2019-20 ANNUAL REPORT

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 integ**rity**

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. We pay our respects to their Elders past, present and emerging.

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Board Chair and CEO Message

A message from the Board Chair and the Chief Executive

Our ability to adapt and innovate is a source of pride at Western Health. As we provide care for the very diverse communities of one of the fastest growing regions of Australia, our agility and teamwork across our sites and departments is vital to our everyday operations. In 2020, these qualities became more valuable than ever. Just like health services all around Australia and the world, Western Health and its resources have been tested by the COVID-19 pandemic. We are extremely proud of the way our 7000+ staff members have responded to this unprecedented challenge, all the while continuing to provide Best Care for our patients and communities. We also acknowledge and appreciate the tremendous support provided to us by our community during the pandemic.

RESPONDING TO THE COVID-19 PANDEMIC

Western Health's formal coronavirus response began in early February 2020 when we established our COVID Command Centre. This involved establishing an expert in-house team to develop a clear emergency response, specific to COVID-19. Our Surge Management Plan covered the four key areas of Logistics, Operations, Workforce and Quality and Safety, and detailed how all areas of our organisation would respond to surges in patient demand. At a time when our counterparts in Europe were facing outbreaks that were overwhelming their hospitals, we were conscious of the need to plan for any eventuality. We worked closely with other Health Services and the Department of Health and Human Services to develop and refine all aspects of our plan over several months.

With the Surge Management Plan setting our foundation, an extraordinary amount of work across our sites and departments followed, with the safety and wellbeing of our staff, patients, volunteers and visitors prioritised throughout. Our PPE taskforce, for example, worked tirelessly to ensure there was clarity about use and adequate supply of personal protective equipment for staff, as well as ongoing education about its use.

Our many other programs have included the upskilling and retraining of hundreds of nursing staff, ensuring we could cope with increasing numbers of COVID-19 cases and higher acuity patients overall. We have also recruited substantial numbers of nurses, midwives, student nurses/midwives and patient care attendants to place Western Health in the best possible position to manage the COVID-19 pandemic.

Staff wellbeing has been a key focus during the pandemic. This is a difficult time for staff, characterised by increased pressure, uncertainty and worry. We have implemented a range of initiatives to support our staff, including increasing the availability of Employee Assistance Program (EAP) Counsellors and developing Wellbeing Hubs at Footscray, Sunshine and Williamstown Hospital. Since opening over 3,500 employees have used each of the Footscray and Sunshine Hubs, and over 1,500 staff have used the Hub at Williamstown.

To keep staff informed as our preparations – and the pandemic itself – continues to evolve, the COVID leadership team has overseen the development (and continual review) of new clinical and organisational guidelines and a new microsite was developed. This site has attracted more than 77,000 users, from health care staff within and external to Western Health.

We have set up telehealth programs across a range of specialities, allowing our patients to continue to receive care without having to travel to our sites. A similar principle led to the introduction of our new Rapid Allied Health service, which provides urgent home visits from physiotherapists, occupational therapists and social workers.

Western Health has also made a considerable contribution to the Victorian Government's broader response to COVID-19. This includes the running of Respiratory Assessment Clinics at Sunshine and Sunbury, a drive-through testing service at the Melbourne Showgrounds, as well as a number of pop-up testing sites. Our geriatricians and outreach teams have also provided advice and on-site support to significant numbers of residential care facilities across our region.

In the meantime, our intensive care team has made international news for developing the 'COVID-19 hood' in collaboration with the University of Melbourne. This device is now protecting from infection frontline staff caring for COVID-positive patients.

Overall, it has been an incredible effort from everyone at Western Health. We would like to make particular mention of our Infectious Diseases and Infection Prevention teams for their guidance through unprecedented times. However thanks go to every single member of the Western Health team for their ongoing commitment to our patients and communities.

Board Chair and CEO Message

It is a testament to the resilience and dedication of our staff that significant projects have continued over the past year in an environment where providing timely access to safe and effective care for a rapidly growing population with complex health needs has been incredibly challenging.

The following is a summary of significant activity undertaken at Western Health prior to and continuing through our response to the COVID-19 pandemic over 2019-20. In several cases, projects have been adapted to support our pandemic response; adaptions that may result in sustainable enhancements to care and service.

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.

An independent assessment of how well Western Health meets this vision was undertaken when we participated in an organisation wide Accreditation Survey against the eight National Safety and Quality Health Service (NSQHS) Standards from March 2nd – March 6th, 2020.

The final Accreditation report was received in May 2020 and highlights the achievements of Western Health in providing Best Care. All nine Accreditation Assessors conveyed their positive feedback in relation to our services, advising that we met all of the requirements for continued Accreditation, with no recommendations made.

The report reflects that Western Health has been successful with translating knowledge of Best Care from Board to Ward, and our Live Best Care approach has been broadly adopted where patient care takes place.

SUPPORTING THE BEST CLINICAL DECISIONS

In early 2019 Western Health completed a major project to implement an Electronic Medical Record (EMR) across the organisation. This was a detailed and complex process but an important step in supporting clinical decision making and electronic ordering of medications, pathology, imaging and more. Over the past year, planning has commenced for Phase II of EMR implementation.

Tying in with patient information on the Electronic Medical Record, Western Health has become the first health service in Australia to offer the meal-ordering CBORD Patient app, with roll-out across the organisation fast-tracked during the COVID-19 pandemic. CBORD is available to all Western Health patients. However it has been particularly useful for isolated patients during the pandemic as it allows them to select their meals when food services staff are unable to enter their room to discuss meal choices. The new CBORD system represents a quantum leap in the ordering and delivery of meals and creating a record of the dietary and nutritional needs of patients, as well as their preferences.

Our Electronic Medical Record has also supported a significant project to develop and utilise new Comprehensive Care risk assessment tools and inter-disciplinary plans of care.

These went live in the Electronic Medical Record in November 2019 and cover nine domains of patient care: falls, pressure injuries, poor nutrition and malnutrition, continence, delirium/cognitive impairment, end of life, occupational violence and aggression, suicide and self-harm, and restrictive practices. Central to our redesigned Comprehensive Care approach is looking at patients holistically, recognising that all nine domains are linked, and involving patients, families, carers and other support people in the setting of patient goals.

TACKLING CHRONIC DISEASE

The challenge of caring for a diverse community with higher than average rates of chronic and complex disease inspires us to design and deliver innovative service delivery models. Our pilot of the Western HealthLinks program has allowed us to take a different approach to how we manage the needs of patients with complex illnesses. This innovative program aims to improve these patients' experience of care and ultimately provide them with more healthy days back in their own homes. Throughout the pilot, Western HealthLinks continued to achieve positive results, with high levels of patient satisfaction, hospital avoidance and reduced bed day use. Review of sustainable integrated care models has been undertaken to support the delivery of Western HealthLinks going forward, with discussions continuing with the Department of Health and Human Services regarding the continuation of the Program.

Board Chair and CEO Message (continued)

SUPPORTING BEST CARE THROUGH RESEARCH

Western Health has expanded its research efforts over the past year in support of best care, with an emphasis on clinical research that focuses on providing and delivering care during the COVID-19 pandemic.

Western Health in collaboration with Melbourne University has created a world-leading ventilation hood that is placed over COVID-19 patients, with the twin benefit of protecting staff and improving treatments. The results of an initial study into the effectiveness of the hood, which is designed to contain the droplet spread of the coronavirus, has been overwhelmingly positive. The hood, which effectively creates a bubble around the patient, also enables staff to provide less invasive therapies and improved interaction with those being treated.

Western Health's Nursing Research Team has been engaged with a number of COVID-19 research activities, including a project that investigates the Psychosocial Impact of COVID-19 on nurses and midwives. The project led by Western Health involves a number of other Victorian health services and is being replicated in collaboration with Odense University Hospital and the University of Southern Denmark.

In addition, Western Health's Midwifery Research team are actively engaged in local, national and international studies on the impact of COVID-19 on pregnant women and maternity care provision.

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

DEVELOPING BETTER FACILITIES FOR PATIENT CARE

New Era for Women's & Children's Services

An exciting era for Women's and Children's services at Western Health began on 15 May 2019 when the Joan Kirner building (JKWC) opened its doors to patients. The JKWC offers local women and families world-class maternity and paediatric services. From September 2019, it also became home to the western suburbs' first neonatal intensive care unit to care for the most critically-ill babies. One year since JKWC opened, more than 6,000 babies have been delivered. The facility has treated 22,780 patients, including 10,434 children, and has allowed local mums to give birth and access specialist services closer to home.

Progressing the New Footscray Hospital

The new Footscray Hospital is on track to open its doors in 2025. The tender process was temporarily suspended in April to allow for the State Government and Western Health to respond to the COVID-19 pandemic. While this resulted in a slight delay to the start of construction – from late this year to early 2021 – overall the $1.5 billion hospital is on schedule.

The new Footscray Hospital will greatly enhance Western Health's capacity to provide Best Care for our communities. The new hospital, with space for a minimum of 504 beds, will be built on the corner of Geelong and Ballarat Roads in Footscray.

Expanding the Sunshine Hospital Emergency Department

The Sunshine Hospital Emergency Department Expansion Project is on track with the first phase of building program completion due in March 2021, and full completion in June 2021.

