory Committee and a member of the Quality and Safety Committee.

Appointed July 2016

MR DAVID SHAW

LLB

Mr David Shaw has been a partner of law firm, Holding Redlich, since 1989 and has a wealth of experience in complex disputes involving employment law, discrimination, administrative decisions and the rule of organisation. These disputes often play out in the Federal and State Courts and Tribunals, Royal Commissions and investigations by integrity agencies.

In the course of his practice David acts for individuals, companies, unions, not for profit bodies and government agencies. David has had an extensive pro bono practice, most often acting for Indigenous people, Indigenous groups and refugees.

In the health sector, David has acted for a major health industry union and its members, medical practitioners and health professionals. This has involved disputes over the control of the union, disputes over employment conditions, investigations involving the conduct and performance of health professionals, disputes over specialist accreditation and a complex whistleblowing complaint involving a health authority's response to alleged negligence by a surgeon.

David is a previous Board Member of the Falls Creek Alpine Resort Management Board, and the Alfred Health Board.

Mr David Shaw is a Member of the Quality and Safety Committee and a Member of the Audit and Risk Committee.

Appointed July 2017

Corporate Governance (continued)

BOARD MEETING ATTENDANCE 2017/18

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

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.

2017/18 Committee Members (Board Directors):

> Dr Robert Mitchell (Chair)
> The Hon Bronwyn Pike
> Mr David Shaw

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.

2017/18 Committee Members (Board Directors):

> Mrs Elleni Bereded-Samuel (Chair)
> Ms Colleen Gates

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.

2017/18 Committee Members (Board Directors):

> Professor Colin Clark (Chair)
> The Hon Bronwyn Pike
> Mr Kelvyn Lavelle

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

2017/18 Committee Members (Board Directors):

> Dr Robert Mitchell (Chair)
> The Hon Bronwyn Pike
> Mrs Elleni Bereded-Samuel

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.

2017/18 Committee Members (Board Directors):

> Dr Catherine Hutton (Chair)
> Ms Colleen Gates

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 manner

2017/18 Committee Members (Board Directors):

> Dr Phuong Pham (Chair)
> The Hon Bronwyn Pike
> Dr Catherine Hutton
> Mr David Shaw

Corporate Governance (continued)

ATTESTATION FOR FINANCIAL COMPLIANCE

I, Robert Mitchell, Chair Western Health Audit and Risk Committee, on behalf of the Responsible Body, certify that Western Health has complied with the applicable Standing Directions of the Minister for Finance under the Financial Management Act 1994 and Instructions.

Dr Robert Mitchell
Chair of the Audit & Risk Committee
Western Health
10 August 2018

ATTESTATION FOR DATA INTEGRITY

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

Russell Harrison
Chief Executive, Western Health
10 August 2018

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

I, Russell Harrison, Chief Executive certify that Western Health has put in place appropriate internal controls and processes to ensure that it has complied with all requirements set out in the HPV Health 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
Chief Executive, Western Health
10 August 2018

ATTESTATION ON CONFLICT OF INTEREST

I, Russell Harrison, Chief Executive certify that Western Health has put in place appropriate internal controls and processes to ensure that it has complied with the requirements of hospital circular 07/2017 *Compliance reporting in health portfolio entities (Revised)* and has implemented a 'Conflict of Interest' policy consistent with the minimum accountabilities required by the VPSC. Declaration of private interest forms have been completed by all executive staff within Western Health and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive and board meeting.

Russell Harrison
Chief Executive, Western Health
10 August 2018

Corporate Governance (continued)

OCCUPATIONAL HEALTH AND SAFETY (OH&S) 2017/18

To minimise risk and promote the health, safety and wellbeing of our workforce, the following programs and activities were provided:

> Regular reports to the Western Health Board of Directors, Executive and the Occupational Health and Safety Committee detailing OH&S performance.

> OH&S training courses for managers and supervisors

> Efficient and effective employee rehabilitation and return to work processes embedded into organisational standard practice.

> Education and training for employees and volunteers in relation to managing risks eg 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 our workforce.

> Focus on improving and enhancing Western Health's organisational early intervention, prevention and management of occupational violence through improved communication, engagement with internal and external stakeholders and timely reporting and responsiveness to occupational violence events.

> Focus on improving awareness of manual handling and patient care to improve the patient experience and support the workforce in safe and effective techniques.

> A proactive approach adopted and maintained to minimise and control risks by management in conjunction with workforce Health and Safety representatives (HSRs).

> Ongoing support for our employee 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 an 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 HSRs, 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.

OCCUPATIONAL HEALTH AND SAFETY STATISTICS

MEASURE	2017/18	2016/17	2015/16
1. The number of reported incidents for the year per 100 FTE	18.55	20.02	14.48
2. The number of 'lost time' standard WorkCover claims for the year per 100 FTE	0.41	0.40	0.50
3. The average cost per WorkCover claim for the year ('000)	$61	$90	$114

OCCUPATIONAL VIOLENCE STATISTICS

MEASURE	2017/18
1. WorkCover accepted claims with an occupational violence cause per 100 FTE	0.08
2. Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0.33
3. Number of occupational violence incidents reported	266
4. Number of occupational violence incidents reported per 100 FTE	5.74
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	9.77%

Corporate Governance (continued)

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 compassion, 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 perceived unfair or unreasonable treatment.

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

EX-GRATIA PAYMENT

Western Health made no ex-gratia payments for the year ending 30 June 2018.

BUILDING ACT

Western Health fully complied with the building and maintenance provisions of the Building Act 1993 for the period 1 July 2017 to 30 June 2018. 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 and details of car parking fees and concession benefits can be viewed at www.westernhealth.org.au/Our Sites (transport and parking options under each of our listed hospitals).

NATIONAL COMPETITION POLICY

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

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.

2017-18—New/Completed Victorian Industry Participation Projects:

PROCUREMENT NAME	**Sunshine Hospital Multi-Deck Car Park**
Value of Procurement	$26,640,644
Project Location	Sunshine Hospital
VIPP plan with ICN acknowledgement letter	2017/ICN41491
Commencement and Completion Date	Commencement 6/4/2018 Completion 22/8/2019
AEE jobs committed (new and retained)	Committed 6 Retained 102
AEE jobs achieved (new and retained)	Achieved 6 Retained 102
AEE apprenticeships/ traineeships committed (new and retained)	Committed 2 Retained 15
AEE apprenticeships/ traineeships achieved (new and retained)	Achieved 2 Retained 15
Local content (%) committed	82.71%
Local content (%) achieved	82.71%

Corporate Governance (continued)

PROTECTED DISCLOSURE ACT

In accordance with Part 9 of the Protected Disclosure Act 2012 (Vic), Western Health has developed procedures and guidelines to facilitate the handling of a disclosure, the making of 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 provision of sections 21 (2) of the Act, no disclosures were received and notified to IBAC during the 2017/18 financial year.

SAFE PATIENT CARE ACT

Western Health has no matters to report in relation to its obligations under section 40 of the Safe Patient Care Act 2015 (Vic).

CARERS RECOGNITION ACT 2012

In accordance with the Carers Recognition Act 2012 (Vic), Western Health:

A) Takes all practicable measures to ensure that its employees and agents have an awareness and understanding of the care relationship principles; and

B) Takes all practicable measures to ensure that persons who are in care relationships and who are receiving services in relation to the care relationship from the care support organisation have an awareness and understanding of the care relationship principles; and

C) Takes all practicable measures to ensure that the care support organisation and its employees and agents reflect the care relationship principles in developing, providing or evaluating support and assistance for persons in care relationships

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.

The following page of the Western Health website - http://www.westernhealth.org.au/PatientsandVisitors/Medical_Records/Pages/Accessing-information-about-me.aspx guides members of the public on how to make an FOI request. The page contains information such as, an application form, the amount of the application fee, contact details and a link to OVIC's website. If a member of the public calls Western Health seeking information on the FOI process, they will be transferred to the FOI team who will provide verbal information and/or email or post a FOI application form as required.

Western Health receives approximately 1500 FOI requests annually, the vast majority of which are personal requests for medical information. Approximately 60% of these requests are from law firms (on behalf of members of the public), insurance companies and the TAC. The remaining 40% of requests are made personally by members of the public. Western Health has received approximately 5 non-personal requests from media outlets and members of the public. The majority of FOI requests received by WH were acceded to unless the requestor withdrew the request or we did not receive a response to correspondence.