Leading Planning for New Hospitals

Planning for a new hospital in Melton is in its early stages after the State Government's announcement in December 2019 naming Western Health as its operator. A community consultation process has been completed highlighting the strength of local support and interest in the development of the new hospital.

In line with the State Government's investment in providing even more Victorians with the care they need closer to home, Western Health is also taking a leading role in planning for a new community hospital in Point Cook and an upgraded and extended community hospital in Sunbury.

Board Chair and CEO Message (continued)

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. In 2019-20, Western Health were required to respond to the COVID-19 pandemic, and in doing so were unable to achieve elective surgery targets as per the Statement of Priorities.

We continue with a range of initiatives to enhance patient flow, and we appreciate the support of the Department of Health and Human Services to focus and advance these strategies.

Telehealth appointments for our Outpatient Services were quickly implemented mid-March 2020 as part of our COVID-19 response. Patients have been reluctant to attend face to face appointments and have communicated their appreciation of this new model of care. We have also noted a considerable decrease in the numbers of patients who either cancel or do not attend their outpatient appointments following the introduction of Telehealth. Work progresses on developing telehealth as a sustainable model supporting accessible and timely patient care.

It is very challenging when patients experience long delays in accessing mental health beds and we continue to work closely with the Department of Health and Human Services 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.

In addition to the development of a Mental Health Crisis Hub as part of the Sunshine Hospital Emergency Department Expansion Project, Western Health has worked with representatives of the North West Mental Health Service to submit for additional mental health beds at Sunshine Hospital. This was following the interim findings of the Royal Commission on Victoria's Mental Health System.

DOING MORE TO HELP VULNERABLE MEMBERS OF OUR COMMUNITY

Our Health Equity team is overseeing Western Health's role in the Victorian Government's "10-year action plan" on family violence. Over the past year, the team has worked hard to progress roll out a comprehensive, whole of workforce training program, and to strengthen screening, risk assessment and information sharing processes. Due to the COVID-19 pandemic, face to face training for responding to family violence has been placed on hold. However, training is continuing to be delivered via Zoom and there are also a number of online modules that staff can complete. The total number of staff trained since 2017 equates to 23% of Western Health's workforce.

Western Health's DAIAP (Disability Access & Inclusion Action Plan) has been finalised and was launched on International Day of People with Disability – 3 December 2019 by one of our valued consumer representatives.

Plan implementation has commenced. Actions undertaken to-date include installation of a Hearing Loop system at Sunshine Hospital.

SUPPORTING THE HEALTH NEEDS OF ABORIGINAL PATIENTS

At Western Health, we are proud of our achievements to partner with and support our Aboriginal and Torres Strait Islander (Aboriginal) Communities. Over the past year, we have commenced implementation of our Aboriginal Health Cultural Safety Plan 2019-21. This has included development and roll out of a Cultural Safety Audit tool, and an electronic dashboard to record activity and trends against a number of Aboriginal Health metrics.

To support Plan implementation, Membership of the organisation's Aboriginal Health Steering Committee was reviewed in late 2019 to better reflect indigenous interest and the community. An Aboriginal name has been gifted for the Aboriginal Health Service. The name is Wilim Berrbang (meaning 'Place of Connection' in Woi wurrung language).

In January 2020, our award winning Galinjera Maternity Program which is committed to providing continuity of midwifery care for Aboriginal families celebrated the delivery of its 100th baby.

Board Chair and CEO Message (continued)

ADDRESSING OCCUPATIONAL VIOLENCE

At Western Health we are committed to Best Care for our patients, but to do this we need our staff to be safe, uninjured and healthy. A number of initiatives have progressed across Western Health over the past 12 months to support our staff to predict and prevent occupational violence, and effectively and safely manage it when it does occur. These include roll-out of a 'Predict, Prevent, Priority' Safety campaign, refinement of incident management procedures, and inclusion in the Western Health Electronic Medical Record of our locally developed and multi-award winning Behaviours of Concern risk assessment tool. Our systems supporting occupational violence were independently reviewed at March 2020 NSQHS Standard Accreditation Survey, with positive feedback from assessors on our approach and its impact on a safe environment to provide and receive safe care.

RECOGNISING OUR WONDERFUL VOLUNTEERS

Western Health is immensely grateful to the 700+ volunteers who, as well as a number of local schools and community groups, generously donate their time and resources to support our patients and staff. Our volunteers support Best Care at Western Health in a number of ways including assisting patients and visitors find their way around our hospital sites, sitting with families during times of grief, helping patients with their meals, and recognising the time in our emergency departments when a person might need a refreshment or a visitor needs help with the car park machine.

While our Volunteers haven't been able to be on site at our hospitals during the COVID-19 pandemic, they have still been providing wonderful support by making face masks, shields and scrub bags.

RECOGNISING FINANCIAL SUPPORT FROM OUR COMMUNITY

The Western Health Foundation has had a productive year, with a strong financial return to support our health service. We have been able to undertake important upgrades to Williamstown Hospital patient and community facilities over the past twelve months, due to the Heart of Williamstown Appeal, which saw over $2 million secured through our community. These works were completed in early July 2020 and provide new shared staff and patient lounge spaces with views to heavily landscaped external courtyards, outdoor seating, a covered connection to the café and new toilet facilities.

Additionally, the Foundation was able to support the purchase of equipment and fit out for the new Joan Kirner building, including Victoria's first NICU-cam, providing video streaming services for families of very sick babies in our Special Care Nursery.

During the COVID pandemic, the Foundation has also co-ordinated the very generous support from local businesses and individuals, who have rallied together to provide our staff with donations of food, coffee, protective equipment and care packs. These donations are valued at over $650,000 and have been greatly appreciated across the health service.

In addition, the Foundation launched a Western Health Emergency Response Fund in March 2020. Donations so far have provided for the purchase of three video laryngoscopes for the safe treatment of COVID-19 patients, Halo mask respirators for staff working on the frontline, and groceries and essential care items for patients in need.

STRIVING FOR SUSTAINABILITY

We continue to be a leader in environmental sustainability among Victoria's hospitals. For the fourth year running, Western Health has been a finalist in the prestigious Victorian Premier's Sustainability Awards Health category; this year for our Equipment Reissue Program for Hardship, run in conjunction with Rotary's Donations in Kind program. This program sees second-hand healthcare equipment such as crutches, four wheeled frames and shower chairs provided to people who need them most.

Over the past year, we have also joined forces with Oz Harvest to implement a food donation program. Designed to support people in need, this initiative repurposes suitable portion controlled food that would otherwise end up in landfill.

The COVID-19 pandemic has unfortunately had a major effect on Western Health's environmental operations and performance. Many external recycling operators have been forced to close or reduce services. Western Health's signature programs that have been negatively impacted include our PVC and sterile wraps recycling.

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

Board Chair and CEO Message (continued)

FINANCIAL RESPONSIBILITY

Western Health places high value on financial responsibility. In a budget of over $800 million, we have recorded an end of year position within our set and agreed budget.

FAREWELL TO OUR BOARD CHAIR

The Hon. Bronwyn Pike stepped down from her official duties leading the Board of Western Health at the end of June 2020 after six years of service.

Bronwyn led Western Health through a period of extraordinary expansion and development of services and infrastructure through her tenure as Board Chair.

In this time, Bronwyn played a significant role across the organisation, with key achievements including opening of an intensive care unit and cardiac services at Sunshine Hospital; announcing and opening the Joan Kirner Women's and Children's facility, including Victoria's first Neonatal Intensive Care Unit in the west; strategy and service planning leading to Government commitment to the New Footscray Hospital; and Board leadership to support investment in an Electronic Medical Record.

It has been of enormous benefit to Western Health to have such an experienced Chair who always placed the healthcare needs of the community of the west front and centre.

THANKS

Finally, in a particularly challenging year, we would like to thank all of 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, commitment and passion are greatly appreciated and make an incredible difference to the Best 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 2020.

Robyn Batten
Chair of the Board, Western Health
4 September 2020

Russell Harrison
Chief Executive, Western Health
4 September 2020

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 900,000 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 7,000 plus 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 900,000 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 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, including the addition of the Joan Kirner Women's and Children's facility opened in 2019.

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 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, with a 20-bed Dual Diagnosis Residential Rehabilitation Centre opened in late 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 2019-20

Each year, Western Health identifies how it will contribute to Victorian Government policy directions and priorities. The following tables list outcomes against deliverables for 2019/20 agreed between our health service and the Minister for Health.

BETTER HEALTH

GOALS	STRATEGIES
A system geared to prevention as much as treatment	Reduce State-wide Risks
Everyone understands their own health and risks	Build Healthy Neighbourhoods
Illness is detected and managed early	Help people to stay healthy
Health neighbourhoods and communities encourage healthy lifestyles	Target health gaps

WESTERN HEALTH DELIVERABLES

> Progress the *'Future Health Today Project'* supporting detection and management of chronic diseases through the governance structure of the Western Health Chronic Disease Alliance (WHCDA).