TOTAL REQUESTS 2017/18	**1481**
Full Access	998
Partial Access	26
Access Denied	0
Applications Withdrawn	35
Applications Not Proceeded with	57
No Documents	22
Applications in Progress	343
VCAT Appeal	0
Appeal Withdrawn	0
Transfers Received	3
Time of Births	27
Attendance Letter	0

Corporate Governance (continued)

ADDITIONAL INFORMATION

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. A 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 organisation'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	24
FRD 22H	Purpose, functions, powers and duties	24
FRD 22H	Initiatives and key achievements	4-7
FRD 22H	Nature and range of services provided	8-9, 23
Management and structure		
FRD 22H	Organisational Structure	22
Financial and other information		
FRD 10A	Disclosure Index	32-33
FRD 11A	Disclosure of ex-gratia payments	30
FRD 21C	Responsible person and executive officer disclosures	Appendix 50-51
FRD 22H	Application and operation of *Protected Disclosure Act 2012*	31
FRD 22H	Application and operation of *Carers Recognition Act 2012*	31
FRD 22H	Application and operation of *Freedom of Information Act 1092*	31
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	30
FRD 22H	Details of consultancies over $10,000	21
FRD 22H	Details of consultancies under $10,000	21
FRD 22H	Employment and conduct principles	30
FRD 22H	Information and Communication Technology Expenditure	21
FRD 22H	Major changes or factors affecting performance	4-7
FRD 22H	Occupational health and safety	29
FRD 22H	Occupational violence	29
FRD 22H	Operational and budgetary objectives and performance against objectives	16-21
FRD 24C	Summary of the entity's environmental performance	7
FRD 22H	Significant changes in financial position during the year	19-21
FRD 22H	Statement on National Competition Policy	30
FRD 22H	Subsequent events	Appendix 57
FRD22H	Summary of the financial results for the year	20
FRD22H	Additional information available on request	32

Disclosure Index (continued)

LEGISLATION	REQUIREMENT	PAGE
FRD22H	Workforce Data Disclosures including a statement on the application of employment and conduct principles	20, 30
FRD 25C	Victorian Industry Participation Policy disclosures	30
FRD 103F	Non-Financial Physical Assets	Appendix 23-32
FRD 110A	Cash Flow Statements	Appendix 6
FRD 112D	Defined Benefit Superannuation Obligations	Appendix 20
SD 5.2.3	Declaration in report of operations	7
SD 5.1.4	Financial Management Compliance Attestation	28
Other requirements under Standing Directions 5.2		
SD 5.2.2	Declaration in financial statements	Appendix 2
SD 5.2.1(a)	Compliance with Australian accounting standards and other authorative pronouncements	Appendix 9
SD 5.2.1(a)	Compliance with Ministerial Directions	Appendix 9
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Protected Disclosure Act 2012		31
Carers Recognition Act 2012		31
Victorian Industry Participation Policy Act 2003		30
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Financial Management Act 1994		7, Appendix 9
Safe Patient Care Act 2015		31

Financial Statements & Accompanying Notes

For the Year Ended 30th June 2018

Appendix to the Western Health Annual Report

Western Health

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 2018 and the financial position of Western Health as at 30th June 2018.

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	Russell Harrison Chief Executive Officer	Mark Lawrence Chief Financial Officer
Melbourne 10th August 2018	Melbourne 10th August 2018	Melbourne 10th August 2018

Western Health
Comprehensive Operating Statement
For the Financial Year Ended 30th June 2018

	Note	2018 $'000	2017 $'000
Revenue from operating activities	2.1	747,551	714,722
Revenue from non-operating activities	2.1	2,339	2,436
Employee expenses	3.1	(558,724)	(522,731)
Non salary labour expenses	3.1	(11,987)	(11,566)
Supplies and consumables	3.1	(107,698)	(109,829)
Other expenses	3.1	(70,323)	(72,442)
Net Result Before Capital and Specific Items		**1,158**	**590**
Capital purpose income	2.1	100,451	35,651
Assets received free of charge	2.1,2.2	3,674	-
Depreciation and amortisation	3.1,4.3	(41,088)	(40,568)
Expenditure for capital purpose	3.1	(278)	(298)
Gain on disposal of available-for-sale investment	8.1	247	108
Net Result After Capital and Specific Items		**64,164**	**(4,517)**
Other Economic Flows Included in Net Result			
Net gain/(loss) on non-financial assets		(20)	(44)
Other gains/(losses) from other economic flows		(1,304)	-
Revaluation of long service leave		567	4,678
Total Other Economic Flows Included in Net Result		**(757)**	**4,634**
NET RESULT FOR THE YEAR		**63,407**	**117**
Other Comprehensive Income			
Items that will not be reclassified to net result			
Changes in property, plant & equipment revaluation surplus	2.3 & 8.1a	52,825	3,464
Items that may be reclassified subsequently to net result			
Changes to financial assets available-for-sale revaluation surplus	8.1a	765	420
Total Other Comprehensive Income		**53,590**	**3,884**
COMPREHENSIVE RESULT FOR THE YEAR		**116,997**	**4,001**

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

Western Health
Balance Sheet
As at 30th June 2018

	Note	2018 $'000	2017 $'000
Current Assets			
Cash and cash equivalents	6.2	26,355	17,597
Receivables	5.1	12,301	11,576
Investments and other financial assets	4.1	48,591	46,928
Inventories		2,248	2,440
Prepayments and other assets		2,361	1,822
Total Current Assets		**91,856**	**80,363**
Non-Current Assets			
Receivables	5.1	28,134	24,283
Investments and other financial assets	4.1	1	1
Property, plant & equipment	4.2	715,243	592,541
Intangible assets	4.4	5,099	888
Total Non-Current Assets		**748,477**	**617,713**
TOTAL ASSETS		**840,333**	**698,076**
Current Liabilities			
Payables	5.2	44,376	36,648
Provisions	3.3	131,416	114,260
Total Current Liabilities		**175,792**	**150,908**
Non-Current Liabilities			
Provisions	3.3	23,497	23,121
Total Non-Current Liabilities		**23,497**	**23,121**
TOTAL LIABILITIES		**199,289**	**174,029**
NET ASSETS		**641,044**	**524,047**
EQUITY			
Property, plant & equipment revaluation surplus	8.1a	359,066	306,241
Financial asset available for sale revaluation surplus	8.1a	1,286	521
Restricted specific purpose surplus	8.1a	6,606	4,279
Contributed capital	8.1b	202,980	202,980
Accumulated surplus	8.1c	71,106	10,026
TOTAL EQUITY	8.1d	**641,044**	**524,047**

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

Western Health
Statement Of Changes In Equity
For the Financial Year Ended 30th June 2018

	Note	Property, plant & equipment revalua-tion surplus	Financial asset available for-sale revalua tion surplus	Restricted specific purpose surplus	Contributi on by owners	Accumulated surpluses/ (deficits)	Total
		$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1st July 2016		**302,777**	**101**	**2,892**	**202,980**	**11,296**	**520,046**
Net result for the year	8.1c	-	-	-	-	117	117
Other comprehensive income for the year	8.1a	3,464	420	1,387	-	(1,387)	3,884
Balance at 30th June 2017		**306,241**	**521**	**4,279**	**202,980**	**10,026**	**524,047**
Net result for the year	8.1c	-	-	-	-	63,407	63,407
Other comprehensive income for the year	8.1a	52,825	765	2,327	-	(2,327)	53,590
Balance at 30th June 2018		**359,066**	**1,286**	**6,606**	**202,980**	**71,106**	**641,044**

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

Western Health
Cash Flow Statement
For the Financial Year Ended 30th June 2018

	Note	2018 $'000	2017 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		671,031	640,256
Capital grants from government		100,275	35,562
Patient fees received		24,989	25,045
Private practice fees received		24,785	24,695
Donations and bequests received		2,338	1,526
GST received from ATO		11,785	7,617
Recoupment from private practice for use of hospital facilities		828	794
Interest and investment income interest received		2,318	2,478
Other receipts		34,346	27,098
Total receipts		**872,695**	**765,071**
Employee expenses paid		(540,402)	(510,675)
Non salary labour costs		(12,760)	(12,275)
Payments for supplies and consumables		(120,582)	(118,600)
Other payments		(78,021)	(74,835)
Total payments		**(751,765)**	**(716,385)**
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	**120,930**	**48,686**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of non-financial assets		(111,623)	(46,471)
Purchase of investments		(10,650)	(1,300)
Proceeds from sale of non-financial assets		101	3
Proceeds from sale of investments		10,000	-
NET CASH FLOW USED IN INVESTING ACTIVITIES		**(112,172)**	**(47,768)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**8,758**	**918**
Cash and cash equivalents at beginning of financial year		17,597	16,679
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	**26,355**	**17,597**

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

Western Health
Notes To The Financial Statements
For the Financial Year Ended 30th June 2018

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Basis Of Presentation

The consolidated financial statements are prepared in accordance with Australian Accounting Standards (AASs) and relevant Financial Reporting Directions (FRDs). The parent entity is not shown separately as the consolidated entity (Western Health Foundation) is not material and is separately disclosed in Note 8.9.

These consolidated 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 consolidated 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*, contributions by owners (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. No administrative restructuring occurred during the reporting period.

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

These annual financial statements represent the audited general purpose financial statements for Western Health, (the "Health Service"), for the year ended 30th June 2018. 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 10th August 2018.

(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:

Footscray Hospital
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.

(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 2018 and the comparative information presented in these financial statements for the year ended 30th June 2017.

The financial statements are prepared on a going concern basis. Refer to note 8.11 Economic Dependency for information pertaining to this issue.

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 Health Service operates on a fund accounting basis and maintains three funds:Operating, Specific Purpose and Capital Funds. The Health Service's Capital Fund includes all purchase and sale transactions which relate to land, buildings, equipment and furniture, whether funded by the Department of Health and Human Services or from other sources and the Specific Purpose Fund includes all transactions where there is some form of restriction placed on the use of the funds.

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.

Note 1: Summary Of Significant Accounting Policies (continued)

Judgements, estimates and assumptions are required to be made about the carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and underlying assumptions are reviewed on an ongoing basis. 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.