> Progress planning for the future of Western HealthLinks beyond July 2020 to support patients in our community suffering from chronic disease spend more time in their own homes

OUTCOME

IN PROGRESS

The Western Health Chronic Disease Alliance (WHCDA) has supported the 'Future Health Today Project' by providing advice and promoting the program to potential funders, collaborators and other stakeholders. This has led to the development of Future Health Today program partnerships with North West Melbourne PHN, the Heart Foundation, Kidney Health Australia and Diabetes Victoria.

Review of sustainable evidence based integrated care models has been undertaken to support the HealthLinks program, with discussions continuing with DHHS regarding the extension of Western HealthLinks into 2020-21. In April 2020, the Western Health Board re-affirmed the importance of the continuation of the HealthLinks Program and in June 2020, approved an extension of the partnership between Western Health and the Silver Chain Group who help support the program until Dec 31 2020.

Statement of Priorities 2019/20 (continued)

BETTER ACCESS

GOALS	STRATEGIES
Care is always being there when people need it	Plan and invest
Better access to care in the home and community	Unlock innovation
People are connected to the full range of care and support they need	Provide easier access
Equal access to care	Ensure fair access

WESTERN HEALTH DELIVERABLES

> Progress the Sunshine Hospital Emergency Department Expansion Project by meeting project milestones for 2019-20

> Progress planning for the New Footscray Hospital by meeting project milestones for 2019-20

OUTCOME

ACHIEVED

The Sunshine Hospital Emergency Department Expansion Project is on track with the stage 2 building program practical completion of the first phase due in March 2021 with full completion in June 2021. This includes Triage Paediatrics, Short Stay, Fast Track and the Mental Health Crisis Hub. Principles and process for selection of procurement and commissioning of equipment has been development and Model of Care work progresses.

Planning for the New Footscray Hospital has progressed, with the Expression of Interest process completed and three consortia progressing to the bidding stage. There was a pause in the project in April and May 2020 due to the COVID pandemic. On June 1 the project recommenced, with bids received in July 2020. Due to the pandemic the evaluation moved to be agile and remote. The timetable has also moved slightly with work now on site to commence in 2021 and not December 2020 as previously indicated.

Statement of Priorities 2019/20 (continued)

BETTER CARE

GOALS	STRATEGIES
Targeting zero avoidable harm Healthcare that focuses 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

WESTERN HEALTH DELIVERABLES

> Plan for Phase 2 of Electronic Medical Record utilisation within Western Health to support clinical decision making and safe, inclusive and well communicated clinical care.

> Adopt the Safer Care Victoria '*Partnering in healthcare'* framework to focus and enhance current and planned work to improve Western Health patient and consumer participation, experience and outcomes

OUTCOME

ACHIEVED

Planning has progressed for Phase 2 of Electronic Medical Record (EMR) utilisation, with a functionality document developed and reviewed by key stakeholders. This informed EMR Phase 2 contract negotiations with Cerner, which are now complete, with contract documents signed and executed.

Work has been undertaken to align the Safer Care Victoria Partnering in healthcare framework with systems and initiatives for partnering with consumers at Western Health. The Western Health framework ('Patient First') was adopted in September 2019, integrated within the organisation's 'Best Care' Framework, and included in a new 'Live Best Care' learning package. It has informed the focus and activity of a new 'Patient First' Committee. As part of the National Standards / ACHS accreditation survey conducted from 2-6 March 2020, the Patient First Framework was assessed against Standard 2 'Partnering with Consumers' and contributed to the overall positive accreditation result.

Statement of Priorities 2019/20 (continued)

SPECIFIC 2019-20 PRIORITIES … Western Health's contribution to the achievement of Government priorities

STRATEGIES	WESTERN HEALTH DELIVERABLES	OUTCOMES
Supporting the Mental Health System Improve service access to mental health treatment to address the physical and mental health needs of consumers	Progress the development of a Mental Health Crisis Hub as part of the Sunshine Hospital Emergency Department Expansion Project	**ACHIEVED** The Sunshine Hospital Emergency Department Expansion Project is on track with the stage 2 building program practical completion due in June 2021. This includes the Mental Health Crisis Hub Model of Care work.
Addressing Occupational Violence Foster an organisational wide occupational health and safety risk management approach, including identifying security risks and implementing controls, with a focus on prevention and improved reporting and consultation. Implement the department's security training principles to address identified security risks.	Continue to implement the Western Health Occupational Violence and Aggression (OVA) action plan, with a specific focus in 2019-20 on refining OVA incident management, enhancing OVA culture change and training opportunities, and rolling out the locally developed *Behaviours of Concern Chart.*	**ACHIEVED** Implementation of the Western Health Occupational Violence and Aggression (OVA) action plan has progressed, with incident management procedures refined, a 'Predict, Prevent, Priority': Safety campaign implemented, and a learning needs analysis undertaken. The locally developed Behaviours of Concern Chart (BOC) has been incorporated within the organisation's Electronic Medical Record (EMR). Systems supporting OVA at Western Health were independently reviewed at March 2020 NSQHS Standard Accreditation Survey, with positive feedback from Surveyors on approach and impact.
Addressing Bullying & Harassment Actively promote positive workplace behaviours, encourage reporting and action on all reports. Implement the department's *Framework for promoting a positive workplace culture: preventing bullying, harassment and distribution and Workplace culture and bullying, harassment and discrimination training: guiding principles for Victorian health services.*	Continue to implement and evaluate the Western Health Positive Workplace Strategy, with a specific focus in 2019-20 on evaluating the strategy in partnership with the University of Melbourne (Population and Global Health) and implementing Wave III of the '*Sustaining a Culture of Respect and Engagement*' (SCORE) program.	**IN PROGRESS** The Western Health Positive Workplace Strategy has progressed, with an evaluation undertaken in partnership with the University of Melbourne. The results from this evaluation, as well as our experiences with the COVID pandemic will be used to develop the key pillars of a new Positive Workplace Wellbeing framework. Western Health received an Australian Psychological Society Award for work on Wave I and II of the Sustaining a Culture of Respect and Engagement (SCORE) in October 2019. Implementation of SCORE Wave III has commenced, but is currently on hold due to the pandemic.

Statement of Priorities 2019/20 (continued)

SPECIFIC 2019-20 PRIORITIES … Western Health's contribution to the achievement of Government priorities

STRATEGIES	WESTERN HEALTH DELIVERABLES	OUTCOMES
Supporting Vulnerable Patients Partner with patients to develop strategies that build capability within the organisation to address the health needs of communities and consumers at risk of poor access to health care.	Implement year three of the organisation's Health Equity Roadmap, with a focus in 2019-20 on the actions described under the following priority areas of *Aboriginal Cultural Safety, Family Violence, and People with Disabilities.*	**ACHIEVED** Implementation of the organisation's Health Equity Roadmap has progressed, with activity against priority actions outlined below.
Supporting Aboriginal Cultural Safety Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices across all parts of the organisation to recognise and respect Aboriginal culture and deliver services that meet the needs, expectations and rights of Aboriginal patients, their families, and Aboriginal staff.	Commence implementation of the Western Health Aboriginal Health Cultural Safety Plan 2019-21, where strategies were developed in part through use of the 'CQI tool: Aboriginal Health in acute health services and area mental health services' process. A specific focus in 2019-20 is the roll out of an Aboriginal Cultural Safety Audit Program and design of a dashboard to measure activity and performance against Aboriginal Health Cultural Safety.	**ACHIEVED** Implementation of the Western Health Aboriginal Health Cultural Safety Plan 2019-21 has progressed, with a Cultural Safety Audit tool and process implemented, and an electronic dashboard developed to record activity and trends against a number of Aboriginal Health metrics. To support Plan implementation, Membership of the organisation's Aboriginal Health Steering Committee was reviewed in late 2019 to better reflect indigenous interest and the community. An Aboriginal name has been gifted for the Aboriginal Health Service. The name is Wilim Berrbang, meaning 'Place of Connection' in Woi wurrung language.
Addressing Family Violence Strengthen responses to family violence in line with the *Multiagency Risk Assessment and Risk Management Framework* (MARAM) and assist the government in understanding workforce capabilities by championing participation in the census of workforces that intersect with family violence.	Progress the whole of health service roll-out of information and training sessions on the clinical management of Family Violence and Elder Abuse.	**ACHIEVED** The roll-out of Family Violence and Elder Abuse information and training sessions have continued over the past year, with the organisation's Health Equity Team providing clinical consultation support. Due to the COVID pandemic, face to face training has been placed on hold. Training is continuing to be delivered via Zoom and there are also a number of Welearn modules staff can complete. Total staff trained since 2017 equates to 23% of Western Health's workforce. The Strengthening Hospital Responses to Family Violence project will continue to November 2021.

Statement of Priorities 2019/20 (continued)

SPECIFIC 2019-20 PRIORITIES … Western Health's contribution to the achievement of Government priorities

STRATEGIES	WESTERN HEALTH DELIVERABLES	OUTCOMES
Implementing Disability Plans Continue to build upon last year's action by ensuring implementation and embedding of a disability action plan which seeks to reduce barriers, promote inclusion and change attitudes and practices to improve the quality of care and employment opportunities for people with disability.	Finalise the Western Health Disability Action Plan and commence implementation, with a focus in 2019-20 on innovative building design, enhancing communication and partnerships, and supporting the wellbeing of staff with disabilities.	**IN PROGRESS** The Western Health DAIAP (Disability Access & Inclusion Action Plan) has been finalised and was launched on International Day of People with Disability – 3 December 2019 by a consumer representative who is on a range of our committees as an active participant in the work undertaken. Plan implementation has commenced. Actions undertaken to-date include installation of a Hearing Loop system at Sunshine Hospital. The COVID pandemic has slowed implementation of additional actions such as the installation of automated doors in identified toilets at Sunshine and Williamstown Hospitals. The pandemic has also impacted on the ability of the DAIAP working group to meet and the progression of education and training for staff and volunteers.
Supporting Environmental Sustainability Contribute to improving the environmental sustainability of the health systems by identifying and implementing projects and/ or processes to reduce carbon emissions.	Continue to implement Western Health's Environmental Roadmap 2015-20, with a specific focus in 2019-20 on utilising the new Western Health Building Management System to analyse usage and output patterns of our most energy intensive plant and where possible allow us to moderate our programming, consumption and consequently energy emissions.	**IN PROGRESS** The Western Health Environmental Roadmap has progressed, although the utilisation of the new Western Health Building Management System (BMS) has been limited due to the efficiencies of new plant and the COVID pandemic that has resulted in restricted contractor access to facilities. The use of the BMS to support Engineering Asset Planning remains a strong focus.

Key Performance Statistics[1]

HIGH QUALITY AND SAFE CARE

KEY PERFORMANCE INDICATOR	TARGET	2019-20 RESULT
Infection Prevention and control		
Compliance with the Hand Hygiene Australia program	83%	89%
Percentage of healthcare workers immunised for influenza	84%	86%
Patient experience		
VHES —percentage of positive patient experience Quarter 1	95% positive experience	89.9%
VHES —percentage of positive patient experience Quarter 2	95% positive experience	89.2%
VHES —percentage of positive patient experience Quarter 3	95% positive experience	90.5%
VHES - percentage of positive patient experience Quarter 4	95% positive experience	91.1%
VHES —percentage of very positive responses on discharge care Quarter 1	75% very positive experience	72.2%
VHES —percentage of very positive responses on discharge care Quarter 2	75% very positive experience	70.2%
VHES —percentage of very positive responses on discharge care Quarter 3	75% very positive experience	72.7%
VHES - percentage of very positive responses on discharge cares Quarter 4	75% very positive experience	69.6%
VHES —patient perception of cleanliness Quarter 1	70%	63.3%
VHES —patient perception of cleanliness Quarter 2	70%	59.3%
VHES —patient perception of cleanliness Quarter 3	70%	65.2%
VHES —patient perception of cleanliness Quarter 4	70%	55.0%
Healthcare associated infections (HAI's)		
Rate of patients with surgical site infections	No outliers	Not Achieved
Rate of patients with ICU central line associated blood stream infection (CLABSI)	Nil	Not Achieved
Rate of patients with SAB[2] per 10,000 occupied bed days	≤ 1	0.9
Adverse events		
Sentinel events—root cause analysis (RCA) reporting	All RCA reports submitted within 30 business days	Achieved
Maternity and Newborn		
Rate of singleton term infants without birth anomalies with Apgar score <7 to 5 minutes	$\leq 1.4\%$	0.8%
Rate of severe foetal growth restriction in singleton pregnancy undelivered by 40 weeks	$\leq 28.6\%$	12.9%
Proportion of urgent maternity patients referred for obstetric care to a level 4,5 or 6 maternity service who were booked for a specialist clinic appointment within 30 days of accepted referral	100%	90.6%
Continuing Care		
Functional Independence gain from an episode of rehabilitation admission to discharge relative to length of stay	≥ 0.645	0.992

[1]Results are as at June 2020
[2]SAB is Staphylococcus Aureus Bacteraemia

Key Performance Statistics (continued)

TIMELY ACCESS TO CARE[3]

KEY PERFORMANCE INDICATOR	TARGET	FOOTSCRAY	SUNSHINE	W'TOWN
Emergency Care				
Percentage of ambulance patients transferred within 40 minutes	90%	72.8%	64.4%	99.6%
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%	60.9%	50.5%	87.9%
Percentage of emergency patients with a length of stay in the emergency department of less than four hours	81%	50.9%	56.6%	85.8%
Number of patients with a length of stay in the emergency department greater than 24 hours[4]	0	10	260	0

KEY PERFORMANCE INDICATOR	TARGET	2019-20 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%	91.8%
Percentage of patients on the waiting list who have waited longer than clinically recommended time for their respective triage category	5% or 15% proportional improvement from prior year	27.9%
Number of patients on the elective surgery waiting list[5]	4,037	3,656
Number of hospital initiated postponements per 100 scheduled elective surgery admissions	≤ 7/100	5.5%
Number of patients admitted from the elective surgery waiting list	14,811	12,457
Specialist Clinics		
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	86.7%
Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%	84.4%

[3]timely care performance impacted by COVID-19
[4]269/270 mental health patients
[5]the target shown is the number of patients on the elective surgery waiting list as at 30 June 2020

Key Performance Statistics (continued)

STRONG GOVERNANCE, LEADERSHIP AND CULTURE

KEY PERFORMANCE INDICATOR	TARGET	2019-20 RESULT
Organisational Culture		
People matter survey - percentage of staff with an overall positive response to safety and culture questions	80%	90%
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%	90%
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%	91%
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%	85%
People matter survey - percentage of staff with a positive response to the question, "Trainees in my discipline are adequately supervised"	80%	85%
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	2019-20 RESULT
Finance		
Operating result ($m) Being: - SoP includes Western Health and Western Health Foundation only - Jointly Controlled Operations with the Vic Comprehensive Care Centre (VCCC)	-20.0 -20.0 0.0	-20.3 -19.8 -0.5
Average number of days to paying trade creditors	60 days	62 days
Average number of days to receiving patient fee debtors	60 days	48 days
Public and Private WIES[4] activity performance to target	100%	94.6%
Adjusted current asset ratio	0.7	0.56
Forecast number of days the health service can maintain its operations with unrestricted available cash (based on end of year forecast)	14 days	10 days
Actual number of days a health service can maintain its operations with unrestricted available cash, measured on the last day of each month	14 days	Not Achieved
Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June ($m)[5]	Variance <$250,000	5.6

[4]WIES is a Weighted Inlier Equivalent Separation
[5]The result from transactions for which Western Health is monitored excludes jointly controlled operations with the VCCC

Key Performance Statistics (continued)

ACTIVITY & FUNDING

FUNDING TYPE	2019-20 ACTIVITY ACHIEVEMENT
Acute Admitted	
Acute WIES[6]	79,436
WIES DVA	365
WIES TAC	230
Acute Non-Admitted	
Home Enteral Nutrition	616
Home Renal Dialysis	95
Specialist Clinics	182,416
Subacute & Non-Acute Admitted	
Subacute WIES—Rehabilitation Public	768
Subacute WIES—Rehabilitation Private	78
Subacute WIES—GEM Public	2.096
Subacute WIES—GEM Private	280
Subacute WIES—Palliative Care Public	375
Subacute WIES—Palliative Care Private	29
Subacute WIES—DVA	61
Transition Care—Bed Days	10,758
Transition Care—Home days	10,690
Subacute Non-Admitted	
Health Independence Program—Public	95,592
Mental Health and Drug Services	
Drug Services[7]	2,930
Primary Health	
Community Health / Primary Care Programs	2,500

[6]This WIES figure excludes 2019-20 WIES for HealthLinks patients
[7] This figure is based on episodes of care

Financial Snapshot

WORKFORCE FULL TIME EQUIVALENT (FTE) PER ANNUAL ACCOUNTS

HOSPITALS LABOUR CATEGORY	JUNE CURRENT MONTH FTE		AVERAGE MONTHLY FTE	
	2019	2020	2019	2020
Nursing	2318	2409	2201	2353
Administration & Clerical	767	798	734	782
Medical Support	453	488	425	472
Hotel and Allied Services	410	421	389	412
Medical Officers	134	137	122	134
Hospital Medical Officers	529	578	500	547
Sessional Clinicians	128	130	115	126
Ancillary Staff (Allied Health)	398	415	390	410
Total	**5136**	**5376**	**4875**	**5236**

FINANCIAL POSITION

Note: The result from transactions for which Western Health is monitored excludes jointly controlled operations with the Victorian Comprehensive Cancer Centre (VCCC).

SUMMARY OF SIGNIFICANT CHANGE IN FINANCIAL POSITION 2020

In the previous year, the Health Service's SoP result was a $4.1M surplus (excluding -$0.2M VCCC loss).

In the current year, the Health Service's SoP was a $19.8 M deficit (excluding -$0.5M VCCC loss).

The significant change in financial position 2020 was due to an operating funding shortfall for the Joan Kirner Women's & Children's facility which opened in May 2019.

OPERATIONAL AND FINANCIAL PERFORMANCE 2020

The Net Result from Transactions for the 2019/20 year was a surplus of $19.8M (excluding -$0.5M VCCC)

The Net Result for the Year, after Other Economic Flows, for the 2019/20 year was a surplus of $13.8M (excluding -$0.5M VCCC)

The Comprehensive Result for the Year, after the Revaluation of Assets, for the 2019/20 year was a surplus of $13.8M (excluding -$0.5M VCCC)

SUBSEQUENT EVENTS

The Health Service has acquired a local-government owned enterprise, Regional Kitchen Pty Ltd. The date of this acquisition was 7 August 2020.