Revisions to accounting estimates are recognised in the period within 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 and plant and equipment (refer to Note 4.2 Property, Plant and Equipment);
- Superannuation expense (refer to Note 3.4 Superannuation);
- Employee benefit provisions are based on the likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3 Employee Benefits in the Balance Sheet); and
- Managed investment funds classified at level 2 of the fair value hierarchy (refer to Note 7.1 Financial Instruments)

Goods and Services Tax (GST)
Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the Australian Taxation Office (ATO). In this case the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable and payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables and payables in the Balance Sheet.

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

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

(d) Principles of Consolidation

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

- The consolidated financial statements of the Health Service includes all reporting entities controlled by the Health Service as at the 30th June 2018.
- Control exists when the Health Service has the power to govern the financial and operating policies of an organisation 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 entity listed in note 8.9 Controlled Entities.
- 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.

Note 1: Summary Of Significant Accounting Policies (continued)

(e) Jointly Controlled Assets and Operations

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.

In respect of any interests 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 is a member of the Victorian Comprehensive Cancer Care Centre (VCCC), which it has classified as a joint operation. 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 8.10 Jointly Controlled Operations. The VCCC is the only jointly controlled asset or operation of the Health Service.

Note 2: Funding for Delivery Of Services

The overall objective of the Health Service is to provide quality health services, deliver programs and services that support and enhance the wellbeing of all Victorians. The Health Service is predominantly funded by accrual based grant funding for the provision of outputs. The Health Service also receives income from the supply of services.

Structure

2.1 Analysis of revenue by source
2.2 Assets received free of charge or for nominal consideration
2.3 Specific income

Note 2.1: Analysis Of Revenue By Source

2018	Admitted Patients $'000	Non Admitted $'000	Emergency Dept $'000	Aged Care $'000	Others* $'000	Total $'000
Government grants	538,308	50,907	55,286	10,419	9,440	664,360
Indirect contributions by the Department of Health and Human Services	4,225	-	-	-	-	4,225
Patient fees	21,444	754	1,976	458	-	24,632
Private practice fees	2,361	6,710	852	8	12,268	22,199
Commercial activities and special purpose funds	8,040	854	812	-	477	10,183
Donations and bequests	8	1	1	-	2,229	2,239
Other revenue from operating activities	7,743	560	744	64	10,602	19,713
Total Revenue from Operating Activities	**582,129**	**59,786**	**59,671**	**10,949**	**35,016**	**747,551**
Interest	1,731	246	246	11	105	2,339
Total Revenue from Non-Operating Activities	**1,731**	**246**	**246**	**11**	**105**	**2,339**
Capital purpose income					100,372	100,372
Asset received free of charge					3,674	3,674
Capital interest	-	79	-	-	-	79
Total Capital Purpose Income	**-**	**79**	**-**	**-**	**104,046**	**104,125**
Available-for-sale revaluation surplus gain recognised	-	-	-	-	247	247
Total Revenue	**583,860**	**60,111**	**59,917**	**10,960**	**139,414**	**854,262**

2017	Admitted Patients $'000	Non Admitted $'000	Emergency Dept $'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 the 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 and special purpose funds	7,352	773	772	-	412	9,309
Donations and bequests	-	-	-	-	1,612	1,612
Other revenue from operating activities	7,069	311	724	56	9,918	18,078
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
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 gain recognised	-	-	-	-	108	108
Total Revenue	**557,559**	**57,033**	**59,501**	**11,120**	**67,704**	**752,917**

**Other Programs include Commercial Activities, Special Purpose Funds and Capital.*

Revenue has been classified across programs as defined in the Agency Information Management System (AIMS) guidelines. For clinical support, infrastructure and corporate and medical services, related patient activity and cost recovery drivers have been used to allocate revenue across the programs. Non-public patient private practice diagnostic is allocated to the internal business unit.

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

Note 2.1: Analysis Of Revenue By Source (continued)

Revenue/Income Recognition
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.

Government Grants and Other Transfers of Income (other than contributions by owners)
In accordance with AASB 1004 *Contributions*, government grants and other transfers of income (other than contributions by owners), are recognised as income when the Health Service gains control of the underlying assets irrespective of whether conditions are imposed on the Health Service's use of the contributions.

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

In the 2017/18 year there was a significant Capital Purpose Grant of $75 million for the Joan Kirner Women's and Children's Hospital as well as $11 million provided for the support of Footscray Hospital infrastructure.

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 per 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 DHHS Hospital Circular 04/2017. 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 on an accrual basis.

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.

Other Income
Other income includes recoveries for salaries and wages and external services provided.

Note 2.1: Analysis Of Revenue By Source (continued)

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

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 services delivered via the emergency department.

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.

Other Services excluded from National Health Care Agreement (NHCA) (Other) comprises services not separately classified above, including: sexually transmitted infections clinical services, Koori liaison officers, immunisation and screening services, drugs services and community care programs, including sexual assault support, early parenting services, parenting assessment and skills development.

Note 2.2: Assets Received Free of Charge or for Nominal Consideration

	2018 $'000	2017 $'000
During the reporting period, the fair value of assets received free of charge was as follows:		
- Land	2,662	-
- Building	1,012	-
Total	**3,674**	**-**

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

Note 2.3: Specific Income

	2018 $'000	2017 $'000
Specific Income		
Revaluation increment on non current assets:		
- Land	8,965	3,464
- Buildings	43,860	-
Total	**52,825**	**3,464**

Note 3: The Cost Of Delivering Services

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

2018	Admitted Patients $'000	Non Admitted $'000	Emergency Dept $'000	Aged Care $'000	Other* $'000	Total $'000
Employee Expenses	396,284	61,730	74,963	11,276	14,471	558,724
Other Operating Expenses						
Non salary labour expenses	8,741	1,923	839	78	406	11,987
Supplies and consumables	83,912	10,569	10,099	1,099	2,019	107,698
Other expenses	47,877	9,260	9,021	1,520	2,645	70,323
Total Expenditures from Operating Activities	**536,814**	**83,482**	**94,922**	**13,973**	**19,541**	**748,732**
Other Non-Operating Expenses						
Expenditure for capital purposes	-	-	-	-	278	278
Depreciation and amortisation (refer note 4.3)	28,354	5,686	5,209	767	1,072	41,088
Total Other Expenses	**28,354**	**5,686**	**5,209**	**767**	**1,350**	**41,366**
Total Expenses	**565,168**	**89,168**	**100,131**	**14,740**	**20,891**	**790,098**

2017	Admitted Patients $'000	Non Admitted $'000	Emergency Dept $'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 and 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 and amortisation (refer note 4.3)	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**

**Other Programs include Commercial Activities, Special Purpose Funds and Capital.*

Expenditure has been classified across programs as defined in the Agency Information Management System (AIMS) guidelines. For clinical, infrastructure and corporate and medical services, related patient activity and cost recovery drivers have been used to allocate expenditure across the programs. Non-public patient private practice diagnostic expenditures is allocated to the internal business unit.

Note 3.1: Analysis Of Expenses By Source (continued)

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

Employee Expenses
Employee expenses include:

- Wages and salaries
- Fringe benefits tax
- Leave entitlements
- Termination payments
- Workcover premiums
- Superannuation expenses

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 services 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.
- 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.

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 4.2 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.

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)
- Disposals of financial assets and derecognition of financial liabilities.

Other Gains/(Losses) From Other Economic Flows
Other gains/(losses) include:

- the revaluation of the present value of the long service leave liability due to changes in bond rate movements, inflation rate movements and the impact of changes in probability factors; and
- transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

De-recognition of Financial Liabilities
A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

Note 3.2: Analysis Of Expenses And Revenue By Internally Managed And Restricted Specific Purpose Funds

	Expense		Revenue	
	2018 $'000	2017 $'000	2018 $'000	2017 $'000
Commercial Activities				
Diagnostic Imaging	6,318	6,082	12,399	12,189
Car Parking	675	591	4,831	4,380
Property	24	-	112	96
Internal and Specific Purpose Funds	1,134	761	1,450	746
Other	272	146	1,443	1,199
Other Activities				
Fundraising and Community Support	598	500	2,239	1,612
Research	2,543	2,949	2,730	3,492
TOTAL	**11,564**	**11,029**	**25,204**	**23,714**

Note 3.3: Employee Benefits In The Balance Sheet

	2018 $'000	2017 $'000
CURRENT PROVISIONS		
Employee Benefits [(i)]		
Accrued Days Off	933	901
- Unconditional and expected to be settled wholly within 12 months[(ii)]		
Annual Leave		
- Unconditional and expected to be settled wholly within 12 months[(ii)]	33,815	31,654
- Unconditional and expected to be settled wholly after 12 months[(iii)]	5,649	5,186
Long Service Leave		
- Unconditional and expected to be settled wholly within 12 months[(ii)]	8,319	7,397
- Unconditional and expected to be settled wholly after 12 months[(iii)]	50,174	44,349
	98,890	89,487
Provisions Related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months[(ii)]	4,483	4,083
- Unconditional and expected to be settled after 12 months[(iii)]	5,909	5,104
Accrued salaries and wages	22,134	15,586
TOTAL CURRENT PROVISIONS	**131,416**	**114,260**
NON-CURRENT PROVISIONS		
Employee Benefits [(i)]	21,247	20,961
Provisions related to employee benefit on-costs	2,250	2,160
TOTAL NON-CURRENT PROVISIONS	**23,497**	**23,121**
TOTAL PROVISIONS	**154,913**	**137,381**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Unconditional long service leave entitlements	64,691	57,081
Annual leave entitlements	43,562	40,598
Accrued wages and salaries	22,133	15,586
Accrued days off	1,030	995
Non-Current Employee Benefits and Related On-Costs		
Conditional long service leave entitlements[(iii)]	23,497	23,121
Total Employee Benefits and Related On-Costs	**154,913**	**137,381**
(b) Movements in Provisions		
Movement in Long Service Leave:		
Balance at start of year	**80,203**	**78,589**
Provision made during the year		
- Revaluations	(567)	(4,678)
- Expense recognising employee service	15,833	13,390
Settlement made during the year	(7,281)	(7,098)
Balance at end of year	**88,188**	**80,203**

Notes:

(i) Employee benefits consist of amounts for accrued days off, 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 3.3: Employee Benefits In The Balance Sheet (continued)

Employee Benefit Recognition
Provision is made for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

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.

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, annual leave and accrued days off 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, annual leave and accrued days off 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 - if the Health Service does not expect to wholly settle within 12 months.

Conditional LSL is disclosed as a non-current liability. 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 flows.

Termination Benefits
Termination benefits are payable when employment is terminated before the normal retirement date or when an employee decides to accept an offer of benefits in exchange for the termination of employment.

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	
	2018 $'000	2017 $'000	2018 $'000	2017 $'000
Defined benefit plans[(i)]:				
State Superannuation Fund - revised and new	405	464	13	12
Defined contribution plans:				
First State Super	25,459	24,695	660	598
Hesta	13,355	12,731	397	298
Choice of Funds (various)	1,826	1,242	196	123
	41,045	**39,132**	**1,266**	**1,031**

(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.

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.

The Health Service does not recognise any unfunded 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.

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 major employee superannuation funds and contributions made by the Health Service are disclosed above.

Note 4: Key Assets To Support Service Delivery

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

4.1 Investments and other financial assets
4.2 Property, plant and equipment
4.3 Depreciation and amortisation
4.4 Intangible assets

Note 4.1: Investments And Other Financial Assets

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	
	2018 $'000	2017 $'000	2018 $'000	2017 $'000	2018 $'000	2017 $'000	2018 $'000	2017 $'000
CURRENT								
Loans and Receivables								
Term Deposit								
- Term deposit > 3 months	-	-	950	300	-	-	950	300
Available for sale								
Managed Investment								
- VFMC Multi Strategy Funds	14,979	25,555	14,872	14,450	17,790	6,623	47,641	46,628
Total Current	**14,979**	**25,555**	**15,822**	**14,750**	**17,790**	**6,623**	**48,591**	**46,928**
NON CURRENT								
Investment								
- Cancer Therapeutics CRC	-	-	1	1	-	-	1	1
Total Non Current	**-**	**-**	**1**	**1**	**-**	**-**	**1**	**1**
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**14,979**	**25,555**	**15,823**	**14,751**	**17,790**	**6,623**	**48,592**	**46,929**
Represented by:								
Health Service Investments	14,979	25,555	14,872	14,450	17,790	6,623	47,641	46,628
Foundation investments	-	-	-	-	-	-	-	-
Jointly controlled operations investments	-	-	951	301	-	-	951	301
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**14,979**	**25,555**	**15,823**	**14,751**	**17,790**	**6,623**	**48,592**	**46,929**

(a) 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

Note 4.1: Investments And Other Financial Assets (continued)

Investment Recognition
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 as available-for-sale financial assets.

The Health Service classifies its other financial assets between current and non-current assets based on the Board or Management's intention at balance date with respect to the timing of disposal of each asset. The Health Service assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

The Health Service's investments must comply with Standing Direction 3.7.2 - Treasury and Investment Risk Management. The investment portfolio of the Health Service is managed by the Victorian Funds Management Corporation (VFMC) through specialist fund managers and a Master Custodian. The Master Custodian holds the investments and conducts settlements pursuant to instructions from the specialist fund managers.

All financial assets, except those measured at fair value through Comprehensive Operating Statement 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:
  - has transferred substantially all the risks and rewards of the asset; or
  - 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 Comprehensive Operating Statement, are subject to annual review for impairment.

In order to determine an appropriate fair value as at 30th June 2018 for its portfolio of financial assets, the Health Service used the market value of investments held, as provided by the portfolio managers.

The above valuation process was used to quantify the level of impairment (if any) on the portfolio of financial assets as at year end.

Doubtful Debts
Receivables are assessed for bad and doubtful debts on a regular basis. Those bad debts considered as written off by mutual consent are classified as a transaction expense. Bad debts not written off by mutual consent and the allowance for doubtful debts are classified as other economic flows included in the net result.

Note 4.2: Property, Plant & Equipment

(a) Gross carrying amount and accumulated depreciation

	2018 $'000	2017 $'000
Land		
Land at Fair Value	90,180	78,552
Total Land	**90,180**	**78,552**
Buildings		
Buildings under Construction at Cost	109,079	24,040
Buildings at Fair Value	545,687	498,895
Less Accumulated Depreciation	(113,206)	(84,593)
Total Buildings	**541,560**	**438,342**
Plant and Equipment		
Plant and Equipment at Fair Value	55,155	45,674
Less Accumulated Depreciation	(13,488)	(12,223)
Total Plant and Equipment	**41,667**	**33,451**
Medical Equipment		
Medical Equipment at Fair Value	108,843	101,616
Less Accumulated Depreciation	(72,717)	(65,774)
Total Medical Equipment	**36,126**	**35,842**
Non Medical Equipment		
Non Medical Equipment at Fair Value	6,718	6,534
Less Accumulated Depreciation	(4,647)	(4,167)
Total Non Medical Equipment	**2,071**	**2,367**
Computers and Communication		
Computers and Communication at Fair Value	18,122	17,119
Less Accumulated Depreciation	(17,183)	(16,502)
Total Computers and Communications	**939**	**617**
Furniture and Fittings		
Furniture and Fittings at Fair Value	7,566	7,551
Less Accumulated Depreciation	(4,866)	(4,181)
Total Furniture and Fittings	**2,700**	**3,370**
Motor Vehicles		
Motor Vehicles at Fair Value	93	93
Less Accumulated Depreciation	(93)	(93)
Total Motor Vehicles	**-**	**-**
TOTAL PROPERTY, PLANT & EQUIPMENT	**715,243**	**592,541**

Share of jointly controlled assets included in property, plant and equipment are separately disclosed in Note 8.10 Jointly Controlled Operations and Assets.

Note 4.2: Property, Plant & Equipment (continued)

(b) Reconciliations of the carrying amounts of each class of asset

	Land	Buildings	Buildings Under Constn	Plant and Equipment	Medical Equipment	Non Medical Equip-ment	Computer & Comm	Furniture and Fittings	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
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 transfers between classes	-	3,712	(10,940)	(1,117)	7,747	209	264	125	-
Depreciation and amortisation (note 4.3)	-	(28,464)	-	(1,557)	(7,414)	(489)	(778)	(698)	(39,400)
Balance at 1 July 2017	**78,552**	**414,302**	**24,040**	**33,451**	**35,842**	**2,367**	**617**	**3,370**	**592,541**
Additions	2,663	2,357	85,259	14,265	4,570	39	679	11	109,843
Disposals	-	-	-	-	(118)	-	-	(4)	(122)
Revaluation increments/ (decrements)	8,965	43,860	-	-	-	-	-	-	52,825
Net transfers between classes	-	574	(220)	(4,784)	3,948	145	324	13	-
Depreciation and amortisation (note 4.3)	-	(28,612)	-	(1,265)	(8,116)	(480)	(681)	(690)	(39,844)
Balance at 30 June 2018	**90,180**	**432,481**	**109,079**	**41,667**	**36,126**	**2,071**	**939**	**2,700**	**715,243**

Land and Buildings Carried At Valuation
As at 30th June 2014, the Valuer-General Victoria (VGV) re-valued all of the Health Service's owned land and buildings to determine their fair value. The valuation, which conformed to Australian Valuation Standards, was based on independent assessments and was underpinned by the theory that the valuations should reflect the amounts for which assets "could be exchanged between knowledgeable willing parties in an arm's length transaction". The fair value of the land was adjusted by a managerial valuation in 2017; this change was not material. Buildings had no material change to value assessed in 2017.

In compliance with FRD103F, in the year ended 30th June 2018, the Health Service's management conducted an annual assessment of the fair value of land and buildings by using the Department of Treasury and Finance Valuer-General Victoria indices for the financial year ended 30th June 2018. The indexed value was compared to individual assets written down book value as at 30th June 2018 to determine any changes in fair value.

The Department of Health and Human Services approved a managerial revaluation of the land asset class of $9 million (2017: $3.5 million) and a managerial revaluation of the buildings asset class of $43.9 million (2017: $0).

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 2018. The outcome indicated that the carrying amount of plant and equipment does approximate fair value.