The Covid-19 pandemic has created unprecedented economic uncertainty. Actual economic events and conditions in the future may be materially different from those estimated by the health service at the reporting date. As responses by government continue to evolve, management recognises that it is difficult to reliably estimate with any degree of certainty the potential impact of the pandemic after the reporting date on the health service, its operations, its future results and financial position.

No other matters or circumstances have arisen since the end of the financial year which significantly affected or may affect the operations of the health service, the results of the operations or the state of affairs of the health service in future financial years.

Financial Snapshot (continued)

FINANCIAL SNAPSHOT

$'000	2019/20	2018/19	2017/18	2016/17	2015/16
OPERATING RESULT [+]	**(20,295)**	**3,935**	**1,158**	**590**	**320**
Total Revenue	998,005	968,706	854,829	757,595	686,303
Total Expenses	984,723	887,048	791,422	757,478	712,133
Net result from transactions					
Total other economic flows					
Net Result	**13,282**	**81,658**	**63,407**	**117**	**(25,830)**
Total Assets	1,104,620	1,069,028	840,333	698,076	684,212
Total Liabilities	300,023	266,854	199,289	174,029	164,166
Net Assets/Total equity	**804,597**	**802,174**	**641,044**	**524,047**	**520,046**

	2019/20 $'000
Net operating result+	**(20,295)**
Capital purpose income	110,103
COVID-19 State Supply Arrangement - Assets received free of charge or for nil consideration under the State Supply	0
State supply items consumed up to 30 June 2020	0
Expenditure for capital purpose	0
Depreciation and amortisation	(70,471)
Impairment of non-financial assets	0
Finance costs (other)	(18)
Net Result from transactions	**19,319**

[+] The result for which Western Health is monitored in its Statement of Priorities
($19.8M) = SoP includes Western Health and Western Health Foundation.
($0.5M) = Jointly Controlled Operations with the Victorian Comprehensive Cancer Centre (VCCC)

Financial Snapshot (continued)

CONSULTANCIES

DETAILS OF CONSULTANCIES [UNDER $10,000]
In 2019-20, there were six (6) consultancies where the total fees payable *to* the consultant were less than $10,000.
The total expenditure incurred during 2019-20 in relation to these consultancies is $34,363 (excl. GST)

DETAILS OF CONSULTANCIES [VALUED AT $10,000 OR GREATER]
In 2019-20, there were five (5) consultancies where the total fees payable to the consultant were $10,000 or greater.
The total expenditure incurred during 2019-20 in relation to the consultancy is $94,100 (excl. GST). Details of individual consultancy are as follows:

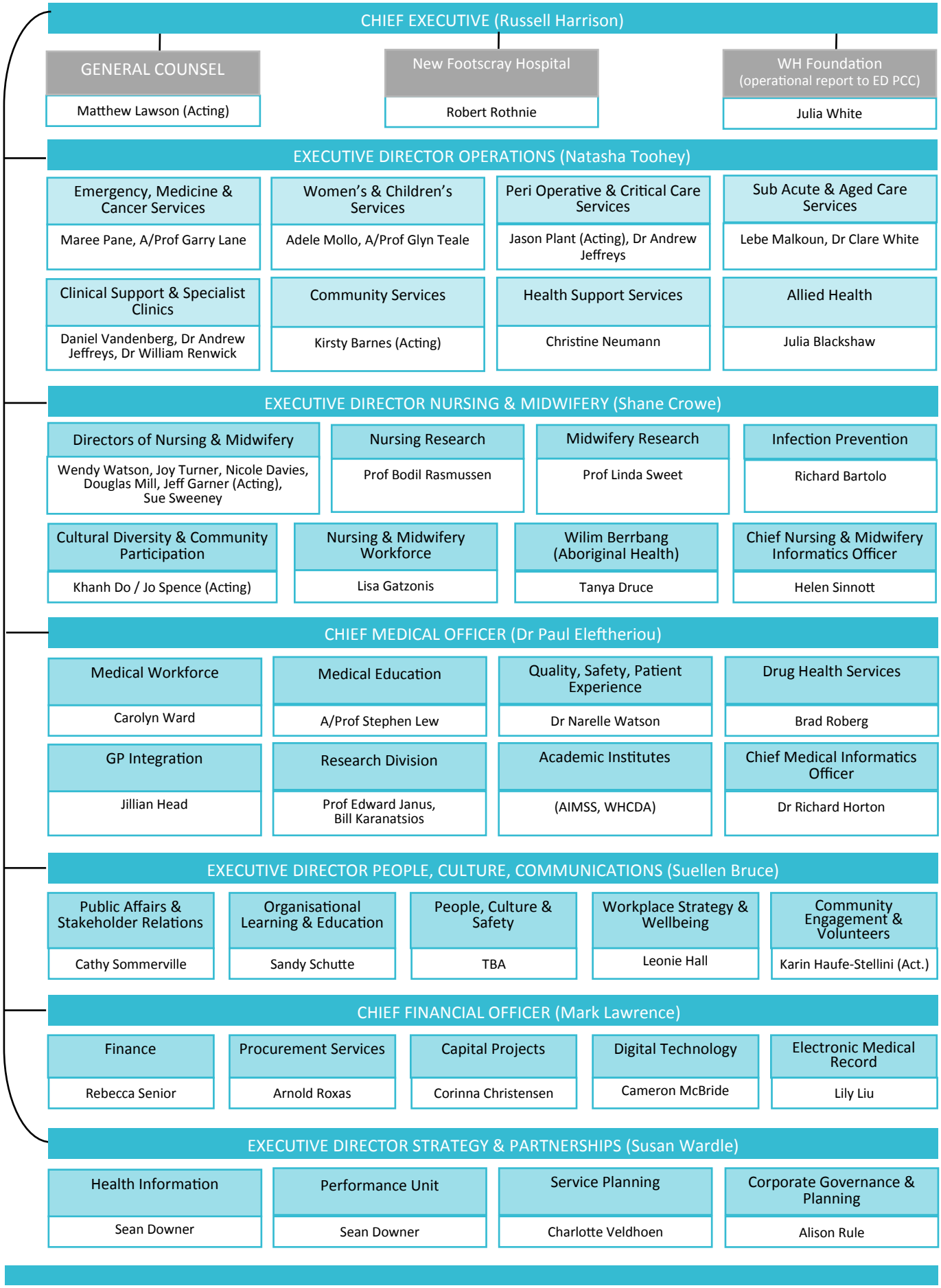
Consultant	Purpose of consultancy	Start Date	End Date	Total approved project fee (excluding GST)	Expenditure 2019-20 (excluding GST)	Future expenditure (excluding GST)
Department of Environment Land Water and Planning	Valuation of Properties for Western Health for Financial Reporting Purposes	Jul-19	Jul-19	$25,400	$25,400	$0
Innova	Development of an initial information security plan	Jul-19	Sep-19	$17,050	$17,050	$0
Price Waterhouse Coopers	Western Health Electronic Medical Record Business Care Review	Jul-19	Jul-19	$15,300	$15,300	$0
PMC Drafting Services	Reviewing Emergency Exit plans for Joan Kirner Women's & Children's	Jul-19	Jul-19	$11,300	$11,300	$0
Saterhan Investments Pty Ltd	New Footscray Hospital Consultancy	Jul-19	Jul-19	$25,000	$25,000	$0
	TOTALS			**$94,100**	**$94,100**	**$0**

DETAILS OF INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE

The total ICT expenditure incurred during 2019-20 is $28.6 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)**
$19.5 million	$9.1 million	$2.1 million	$7.0 million

Organisational Structure (as at end June 2020)



Western Health Services

EMERGENCY, MEDICINE AND CANCER SERVICES

- Dermatology
- Endocrinology and Diabetes
- Emergency Medicine
- Gastroenterology
- General Medicine
- Haematology
- Hospital In The Home
- 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
- Newborn Services, including Neonatal Intensive Care
- 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
- Infection Prevention
- Office of Research
- 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.

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 2019 to 30 June 2020, the Minister for Health was Jenny Mikakos MP.

Over the period 1 July 2019 to 30 June 2020, the Board comprised up to nine Members at any one time, 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 was 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

Term Completed June 2020

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 prior to 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 was Chair of the Finance and Resources Committee and a Member of the Audit and Risk Committee.

Appointed July 2010

Term Completed June 2020

MS TRICIA MALOWNEY OAM

DLI, MAICD

Ms Patricia (Tricia) Malowney was the inaugural president of the Victorian Disability Services Board and inaugural Chair of the Board of Women with disabilities Victoria. Tricia has roles on a range of boards and committees including chair of Independent Disability Services Board, a member of Australian Orthotics and Prosthetics Association and a director at Scope. Tricia is a member of the Eastern Metropolitan Family Violence Partnership Executive Committee and a member of the Victorian Government Diversity and Inclusion Community of Practice.

Tricia received a medal in the general division (OAM) in 2017 for service to people with a disability through advocacy roles. Tricia contracted polio at age four months and used calipers until 16 years of age. At age 36, Tricia developed post-polio syndrome, was retired from a middle management position with Victoria Police at age 46 and now uses a range of mobility aids.

Ms Patricia Malowney is the Chair of the Cultural Diversity and Community Advisory Committee and a Member of the Quality and Safety Committee.

Appointed July 2018

Corporate Governance (continued)

MRS ELLENI BEREDED-SAMUEL OAM

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 was Chair of the Cultural Diversity and Community Advisory Committee and a Member of the Governance & Remuneration Committee

Appointed July 2011

Resigned November 2019

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 the 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 Chair of the Quality and Safety Committee and Chair of the Primary Care and Population Health Advisory Committee

Appointed July 2016

MR DAVID SHAW

LLB

Mr David Shaw has been a partner of law firm, Holding Redlich, since 1989. He has a wealth of experience in complex disputes involving employment, discrimination, administrative decisions and the management of organisations. These disputes often play out in 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 bodes 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 employment conditions, investigations involving the conduct and performance of health professionals, disputes over specialist accreditation and whistleblowing complaints.

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

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

Appointed July 2017

Resigned February 2020

Corporate Governance (continued)

MS NICOLE BARTHOLOMEUSZ

Ms Nicole Bartholomeusz has worked extensively in public health and government in executive and non-executive roles for over 20 years and is currently the Interim Chief Executive of cohealth.

Nicole has a background as a clinician and has a Masters in Business Administration. Nicole has a strong interest in health policy, service planning and redesign together with leading and managing change and governance of health services and not for profit organisations.

Nicole is a Council Member with the Australian Healthcare and Hospital Association.

Ms Nicole Bartholomeusz was Chair of the Primary Care & Population Health Advisory Committee and a Member of the Cultural Diversity and Community Advisory Committee.

Appointed July 2019

Resigned November 2019

MS ROBYN BATTEN

BSW, MSW, MBA, FAICD

Ms Robyn Batten is an experienced Chief Executive Officer, non-Executive Director who has led very large and complex organisations in a range of industries. With over twenty-five years of Executive and Board experience, Robyn is a strategic thinker who can translate strategy into outcomes.

In addition to working in diverse industries and roles, Robyn has worked in the United Kingdom, Asia, three Australian States and the Northern Territory. Robyn has also contributed to national policy development during the last decade.

Robyn is currently a Director of Uniting Victoria and Tasmania, The Australian Psychological Society, East Melbourne PHN and Chair of Leap in! Australia.

Robyn is commercially focused and brings expertise to her board roles in areas such as strategic and innovative thinking, business performance and improvement, technology transformation, and infrastructure development and management.

Ms Robyn Batten is Chair of the Audit and Risk Committee, Chair of the Governance and Remuneration Committee, and a Member of the Primary Care and Population Health Committee.

Appointed Board Director July 2019 with Term Completed June 2020

Appointed WH Board Chair from 1 July 2020

MS SHEREE PROPOSCH

B.Arch, Grad Dip Bus Admin, MAICD, *ARBV, AIA*

Ms Sheree Proposch is a leading specialist in healthcare design and strategy, and has worked in Australia, the UK and Singapore. An accomplished architect, business leader and committee member, Sheree has extensive experience in the construction, healthcare and tertiary education sectors.

Sheree has acted as an advisor to public, private and not for profit boards on major infrastructure strategy and capital investment. She combines her sector experience to provide strategic advice for health and education precincts.

Sheree contributes to public health boards through specialist insight into capital development, stakeholder engagement, and risk management.

Ms Sheree Proposch is a Member of the Finance and Resources Committee and a Member of the Cultural Diversity and Community Advisory Committee.

Appointed July 2019

PROFESSOR ANDREW CONWAY

FIPA FFA FCMA FCPA (UK) MAICD FAIM BCom BTeach(Sec)

Professor Conway is the Chief Executive Officer of the Institute of Public Accountants - one of Australia's largest professional accounting bodies. Andrew represents the Australian profession in a range of global Board and committees and is a current member of the ASX Corporate Governance Council.

Prior to working with the Institute, Andrew was an Australian Government Treasury Ministry Chief of Staff and Senior Advisor. In 2001, he was awarded the Centenary of Federation Medal and was subsequently awarded Australian Young Professional of the Year and AFR BOSS Magazine Young Executive of the Year. Andrew was appointed a Professor of Accounting at the Shanghai University of Finance and Economics (honoris causa) and is also a Vice chancellor's Distinguished Fellow and Adjunct Professor at Deakin University. In 2011 he was appointed as a Board Director of Eastern Health. 2020 marked the completion of his final term at Eastern.

In addition, Andrew is actively involved in community groups and volunteers his time freely. Andrew was elected Chairman of the Council of Small Business Australia (COSBOA), and now Chairs the IPA Deakin University SME Research Partnership and co-authored the landmark Australian Small Business White Paper.

Andrew is a devoted husband and father of three children.

Appointed May 2020

Corporate Governance (continued)

BOARD MEETING ATTENDANCE 2019/20

DIRECTORS	BOARD MEETINGS ATTENDED/ MEETINGS HELD
Hon Bronwyn Pike	10/11
Prof Colin Clark	11/11
David Shaw	6/6
Elleni Bereded-Samuel	3/4
Dr Catherine Hutton	10/11
Tricia Malowney	10/11
Robyn Batten	10/11
Sheree Proposch	11/11
Nicole Bartholomeusz	4/4
Prof Andrew Conway	1/1

BOARD COMMITTEES

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

AUDIT AND RISK COMMITTEE

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

Committee Members (Board Directors) 2019-20:

> Ms Robyn Batten (Chair)
> The Hon Bronwyn Pike
> Mr David Shaw
> Professor Colin Clark

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.

Committee Members (Board Directors) 2019-20

> Mrs Elleni Bereded-Samuel (Chair)
> Ms Tricia Malowney (Chair)
> Ms Nicole Bartholomeusz
> Ms Sheree Proposch

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.

Committee Members (Board Directors) 2019-20:

> Professor Colin Clark (Chair)
> The Hon Bronwyn Pike
> Ms Sheree Proposch

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.

Committee Members (Board Directors) 2019-20:

> Ms Robyn Batten (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.

Committee Members (Board Directors) 2019-20:

> Ms Nicole Bartholomeusz (Chair)
> Dr Catherine Hutton (Chair)
> Ms Robyn Batten

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

Committee Members (Board Directors) 2018-2019:

> Dr Catherine Hutton (Chair)
> The Hon Bronwyn Pike
> Mr David Shaw
> Ms Tricia Malowney

Corporate Governance (continued)

ATTESTATION FOR FINANCIAL COMPLIANCE

I, Robyn Batten, Board Chair of Western Health, certify that Western Health has no Material Compliance Deficiency with respect to the applicable Standing Directions under the Financial Management Act 1994 and Instructions.

Robyn Batten
Chair of the Board,
Western Health
4 September 2020

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
4 September 2020

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
4 September 2020

ATTESTATION FOR INTEGRITY, FRAUD AND CORRUPTION

I, Russell Harrison, Chief Executive certify that Western Health has put in place appropriate internal controls and processes to ensure that Integrity, fraud and corruption risks have been reviewed and addressed at Western Health during the year.

Russell Harrison
Chief Executive,
Western Health
4 September 2020

Corporate Governance (continued)

OCCUPATIONAL HEALTH AND SAFETY (OHS)

To minimise risk and promote the health, safety and wellbeing of our workforce, the following programs and activities were provided over 2019-20:

⇒ The multi-disciplinary Bariatric Assessment Team (BAT) continues to provide patient care, timely access to appropriate equipment and both safe working environments and places of care for staff and patients. This has resulted in a significant reduction in staff injuries particularly musculoskeletal. There has also been a reduction in the number of preventable clinical complications being reported as our frontline clinicians are better equipped in dealing with the complex needs of the bariatric patient. The BAT has shared their model of care with their New Zealand counterparts.

⇒ Building on the strength of the Health and Safety Representatives (HSR) Engagement Program, Western Health continues to work collaboratively with our elected HSRs to build consultative and positive relationships. HSRs are also active members on the Occupational Health and Safety Committee which supports the elimination or reduction of workplace injuries and risks and legislative compliance.

⇒ Western Health were recipients of the Covenant 2019 Victoria Public Health Care Award in the area of improving workforce wellbeing and safety for developing routine emergency department risk assessments for patients presenting for care with behaviours of concern (BOC) . Following the introduction of the BOC, no serious notifiable incidents have been recorded in our emergency departments. This initiative was also a finalist of two Worksafe Awards in the categories of 'Commitment to Workplace Health, Safety and Well-being' and 'Best Solution to a Specific Workplace Health and Safety Issue'. The latter receiving a 'Highly Commended. The initiative was consequently included as part of the Electronic Medical Record and successfully rolled out to all other clinical areas in November 2019.

⇒ Occupational Violence and Aggression (OVA) has continued to be a major focus within Western Health with a new promotional campaign named 'Predict, Prevent Priority: Safety'. Launched by the CEO, the campaign highlights Western Health staff videos recounting real life stories that promote key messages to the workforce about challenging common unsafe practices and promoting positive stories.