Note 4.2: Property, Plant & Equipment (continued)

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30th June 2018	Fair value measurement at end of reporting period using: Level 1[(i)]	Level 2[(i)]	Level 3[(i)]
	$'000	$'000	$'000	$'000
Land at fair value				
Specialised Land	81,714	-	-	81,714
Non-Specialised Land	8,466	-	8,466	-
Total Land at fair value	**90,180**	**-**	**8,466**	**81,714**
Buildings at fair value		-		
Specialised Buildings	432,133	-	-	432,133
Non-Specialised Buildings	348	-	348	-
Total Buildings at fair value	**432,481**	**-**	**348**	**432,133**
Buildings under construction at fair value	109,079	-	-	109,079
Plant and Equipment at fair value	41,667	-	-	41,667
Medical Equipment at fair value	36,126	-	-	36,126
Non-Medical Equipment at fair value	2,071	-	2,071	-
Computers and Communication at fair value	939	-	939	-
Furniture and Fittings at fair value	2,700	-	2,700	-
Motor Vehicles at fair value	-	-	-	-
TOTAL PROPERTY, PLANT & EQUIPMENT	**715,243**	**-**	**14,524**	**700,719**

Note 4.2: Property, Plant & Equipment (continued)

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30th June 2017 $'000	Fair value measurement at end of reporting period using: Level 1(i) $'000	Level 2(i) $'000	Level 3(i) $'000
Land at fair value				
Specialised Land	71,054	-	-	71,054
Non-Specialised Land	7,498	-	7,498	-
Total Land at fair value	**78,552**	**-**	**7,498**	**71,054**
Buildings at fair value				
Specialised Buildings	413,918		-	413,918
Non-Specialised Buildings	384	-	384	-
Total Buildings at fair value	**414,302**	**-**	**384**	**413,918**
Buildings under construction at fair value	24,040	-	-	24,040
Plant and Equipment at fair value	33,451	-	-	33,451
Medical Equipment at fair value	35,842	-	-	35,842
Non-Medical Equipment at fair value	2,367	-	2,367	-
Computers and Communication at fair value	617	-	617	-
Furniture and Fittings at fair value	3,370	-	3,370	-
Motor Vehicles at fair value	-	-	-	-
TOTAL PROPERTY, PLANT & EQUIPMENT	**592,541**	**-**	**14,236**	**578,305**

(i) Classified in accordance with the fair value hierarchy.
(ii) There have been no transfers between levels during the period.

Note 4.2: Property, Plant & Equipment (continued)

(d) Reconciliation of Level 3 Fair Value

2018	Land $'000	Buildings $'000	Assets Under Constn $'000	Plant and Equipment $'000	Medical Equipment $'000	Total $'000
Balance at 1st July 2017	**71,054**	**413,918**	**24,040**	**33,451**	**35,842**	**578,305**
Additions/(disposals)	-	1,922	85,259	14,265	4,452	105,898
Assets received free of charge	2,662	1,012	-	-	-	3,674
Net transfers between classes	-	-	(220)	(4,784)	3,948	(1,056)
						-
Gains/(losses) recognised in net result						-
- Depreciation	-	(28,579)	-	(1,265)	(8,116)	(37,960)
	73,716	**388,273**	**109,079**	**41,667**	**36,126**	**648,861**
Items recognised in other comprehensive income						
- Revaluation	7,998	43,860	-	-	-	51,858
Balance at 30th June 2018	**81,714**	**432,133**	**109,079**	**41,667**	**36,126**	**700,719**

2017	Land $'000	Buildings $'000	Assets Under Constn $'000	Plant and Equipment $'000	Medical Equipment $'000	Total $'000
Balance at 1st July 2016	**68,929**	**437,623**	**13,573**	**16,237**	**32,031**	**568,393**
Additions/(disposals)	-	980	21,407	19,888	3,522	45,797
Net transfers between classes	-	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**

Note 4.2: Property, Plant & Equipment (continued)

(e) 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	Community Service Obligations adjustments [(b)]
Non-Specialised Buildings	For general/commercial buildings that are just built	Level 2	Market approach	N/A
Specialised Buildings[(a)]	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[(a)]	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Cost per square metre 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

(a) Newly built/acquired assets could be categorised as Level 2 assets as depreciation would not be a significant unobservable input (based on the 10 percent materiality threshold)

(b) CSO adjustment of 20% was applied to reduce the market approach value for the Health Service's specialised land. There were no changes in valuation techniques throughout the period to 30th June 2018.

Note 4.2: Property, Plant & Equipment (continued)

Initial Recognition
Items of property, plant and equipment are initially measured at cost and subsequently revalued at fair value less accumulated depreciation and impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government change are transferred at their carrying amounts.

Crown land is measured at fair value with regard to the property's highest and best use after consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset.

Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

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

All property, plant and equipment for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

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 reassessing 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.

For the purpose of fair value, 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 VGV is the Health Service's independent valuation agency.

The estimates and underlying assumptions are reviewed on an ongoing basis.

Fair Value Measurement
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.

Consideration of Highest and Best Use (HBU) for Non-Financial Physical Assets
Judgements about highest and best use take into account the characteristics of the assets concerned, including restrictions on the use and disposal of assets arising from the asset's physical nature and any applicable legislative/contractual arrangements.

In accordance with paragraph AASB 13.29, the current use of a non-physical asset is its HBU unless market and other factors suggest that a different use by market participants would maximise the value of the asset.

Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, the Health Service is required to engage with VGV for formal HBU assessment.

Note 4.2: Property, Plant & Equipment (continued)

These indicators, as a minimum, include:

External factors:
- Changed acts, regulations, local law or such instrument which affects or may affect the use or development of the asset.
- Changes in planning scheme, including zones, reservations, overlays that would affect or remove the restrictions imposed on the asset's use from its past use.
- Evidence that suggests the current use of an asset is no longer core to requirements to deliver the Health Service's service obligations.
- Evidence that suggests that the asset might be sold or demolished upon reaching the late stage of an asset's life cycle.

Valuation Hierarchy
The Health Service uses valuation techniques that are appropriate for the circumstances and where there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy.

Identifying Unobservable Inputs (Level 3) Fair Value Measurements
Level 3 fair value inputs are unobservable valuation inputs for an asset or liability. These inputs require significant judgement and assumptions in deriving fair value for both financial and non-financial assets.

Unobservable inputs shall be used to measure fair value when relevant observable inputs are not available. This caters for assets or liabilities which have little to no associated market activity at the measurement date. The fair value measurement objective remains the same, that is, an exit price at the measurement date from the perspective of a market participant that holds the asset or incurred the liability. Therefore, unobservable inputs shall reflect the assumptions that market participants would use when pricing the asset or liability, including assumptions about risk.

Assumptions about risk include the inherent risk in a particular valuation technique used to measure fair value (such as a pricing risk model) and the risk inherent in the inputs to the valuation technique. A measurement that does not include an adjustment for risk would not represent a fair value measurement if market participants would include one when pricing the asset or liability, that is, it might be necessary to include a risk adjustment when there is significant measurement uncertainty.

The Health Service develops unobservable inputs using the best information available in the circumstances, which might include its own data. In developing unobservable inputs, the Health Service begins with its own data but it shall adjust this data if reasonably available information indicates that other market participants would use different data or there is something particular to the Health Service that is not available to other market participants. Unobservable inputs developed in the manner described are considered market participant assumptions and meet the object of a fair value measurement.

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, 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 was 30th June 2014.

In June 2018 a managerial valuation was carried out in accordance with FRD 103F to revalue the land and buildings to its fair value (June 2017 managerial valuation done for land only).

Note 4.2: Property, Plant & Equipment (continued)

Specialised Land and Specialised Buildings
Specialised land includes Crown Land which is measured at fair value with regard to the property's highest and best use after consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the assets are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best use.

During the reporting period, the Health Service held Crown land. The nature of this asset means that there are certain limitations and restrictions imposed on its use and/or disposal that may impact their fair value.

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 Service, 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 VGV. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation was 30th June 2014. Subsequent to scheduled revaluation, land and buildings fair value assessment were carried out using VGV published indices.

In June 2018 a managerial valuation was carried out in accordance with FRD 103F to revalue the land and buildings to its fair value.

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 2018.

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

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

Note 4.2: Property, Plant & Equipment (continued)

Revaluations increments are recognised in Other Comprehensive Income and are credited directly to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net result, the increment is recognised as income in the net result.

Revaluations 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 asset.

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 class.

Revaluation surplus is not transferred to accumulated funds on de-recognition of the relevant asset, except where an asset is transferred via contributed capital.

In accordance with FRD 103F, the Health Service's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Note 4.3: Depreciation And Amortisation

	2018 $'000	2017 $'000
Depreciation		
Buildings	28,612	28,464
Plant and Equipment	1,265	1,557
Medical Equipment	8,116	7,414
Computers and Communication	681	778
Furniture and Fittings	690	698
Non Medical Equipment	480	489
Total Depreciation	**39,844**	**39,400**
Amortisation		
Intangibles Assets	1,244	1,168
Total Amortisation	**1,244**	**1,168**
Total Depreciation and Amortisation	**41,088**	**40,568**

Depreciation
All infrastructure assets, buildings, plant and equipment and other non-financial physical assets (excluding items under operating leases, assets held for sale, land and investment properties) that have finite useful lives are depreciated. Depreciation is calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life (refer AASB 116 *Property, Plant and Equipment)* .