⇒ Occupational Violence and Aggression (OVA) team members developed interactive eLearning modules for use across Western Health. The modules align with the elements of core training outlines in the 'Guide for Violence and Aggression training In Victorian Health Services'. The modules include de-escalation techniques, risk assessment, Code Grey and Code Black and roles and responsibilities and reporting of incidents.

⇒ Western Health's Injury Management and Workplace Health Team continues to work collaboratively to support employees returning to work following a work related injury or illness. Early intervention strategies and encouraging more employee engagement has contributed to the overall positive results of the injury management process.

OCCUPATIONAL HEALTH AND SAFETY STATISTICS

MEASURE	2019/20	2018/19	2017/18
1. The number of reported incidents for the year per 100 FTE	20.87	16.44	18.55
2. The number of 'lost time' standard WorkCover claims for the year per 100 FTE	0.59	0.69	0.41
3. The average cost per WorkCover claim for the year ('000)	$84	$87	$61

OCCUPATIONAL VIOLENCE STATISTICS

MEASURE	2019/20
1. WorkCover accepted claims with an occupational violence cause per 100 FTE	0.03
2. Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0.022
3. Number of occupational violence incidents reported	381
4. Number of occupational violence incidents reported per 100 FTE	7.27
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	7.08%

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 2020.

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).

BUILDING ACT

Western Health fully complied with the building and maintenance provisions of the Building Act 1993 for the period 1 July 2019 to 30 June 2020. Where applicable, the appropriate Building Permits and Certificates of Occupancy were obtained in line with the requirements of the Building Act 1993.

Western Health is participating in the state-wide building cladding replacement program in order to support compliance with Fire Risk Management Guidelines.

NATIONAL COMPETITION POLICY

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

LOCAL JOBS FIRST ACT

Western Health complies with the intent of the Local Jobs First Act (Vic) 2003 which ensures that local projects create opportunities for Victorian businesses and workers.

There were no new or completed Local Jobs First Projects at Western Health within 2019/20.

Corporate Governance (continued)

PUBLIC INTEREST DISCLOSURES ACT

In accordance with the Public Interest Disclosures 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 provisions of the Act, no disclosures were received and notified to IBAC during the 2019/20 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.

Guidance to members of the public on how to make an FOI request can be viewed at www.westernhealth.org.au/ Patient and Visitors/Medical Records. This site 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 2 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 FOI REQUESTS 2019/20	**1459**
Full Access	1009
Partial Access	26
Access Denied	0
Applications Withdrawn	109
No Documents	14
Applications in Progress	278
VCAT Appeal	0
Appeal Withdrawn	0
Transfers Received	3
Time of Births	24

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	27
FRD 22H	Purpose, functions, powers and duties	27
FRD 22H	Nature and range of services provided	10-11, 26
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FRD 22H	Significant changes in key initiatives and expectations for the future	4-9
Management and structure		
FRD 22H	Organisational Structure	25
FRD 22H	Workforce data/employment and conduct principles	22, 33
FRD 22H	Occupational health and safety	32
Financial information		
FRD 22H	Summary of the financial results for the year	20, 22-23
FRD 22H	Significant changes in financial position during the year	22
FRD 22H	Operational and budgetary objectives and performance against objectives	18-23
FRD 22H	Subsequent events	22
FRD 22H	Details of consultancies under $10,000	24
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FRD 22H	Disclosure of ICT expenditure	24
Legislation		
FRD 22H	Application and operation of *Freedom of Information Act 1982*	34
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	33
FRD 22H	Application and operation of *Public Interest Disclosures Act 2012*	34
FRD 22H	Statement on National Competition Policy	33
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FRD 22H	Summary of the entity's environmental performance	8
FRD 22H	Additional information available on request	35

Disclosure Index (continued)

LEGISLATION	REQUIREMENT	PAGE
Other relevant reporting directives		
FRD 25D	Local Jobs First Act Disclosures	33
SD 5.1.4	Financial Management Compliance attestation	31
SD 5.2.3	Declaration in report of operations	9
Attestations		
Attestation on Data Integrity		31
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Reporting of outcomes from Statement of Priorities 2019-20		12-17
Occupational violence reporting		32
Reporting obligations under the *Safe Patient Care Act 2015*		34
Reporting of compliance regarding Car Parking Fees		33

Financial Statements & Accompanying Notes

For the Financial Year Ended 30th June 2020

Appendix to the Western Health Annual Report

Notes To The Financial Statements

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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 Assistant Treasurer 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 2020 and the consolidated financial position of Western Health as at 30th June 2020.

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 4th September 2020.

Robyn Batten
Board Chair

Melbourne
4th September 2020

Russell Harrison
Chief Executive Officer

Melbourne
4th September 2020

Mark Lawrence
Chief Financial Officer

Melbourne
4th September 2020

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 balance sheet as at 30 June 2020
- consolidated entity comprehensive operating statement for the year then ended
- consolidated entity statement of changes in equity for the year then ended
- consolidated entity 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 financial officer's declaration.

In my opinion, the financial report presents fairly, in all material respects, the financial position of the consolidated entity as at 30 June 2020 and the consolidated entity's 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
1 October 2020

Travis Derricott
as delegate for the Auditor-General of Victoria

Western Health
Consolidated Comprehensive Operating Statement
For the Financial Year Ended 30th June 2020

	Note	2020 $'000	2019 $'000
Revenue and Income from Transactions			
Operating Activities	2.1	994,898	964,817
Non-operating Activities - Interest	2.1	3,107	3,890
Total Revenue and Income from Transactions		**998,005**	**968,707**
Expenses from Transactions			
Employee Expenses	3.1	(711,793)	(630,114)
Consumable Expenses	3.1	(119,411)	(117,489)
Finance Expenses	3.1	(425)	(225)
Depreciation and Amortisation	4.4	(70,471)	(48,028)
Other Operating Expenses	3.1	(76,586)	(79,604)
Total Expenses from Transactions		**(978,686)**	**(875,460)**
Net Result from Transactions - Net Operating Balance		**19,319**	**93,247**
Other Economic Flows Included in Net Result			
Net gain/(loss) on Sale of Non-Financial Assets	3.2	(59)	-
Other gains/(losses) from Other Economic Flows	3.2	(2,914)	(8,978)
Net gain/(loss) on Financial Instruments at Fair Value	3.2	(3,064)	(2,546)
Total Other Economic Flows Included in Net Result		**(6,037)**	**(11,524)**
Net Result for the Year		**13,282**	**81,723**
Other Comprehensive Income			
Items that will not be reclassified to Net Result			
Changes in Property, Plant & Equipment Revaluation Surplus	4.2 (b)	**-**	79,408
Total Other Comprehensive Income		**-**	**79,408**
Comprehensive Result for the year		**13,282**	**161,131**

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

Western Health
Consolidated Balance Sheet
As at 30th June 2020

	Note	2020 $'000	2019 $'000
Current Assets			
Cash and Cash Equivalents	6.2	43,499	22,104
Receivables	5.1	10,280	19,488
Investments and Other Financial Assets	4.1	25,222	58,656
Inventories	4.5	3,990	2,352
Prepayments and Other Non Financial Assets		3,390	3,122
Total Current Assets		**86,381**	**105,722**
Non-Current Assets			
Receivables	5.1	39,518	35,103
Investments and Other Financial Assets	4.1	1	1
Property, Plant & Equipment	4.2 (a)	956,673	901,458
Intangible Assets	4.3	22,047	26,745
Total Non-Current Assets		**1,018,239**	**963,307**
TOTAL ASSETS		**1,104,620**	**1,069,029**
Current Liabilities			
Payables	5.2	50,434	72,388
Borrowings	6.1	25,045	874
Provisions (Employee Benefits)	3.4	150,038	130,663
Contract Liabilities	5.2	17,807	14,236
Total Current Liabilities		**243,324**	**218,161**
Non-Current Liabilities			
Borrowings	6.1	20,155	19,491
Provisions (Employee Benefits)	3.4	31,470	29,202
Contract Liabilities	5.2	5,074	-
Total Non-Current Liabilities		**56,699**	**48,693**
TOTAL LIABILITIES		**300,023**	**266,854**
NET ASSETS		**804,597**	**802,175**
EQUITY			
Property, Plant & Equipment Revaluation Surplus	4.2(f)	438,474	438,474
Restricted Specific Purpose Surplus		6,334	8,311
Contributed Capital		203,291	202,980
Accumulated Surplus		156,498	152,410
TOTAL EQUITY		**804,597**	**802,175**

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

Western Health
Consolidated Statement Of Changes In Equity
For the Financial Year Ended 30th June 2020