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

	2018	2017
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	5-10 Years	5-10 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.

Indefinite life assets: Land is considered to have an indefinite life, is not depreciated. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

Note 4.4: Intangible Assets

	2018 $'000	2017 $'000
Intangible Produced Assets - Software	18,335	12,879
Less Accumulated Amortisation	(13,236)	(11,991)
Total Intangible Assets	**5,099**	**888**

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 2016	**1,631**	**1,631**
Additions	425	425
Amortisation	(1,168)	(1,168)
Balance at 1st July 2017	**888**	**888**
Additions	5,455	5,455
Amortisation	(1,244)	(1,244)
Balance at 30th June 2018	**5,099**	**5,099**

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 in which it is incurred.

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 systematic basis over the asset's useful life. Intangible assets with finite useful lives are amortised over a 3 year period (2017: 3 years).

Note 5: Other Assets And Liabilities

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

Structure
5.1 Receivables
5.2 Payables

Note 5.1: Receivables

	2018 $'000	2017 $'000
CURRENT		
Contractual		
Inter Hospital Debtors	852	1,038
Trade Debtors	2,291	1,825
Patient Fees	4,758	6,259
Accrued Revenue	5,871	4,631
less Allowance for Doubtful Debts		
Trade Debtors	(156)	(160)
Patient Fees	(2,279)	(3,824)
	11,337	**9,769**
Statutory		
GST Receivable	964	1,358
Accrued Revenue - Department of Health and Human Services	-	449
	964	**1,807**
TOTAL CURRENT RECEIVABLES	**12,301**	**11,576**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	28,134	24,283
TOTAL NON CURRENT RECEIVABLES	**28,134**	**24,283**
TOTAL RECEIVABLES	**40,435**	**35,859**

(a) Movement in the allowance for doubtful debts

	2018 $'000	2017 $'000
Balance at beginning of year	3,984	2,472
Increase/(decrease) in allowance recognised in net result	(1,549)	1,512
Balance at end of year	**2,435**	**3,984**

(b) 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.

Note 5.1: Receivables (continued)

Receivables
Receivables consist of:

- contractual receivables, which consists of 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. Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition.

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

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.*

A provision is made for estimated irrecoverable amounts when there is objective evidence that an individual receivable is impaired. The increase in the provision for the year is recognised in the net result.

Bad debts considered as written off by mutual consent are classified as a transaction expense. Bad debts not written off but included in the provision for doubtful debts are classified as other economic flows in the net result.

Note 5.2: Payables

	2018 $'000	2017 $'000
CURRENT		
Contractual		
Trade Creditors	10,265	12,106
Accrued Expenses	13,654	14,360
Salary Packaging	2,252	2,544
Amounts payable to Governments and Agencies	5,175	5,416
Other	10,636	2,222
	41,982	**36,648**
Statutory		
Repayable Grants - Department of Health and Human Services	2,394	-
	2,394	**-**
TOTAL PAYABLES	**44,376**	**36,648**

(a) 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, classified as financial instruments and measured at amortised cost. Accounts payable represent liabilities for goods and services provided to the Health Service prior to the end of the financial year that are unpaid. The credit terms for accounts payable is Net 30 days.
- statutory payables, that are recognised and measured in the same way as 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 contracts.

Maturity Analysis of Financial Liabilities as at 30th June

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.

	Carrying Amount	Nominal Amount	Maturity Dates			
			Less than 1 Month	1-3 Months	3 Months-1 Year	1-5 Years
2018	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Liabilities						
At amortised cost						
Payables	31,346	31,346	30,755	570	21	-
Other Financial Liabilities[(i)]	10,636	10,636	10,636	-	-	-
Total Financial Liabilities	**41,982**	**41,982**	**41,391**	**570**	**21**	**-**
2017						
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**	**-**

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

Note 6: Funding For Operations

This section provides information on the sources of finance utilised by the Health Service during its operations, along with interest expenses (the cost of borrowings) and other information related to financing activities of the Health Service.

This section includes disclosures of balances that are financial instruments (such as borrowings and 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

Finance Leases
The Health Service does not hold any finance lease arrangements, either as a lessor or as a lessee.

Operating Leases

	2018 $'000	2017 $'000
Non-cancellable operating lease		
Not longer than one year	767	426
Longer than one year but not longer than five years	994	788
Longer than five years	-	-
	1,761	**1,214**

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.

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.

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

	2018 $'000	2017 $'000
Cash on Hand	14	16
Cash at Bank	26,341	17,581
Total Cash and Cash Equivalents	**26,355**	**17,597**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	26,355	17,597
Total Cash and Cash Equivalents	**26,355**	**17,597**

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. These 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.

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

Note 6.3: Commitments For Expenditure

(a) Commitments

	2018 $'000	2017 $'000
Capital Expenditure Commitments		
Payable:		
Buildings	259,286	145,465
Plant and equipment	3,809	3,997
Medical equipment	1,156	2,120
Computer equipment	2,360	7,623
Furniture and fittings	567	913
Intangible assets	5,875	12,673
Total capital expenditure commitments	**273,053**	**172,791**
Operating Commitments		
Payable:		
Operating commitments	168,238	188,847
Total operating commitments	**168,238**	**188,847**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating leases - non cancellable	1,761	1,214
Total lease commitments	**1,761**	**1,214**
Total Commitments (inclusive of GST)	**443,052**	**362,852**

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

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 6.3: Commitments For Expenditure (continued)

(b) Commitments Payable

	2018 $'000	2017 $'000
Capital Expenditure Commitments		
Less than 1 year	214,495	172,110
Longer than 1 year but not longer than 5 years	58,558	681
5 years or more	-	-
Total capital expenditure commitments	**273,053**	**172,791**
Operating Commitments		
Less than 1 year	69,698	70,131
Longer than 1 year but not longer than 5 years	96,461	104,154
5 years or more	2,079	14,562
Total operating commitments	**168,238**	**188,847**
Lease Commitments		
Less than 1 year	767	426
Longer than 1 year but not longer than 5 years	994	788
5 years or more	-	-
Total lease commitments	**1,761**	**1,214**
Total Commitments (inclusive of GST)	**443,052**	**362,852**
Less: GST recoverable from the Australian Tax Office [(i)]	(38,045)	(26,843)
Total Commitments (exclusive of GST)	**405,007**	**336,009**

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

Note 7: Risks, Contingencies And Valuation Uncertainties

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 subjective assessment, which for the Health Service is related mainly to fair value determination.

Structure

7.1 Financial instruments
7.2 Contingent assets and liabilities

Note 7.1: Financial Instruments

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

Financial Instruments: categorisation

2018	Contractual financial assets - receivables $'000	Contractual financial assets - available-for-sale $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets				
Cash and Cash Equivalents	26,355	-	-	26,355
Receivables				
- Trade Debtors	3,143	-	-	3,143
- Patient Fees	4,758	-	-	4,758
- Other Receivables	5,871	-	-	5,871
Other Financial Assets				
- Term Deposit	950	-	-	950
- Managed Funds	-	47,641	-	47,641
- Shares in Other Entities	-	1	-	1
Total Financial Assets [(i)]	**41,077**	**47,642**	**-**	**88,719**
Financial Liabilities				
Payables	-	-	31,346	31,346
Other Financial Liabilities	-	-	10,636	10,636
Total Financial Liabilities [(i)]	**-**	**-**	**41,982**	**41,982**

Note 7.1: Financial Instruments (continued)

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 [i]	**-**	**-**	**36,648**	**36,648**

(i) The carrying amount excludes statutory receivables (i.e. GST input tax credit recoverable) and statutory payables (i.e. Revenue in advance and DHHS payable).

Net holding gain/(loss) on financial instruments by category

2018	Net Holding Gain/(Loss) $'000	Total Interest Income/ (Expense) $'000	Fee Income/ (Expense) $'000	Impairment Loss $'000	Total $'000
Financial Assets					
Cash and Cash Equivalents[i]	-	890	-	-	890
Available-for-Sale[i]	765	1,527	-	-	2,292
Total Financial Assets	**765**	**2,417**	**-**	**-**	**3,182**
2017					
Financial Assets					
Cash and Cash Equivalents[i]	-	934	-	-	934
Available-for-Sale[i]	419	1,566	-	-	1,985
Total Financial Assets	**419**	**2,500**	**-**	**-**	**2,919**

(i) For cash and cash equivalents, loans and receivables and financial assets available-for-sale, the net gain or loss is calculated by taking the movement in the fair value of the asset, the interest revenue, plus or minus foreign exchange gains or losses arising from revaluation of the financial assets, and minus any impairment recognised in the net result.

Note 7.1: Financial Instruments (continued)

Categories of Financial Instruments

Loans and receivables and cash

Loans and receivables and cash 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, and for assets, less any impairment. The Health Service recognises the following assets in this category:

- cash and deposits
- receivables (excluding statutory receivables)
- term deposits

Available-For-Sale financial instrument 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, they are measured at fair value with gain and losses arising from changes in fair value recognised in "Other Economic Flows - Other Comprehensive Income" until the investment is disposed. Movements resulting from impairment are recognised in the net result as other economic flows. On disposal, the cumulative gain or loss previously recognised in "Other Economic Flows - Other Comprehensive Income" is transferred to other economic flows in the net result.

Financial assets and liabilities at fair value through net result

Financial assets are categorised as fair value through net result at trade date, or 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 net result are initially measured at fair value; attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net result as other economic flows.

Financial liabilities at amortised cost

Financial liabilities at amortised cost 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. The Health Service recognises the following liabilities in this category:

- payables (excluding statutory payables)

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.

Some master netting arrangements do not result in an offset of balance sheet assets and liabilities. Where the Health Service does not have a legally enforceable right to offset recognised amounts, because the right to offset is enforceable only on the occurrence of future events such as default, insolvency or bankruptcy, they are reported on a gross basis.

Note 7.1: Financial Instruments (continued)

Derecognition of financial assets
A financial asset or, where applicable, a part of a financial asset or 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 neither transferred its rights to receive cash flows from the asset and either:
  - has transferred substantially all the risks and rewards of the asset; or
  - 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* .

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

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 "other economic flow" in the Comprehensive Operating Statement.

Note 7.2: Contingent Assets & Contingent Liabilities

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

	2018 $'000	2017 $'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
Total Quantifiable Contingent Liabilities	**-**	**260**
Non-Quantifiable	**-**	**-**

All amounts shown in the 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.

Any claims against the Health Service are covered by the public healthcare insurance managed by the Victorian Managed Insurance Authority (VMIA).

Note 8: Other Disclosures

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

Structure

Note 8.1: Equity

	2018 $'000	2017 $'000
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus[(i)]		
Balance at the beginning of the reporting period	306,241	302,777
Revaluation Increment/(Decrement)		
- Land	8,965	3,464
- Buildings	43,860	-
Balance at the end of the reporting period	**359,066**	**306,241**
Represented by:		
- Land	75,342	66,377
- Buildings	283,724	239,864
	359,066	**306,241**
Financial Assets Available-for-Sale Revaluation Surplus [(ii)]		
Balance at the beginning of the reporting period	521	101
Valuation gain recognised	1,012	528
Cumulative gain transferred to Operating Statement on sale of financial asset	(247)	(108)
Balance at the end of the reporting period	**1,286**	**521**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	4,279	2,892
Transfer from Accumulated Surplus	2,327	1,387
Share of decrements in surplus attributed to joint venture	-	-
Balance at the end of the reporting period	**6,606**	**4,279**
Total Surpluses	**366,958**	**311,041**
(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**

Note 8.1: Equity (continued)

(c) Accumulated Surplus		
Balance at the beginning of the reporting period	10,026	11,296
Net Result for the Year	63,407	117
Transfers to Restricted Specific Purpose Surplus	(2,327)	(1,387)
Balance at the end of the reporting period	**71,106**	**10,026**
(d) Total Equity at End of Year	**641,044**	**524,047**

(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. Where a revalued financial asset is sold, that portion of the reserve which relates to the financial asset is effectively realised and is recognised in the Comprehensive Operating Statement. Where a revalued financial asset is impaired, that portion of the reserve which relates to that financial asset is recognised in the Comprehensive Operating Statement.*

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 or distributions or that have been designated as contributed capital are also treated as contributed capital. Contributed capital consists of grants received from the owners, being the DHHS. No contributed capital was received in the 2017/18 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 Flow From Operating Activities

	2018 $'000	2017 $'000
Net Result For The Year	63,407	117
Non-cash movements:		
Depreciation and amortisation	41,088	40,568
Revaluation of long service leave	(567)	(4,678)
Provision for doubtful debts	(1,546)	1,512
Asset received free of charge	(3,674)	
Movements included in investing and financing activities:		
Net (gain)/loss from disposal of non financial physical assets	20	44
Net (gain)/loss from disposal of financial assets	(247)	(108)
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/decrease in receivables	(22)	1,101
(Increase)/decrease in other assets	(3,457)	(2,662)
(Increase)/decrease in prepayments	(537)	(1,417)
Increase/(decrease) in payables	(238)	1,997
Increase/(decrease) in provisions	18,098	11,397
Increase/(decrease) in other liabilities	8,414	1,151
Change in inventories	191	(336)
NET CASH INFLOW FROM OPERATING ACTIVITIES	**120,930**	**48,686**

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 Ministers	
The Honourable Jill Hennessy, Minister for Health and Minister for Ambulance Services	1/07/2017 - 30/06/2018
The Honourable Martin Foley, Minister for Housing, Disability and Ageing and Minister for Mental Health	1/07/2017 - 30/06/2018
Governing Board	
The Honourable Bronwyn Pike (Chair)	1/07/2017 - 30/06/2018
Professor Colin Clark	1/07/2017 - 30/06/2018
Mrs Elleni Bereded-Samuel	1/07/2017 - 30/06/2018
Mr David Shaw	1/07/2017 - 30/06/2018
Dr Robert Mitchell	1/07/2017 - 30/06/2018
Dr Phuong Pham	1/07/2017 - 30/06/2018
Mr Kelvyn Lavelle	1/07/2017 - 30/06/2018
Dr Catherine Hutton	1/07/2017 - 30/06/2018
Ms Colleen Gates	1/07/2017 - 30/06/2018
Accountable Officer	
Mr Russell Harrison	1/07/2017 - 30/06/2018

Remuneration of Responsible Persons
The number of Responsible Persons are shown in their relevant income bands:

	2018 No.	2017 No.
Income Band		
$0 - $9,999	1	3
$10,000 - $19,999	0	0
$20,000 - $29,999	0	0
$30,000 - $39,999	2	1
$40,000 - $49,999	6	7
$50,000 - $59,999	0	1
$60,000 - $69,999	0	0
$70,000 - $79,999	0	1
$80,000 - $89,999	1	0
$310,000 - $319,999	1	0
$400,000 - $409,999	1	0
$480,000 - $489,999	0	1
Total Numbers	**12**	**14**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$1,176,459**	**$982,146**

Note: Above remuneration includes payments made up to 30th June 2018 to an Accountable Officer and Director that have resigned as at 30th June 2018.

Amounts relating to the Governing Board Members and Accountable Officer are disclosed in the Health Service's consolidated financial statements.

Amounts relating to the Responsible Ministers are reported within the Department of Parliamentary Services Financial Report as disclosed in Note 8.5 Related Parties.

Note 8.4: 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
Salaries and wages, 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
Pensions and other retirement benefits paid or payable on a discrete basis when employment has ceased.

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

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

Total remuneration payable to executives during the year included additional executive officers and a number of executives who received bonus payments during the year. These bonus payments depend on the terms of individual employment contracts.

Several factors affected total remuneration payable to executives over the year. A number of employment contracts were completed and renegotiated and a number of executive officers retired, resigned or were retrenched in the past year. This has an impact on remuneration figures for the termination benefits category.

Remuneration of Executive Officers (including Key Management Personnel disclosed in Note 8.5)	**Total Remuneration**	
	2018 ($'000)	**2017 ($'000)**
Short-term employee benefits	7,280	6,840
Post-employment benefits	581	619
Other long-term benefits	367	224
Termination benefits	69	-
Total remuneration[(i)]	**8,297**	**7,683**
Total number of executives	38	41
Total annualised employee equivalent (AEE)[(ii)]	**33**	**37**

(i) 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 Note 8.5 Related Parties.

(ii) Annualised employee equivalent is based on working 38 ordinary hours per week 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 (KMP) and their close family members;
- Cabinet ministers (where applicable) and their close family members; and
- All hospitals and public sector entities that are controlled and consolidated into the State of Victoria financial statements.

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of the Health Service and its controlled entity, directly or indirectly.

The Board of Directors and the Executive Directors of the Health Service are deemed to be KMPs.

Entity	KMPs	Position Title
Western Health	The Honourable Bronwyn Pike	Chair of the Board
Western Health	Professor Colin Clark	Board Member
Western Health	Mrs Elleni Bereded-Samuel	Board Member
Western Health	Mr David Shaw	Board Member
Western Health	Dr Robert Mitchell	Board Member
Western Health	Dr Phuong Pham	Board Member
Western Health	Mr Kelvyn Lavelle	Board Member
Western Health	Dr Catherine Hutton	Board Member
Western Health	Ms Colleen Gates	Board Member
Western Health	Mr Russell Harrison	Chief Executive Officer
Western Health	Mr Mark Lawrence	Chief Financial Officer
Western Health	Ms Natasha Toohey	Chief Operating Officer
Western Health	Ms Iresha Herath	General Counsel
Western Health	Mr Paul Eleftheriou	Chief Medical Officer
Western Health	Ms Suellen Bruce	Executive Director People & Culture
Western Health	Mr Shane Crowe	Executive Director Nursing & Midwifery
Western Health	Ms Arlene Wake	Executive Director Community Integration, Allied Health & Service Planning

The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances are set by the *Parliamentary Salaries and Superannuation Act 1968*, and is reported within the Department of Parliamentary Services' Financial Report.

Compensation - KMPs	**2018 ($'000)**	**2017 ($'000)**
Short-term employee benefits	2,948	3,135
Post-employment benefits	214	219
Other long-term benefits	139	77
Termination benefits	18	-
Total[(i)]	**3,319**	**3,431**

(i) KMPs are also reported in Note 8.3 Responsible Persons or Note 8.4 Remuneration of Executives.

Note 8.5: Related Parties

Significant Transactions with Government Related Entities
The Health Service received funding from the Department of Health and Human Services of $664 million (2017: $638 million) and indirect contributions of $4 million (2017: $3 million).

Expenses incurred by the Health Service in delivering services and outputs are in accordance with Health Purchasing Victoria requirements. Goods and services including procurement, diagnostics, patient meals and multi-site operational support are provided by other Victorian Health Service Providers on commercial terms.

Professional medical indemnity insurance and other insurance products are obtained from a Victorian Public Finance Corporation.

Treasury Risk Management Directions require the Health Service to hold cash (in excess of working capital) and investments, and source all borrowings from Victorian Public Finance Corporations.

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, all other related party transactions that involved KMPs and their close family members have been entered into on an arm's length basis. Transactions are disclosed when they are considered material to the users of the financial report in making and evaluating decisions about the allocation of scare resources.

There were no related party transactions with Cabinet Ministers required to be disclosed in 2018.

There were no related party transactions required to be disclosed for the Health Service Board of Directors and Executive Directors in 2018.

Except for the transactions listed below, there were no other related party transactions required to be disclosed for the Health Service Foundation Board of Directors in 2018.

Controlled entity related party transactions

Western Health Foundation
The Honourable Bronwyn Pike is the Chair of the Health Service and is a Director of the Western Health Foundation.

The transactions between the entities relate to reimbursements made by the Western Health Foundation to the Health Service for goods and services and the transfer of funds by way of distributions made to the Health Service. All dealings are in the normal course of business and are on normal commercial terms and conditions.

	2018 ($'000)	2017 ($'000)
Distribution and reimbursements of funds by Western Health Foundation	1,116	647
Intercompany receivable at 30th June	-	-
Total	**1,116**	**647**

Note 8.6: Remuneration Of Auditors

	2018 $'000	2017 $'000
Victorian Auditor-General's Office		
Audit of financial statement	132	117
	132	**117**

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 2018 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 2018, 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.

Topic	***Key requirements***	***Effective date***
AASB 9 *Financial instruments*	The key changes introduced by AASB 9 include 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 January 2018
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, and to amend Reduced Disclosure requirements	1 January 2018
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 January 2018
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. Note that amending standard AASB 2015-8 *Amendments to Australian Accounting Standards - Effective Date of AASB 15* has deferred the effective date of AASB 15 to annual reporting periods beginning on or after January 2018, instead of 1 January 2017.	1 January 2018

Note 8.7: AASBs Issued That Are Not Yet Effective (continued)

AASB 2014-5 *Amendments to Australian Accounting Standards arising from AASB 15*	Amends the measurement of trade receivables and the recognition of dividends as follow: - Trade receivables that do not have a significant financing component are to be measured at their transaction price at initial recognition. - Dividends are recognised in the profit and loss only when: o the entity's right to receive payment of the dividend is established; o it is probable that the economic benefits associated with the dividend will flow to the entity; and o the amount can be measured reliably.	1 January 2018, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply 1 January 2018
AASB 2015-8 *Amendments to Australian Accounting Standards - Effective Date of AASB 15*	This standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018
AASB 2016-3 *Amendments to Australian Accounting Standards - Clarifications to AASB 15*	This Standard amends AASB 15 to clarify the requirements for 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 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 to access).	1 January 2018
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-for-profit entities from 1 January 2018 to 1 January 2019.	1 January 2019
AASB 2016-8 *Amendments to Australian Accounting Standards - Australian Implementation Guidance for Not-for-Profit Entities*	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	1 January 2019
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of operating leases (which are currently not recognised) on balance sheet.	1 January 2019

Note 8.7: AASBs Issued That Are Not Yet Effective (continued)

AASB 1058 *Income of Not-for-Profit Entities*	AASB 1058 standard will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 *Contributions.* The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context. AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objectives.	1 January 2019

The following pronouncements are also issued but not effective for the 2017-18 reporting period. At this stage, the preliminary assessment suggests they may have insignificant impacts on public sector reporting.

- 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 2017-3 Amendments to Australian Accounting Standards - *Clarifications to AASB 4*
- AASB 2017-5 Amendments to Australian Accounting Standards - *Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections*
- AASB 2017-6 Amendments to Australian Accounting Standards - *Prepayment Features with Negative Compensation.*
- AASB 2017-7 Amendments to Australian Accounting Standards - *Long-term interests in Associates and Joint Ventures.*
- AASB 2018-1 Amendments to Australian Accounting Standards - *Annual Improvements 2015 - 2017 Cycle*
- AASB 2018-2 Amendments to Australian Accounting Standards - *Plan Amendments, Curtailment or Settlement*

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 reporting 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 reporting 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 Entities

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 contributions to the consolidated results

Net Result For The Year	2018 ($'000)	2017 ($'000)
Western Health Foundation Limited	1,214	1,029
	1,214	**1,029**

Note 8.10: Jointly Controlled Operations

Name of Entity	Principal Activity	Ownership Interest 2018 %	Ownership Interest 2017 %
Victorian Comprehensive Cancer Centre Joint Venture (VCCC)	Cancer research, education and training and patient care	10%	10%

The Health Service's interest in the above jointly controlled operations are detailed below. The amounts are included in the consolidated financial statements under the respective categories below.

	2018 $'000	2017 $'000
Current Assets		
Cash and cash equivalents	636	266
Investments and other financial assets	950	301
Receivables	8	3
Prepayments	101	3
Total Current Assets	**1,695**	**573**
Non-Current Assets		
Investments and other financial assets	1	1
Property, plant and equipment	18	3
Total Non-Current Assets	**19**	**4**
TOTAL ASSETS	**1,714**	**577**
Current Liabilities		
Payables	25	17
Accrued expenses	18	10
Provisions	12	8
Total Current Liabilities	**55**	**35**
Non-Current Liabilities		
Provisions	10	6
Total Non-Current Liabilities	**10**	**6**
TOTAL LIABILITIES	**65**	**41**
NET ASSETS	**1,649**	**536**
EQUITY		
Accumulated surplus/(deficit)	1,649	536
TOTAL EQUITY	**1,649**	**536**

Note 8.10: Jointly Controlled Operations (continued)

The Health Service's interest in revenues and expenses resulting from jointly controlled operations are detailed below.

	2018 $'000	2017 $'000
Revenue		
Grants	1,397	512
Members Contribution	147	145
Other Income	13	22
Interest Income	21	9
Total Revenue	**1,578**	**688**
Expenses		
Employee Benefits	242	142
Operating Expenses	221	177
Depreciation	2	1
Total Expenses	**465**	**320**
NET RESULT	**1,113**	**368**

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

Contingent liabilities and capital commitments
There are no known contingent liabilities or capital commitments held by the jointly controlled operations at balance date.

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 (2017: 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 8.11: Economic Dependency

The majority of the Health Service's revenue is provided by grants from the Australian Commonwealth Government and the Victorian State Government funnelled through the Victorian Department of Health and Human Services (DHHS). In total, in the 2017/18 financial year, Commonwealth funding accounted for approximately 44 percent of revenue and State funding accounted for approximately 49 percent of revenue.

The Directors note that at the time of approving the 2017/18 annual accounts, the draft operating budget for 2018/19 is a deficit and there is a significant funding shortfall in regard to the commissioning of the Joan Kirner Women's and Children's Hospital (JKWCH), due to open in May 2019. These issues are subject to change as discussions with the DHHS continue and as the 2018/19 budget setting process is concluded.

In respect to the opening of the JKWCH the DHHS has provided a letter stating that the DHHS is *"committed to providing the funding support required during the 2018/19 to enable the successful opening of JKWCH"* .

Public health services in Victoria have periodically suffered from cash flow shortages brought on by operating deficits. The Victorian State Government stands behind the public health system and has provided additional funds as needed to health services.

Whilst the going concern test is future focussed there are criteria that are used to inform that judgement. These include cash reserves, the current asset ratio, the operating result before capital items and the net cash flow from operations. Western Health had 22 days operating cash at June 30th 2018 which exceeds the DHHS benchmark of 14. The net operating result for the year, before capital items was a small surplus, the benchmark being a surplus. The current asset ratio as at June 30th 2018 was 0.5 however this includes employee entitlements not expected to be paid within the next 12 months. Excluding these entitlements gives a current asset ratio of 0.8 which exceeds the DHHS benchmark of 0.7.

The Directors have no reason to doubt the continued financial support of its service by the Victorian State Government and consequently the financial statements have been prepared on a going concern basis.

Independent Auditor's Report

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 entity and health service balance sheet as at 30 June 2018
- consolidated entity and health service comprehensive operating statement for the year then ended
- consolidated entity and health service statement of changes in equity for the year then ended
- consolidated entity and health service cash flow statement for the year then ended
- notes to the financial statements, including significant accounting policies
- board member's, accountable officer's and chief finance and accounting officer's declaration.

In my opinion, the financial report presents fairly, in all material respects, the financial positions of the consolidated entity and the health service as at 30 June 2018 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. I further describe my responsibilities under that Act and those standards 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 health service and 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 Victoria. 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 health service and 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.

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 my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the health service and 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 health service and 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 health service and 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 health service and consolidated entity to express an opinion on the financial report. I remain responsible for the direction, supervision and performance of the audit of the health service and 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
16 August 2018

Ron Mak
as delegate for the Auditor-General of Victoria

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Western Health

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