	Note	Property, plant & equipment revalua-tion surplus	Financial asset Available-for-Sale Revaluat-ion Surplus	Restricted Specific Purpose Surplus	Contributed Capital	Accumulated surpluses/ (deficits)	Total
		$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1st July 2018		**359,066**	**1,286**	**6,606**	**202,980**	**71,106**	641,044
Net result for the year		-	-	-	-	81,723	81,723
Other comprehensive income for the year	4.2(b)	79,408	-	-	-	-	79,408
Opening balance adjustment on adoption of AASB9		-	(1,286)	-	-	1,286	-
Transfer from/(to) accumulated deficits		-	-	1,705	-	(1,705)	-
Balance at 30th June 2019		**438,474**	**-**	**8,311**	**202,980**	**152,410**	**802,175**
Effect of adoption of AASB 15 and 1058		-	-	-	-	(11,171)	(11,171)
Restated balance as at 30th June 2019		**438,474**	**-**	**8,311**	**202,980**	**141,239**	**791,004**
Net result for the year		-	-	-	-	13,282	13,282
Transfer from/(to) accumulated deficits		-	-	(1,977)	-	1,977	-
Receipt/(return) of contributed capital		-	-	-	311	-	311
Balance at 30th June 2020		**438,474**	**-**	**6,334**	**203,291**	**156,498**	**804,597**

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

Western Health
Consolidated Cash Flow Statement
For the Financial Year Ended 30th June 2020

	Note	2020 $'000	2019 $'000
Cash Flows from Operating Activities			
Operating Grants from Government		797,113	732,359
Capital Grants from Government - State		108,051	126,752
Capital Grants from Government - Commonwealth		570	709
Patient Fees		25,895	25,403
Private Practice Fees		20,341	13,378
Donations and Bequests		1,713	2,987
GST received from ATO		(13,075)	(14,135)
Recoupment from Private Practice for use of Hospital Facilities		653	816
Interest and Investment Income		3,224	3,873
Other Capital Receipts		1,962	11,086
Other Receipts		33,762	19,434
Total Receipts		**980,209**	**922,662**
Employee Expenses		(698,439)	(611,979)
Payments for Supplies and Consumables		(129,525)	(91,030)
Payments for Medical Indemnity Insurance		(14,385)	(14,358)
Payments for Repairs and Maintenance		(7,644)	(9,568)
Finance Expenses		(425)	(225)
Cash outflow for leases		(522)	-
Other Payments		(44,759)	(33,637)
Total Payments		**(895,699)**	**(760,797)**
Net Cash Flows from/(used in) Operating Activities	8.1	**84,510**	**161,865**
Cash Flows from Investing Activities			
Purchase of Non-Financial Assets		(119,390)	(176,481)
Sale/(Purchase) of Investments		31,440	(10,000)
Net Cash Flows from/(used in) Investing Activities		**(87,950)**	**(186,481)**
Cash Flows from Financing Activities			
Proceeds from borrowings		24,835	20,365
Net Cash Flows from /(used in) Financing Activities		**24,835**	**20,365**
Net Increase/(Decrease) in Cash and Cash Equivalents Held		**21,395**	**(4,251)**
Cash and Cash Equivalents at beginning of year		22,104	26,355
Cash and Cash Equivalents at End of Year	6.2	**43,499**	**22,104**

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

Note 1: Summary Of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for Western Health, (the "Health Service"), and its controlled entities for the reporting period. 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 AASBs, which 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 Assistant Treasurer.

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 4th September 2020.

(b) Reporting Entity

The financial statements include all the controlled entities of the Health Service. The entities are the Western Health Foundation Limited and Western Health Foundation Trust Fund.

The principal 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 reporting period and the comparative information presented in these financial statements for the previous reporting period.

The financial statements are prepared on a going concern basis. Refer to note 8.9 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 thousand dollars, unless otherwise stated. Minor discrepancies in tables between totals and sum of components are due to rounding.

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.

Note 1: Summary Of Significant Accounting Policies (continued)

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.

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);
- Defined Benefit Superannuation expense (refer to Note 3.5 Superannuation); and
- 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 3.4 Employee Benefits in the Balance Sheet).

A state of emergency was declared in Victoria on 16 March 2020 due to the global coronavirus pandemic, known as COVID-19. A state of disaster was subsequently declared on 2 August 2020.
To contain the spread of the virus and to prioritise the health and safety of our communities various restrictions have been announced and implemented by the state government, which in turn has impacted the manner in which businesses operate, including Western Health.

In response, Western Health placed restrictions on non-essential visitors, implemented reduced visitor hours, deferred elective surgery and reduced activity, performed COVID-19 testing and implemented work from home arrangements where appropriate.

For further details refer to Note 2.1 Funding delivery of our services and Note 4.2 Property, plant and equipment.

(d) 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 or payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the Balance Sheet.

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

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

(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 8.8 Jointly Controlled Operations. The VCCC is the only jointly controlled asset or operation of the Health Service.

Note 1: Summary Of Significant Accounting Policies (continued)

(f) 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 reporting period.
- 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 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 entities consolidated into the Health Service reports are the Western Health Foundation Limited and the Western Health Foundation Trust Fund. There were no occasions during the financial period where a new entity came under control of the Health Service.

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.

(g) Equity

Contributed Capital

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.

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

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.

Financial Assets 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

The 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 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 Revenue and Income from Transactions

Note 2.1 (a): Revenue and Income from Transactions

	2020 $'000	2019 $'000
Government Grants (State) - Operating [(i)]	773,048	721,523
Government Grants (Commonwealth) - Operating	29,900	26,619
Government Grants (State) - Capital	108,051	126,752
Government Grants (Commonwealth) - Capital	(49)	709
Other Capital Purpose Income (including capital donations)	2,101	11,067
Patient Fees	26,550	26,073
Private Practice Fees	22,039	20,230
Commercial Activities [(ii)]	11,335	9,393
Other Revenue from Operating Activities (including non-capital donations)	21,923	22,452
Total Revenue and Income from Operating Activities	**994,898**	**964,817**
Operating Interest	3,049	3,796
Capital Interest [(iii)]	58	94
Total Revenue and Income from Non-Operating Activities	**3,107**	**3,890**
Total Revenue and Income from Transactions	**998,005**	**968,707**

(i) Government Grant (State) – Operating includes funding of $28.82m which was spent due to the impacts of COVID-19.
(ii) Commercial activities represent business activities which the health service entered into to support its operations.
(iii) Capital Interest represents interest on the Linear Accelerator Bank account, which is for Capital purposes.

Government Grants
Income from grants that are enforceable and with sufficiently specific performance obligations are accounted for under AASB 15 as revenue from contracts with customers, with revenue recognised as these performance obligations are met.

Income from grants without any sufficiently specific performance obligations, or that are not enforceable, is recognised when the Health Service has an unconditional right to receive the cash which usually coincides with receipt of cash. On initial recognition of the asset, the Health Service recognises any related contributions by owners, increases in liabilities, decreases in assets, and revenue ('related amounts') in accordance with other Australian Accounting Standards. Related amounts may take the form of:
a) contributions by owners, in accordance with AASB 1004;
b) revenue or a contract liability arising from a contract with a customer, in accordance with AASB 15;
c) a lease liability in accordance with AASB 16;
d) a financial instrument, in accordance with AASB 9; or
e) a provision, in accordance with AASB 137 Provisions, Contingent Liabilities and Contingent Assets.

Note 2.1 (a): Revenue and Income from Transactions (continued)

As a result of the transitional impacts of adopting AASB 15 and AASB 1058, a portion of the grant revenue has been deferred. If the grant income is accounted for in accordance with AASB 15, the deferred grant revenue has been recognised in contract liabilities whereas grant revenue in relation to the construction of capital assets which the health service controls has been recognised in accordance with AASB 1058 and recognised as deferred grant revenue (refer note 5.2). If the grant revenue was accounted for under the previous accounting standard AASB 1004 in 2019-20, the total grant revenue received would have been recognised in full.

Performance Obligations
The types of government grants recognised under AASB 15 Revenue from Contracts with Customers includes:
a) Activity Based Funding (ABF) paid as WIES casemix; and
b) other one-off grants if funding conditions contain enforceable and sufficiently specific performance obligations.

The performance obligations for ABF are the number and mix of patients admitted to hospital (casemix) in accordance with levels of activity agreed to with the Department of Health and Human Services (DHHS) in the annual Statement of Priorities (SoP). Revenue is recognised when a patient is discharged and in accordance with the WIES activity for each separation. The performance obligations have been selected as they align with funding conditions set out in the Policy and funding guidelines issued by the DHHS.

For other grants with performance obligations the health service exercises judgement over whether the performance obligations have been met, on a grant by grant basis.

Other state operating grants
DHHS makes certain payments on behalf of the health service. These amounts have been brought to account as grants in accordance with the DHHS Statement of Priorities and Policy and Funding Guidelines in determining the operating result for the year by recording them as revenue.

DHHS makes the following payments on behalf of the health service as follows:
a) Victorian Managed Insurance Authority (VMIA) non-medical indemnity insurance payments, which are recognised as revenue based on advice from DHHS; and
b) Long Service Leave (LSL) revenue, which is recognised upon finalisation of movements in LSL liability in line with the LSL funding arrangements set out in the relevant DHHS Hospital Circular.

State capital grants, including capital purpose income

DHHS capital cash grants that are enforceable with a specific performance obligation are recognised on delivery of the capital commitment as specified in the funding agreement, and where the consideration to acquire an asset is required to be 'significantly' less than the fair value of the asset. Funding payments received in advance are treated as deferred revenue. The health service has applied AASB 1058 and restated retained earnings on 1 July 2019 using the modified retrospective approach rather than restating prior year comparatives.

The health service recognises non-cash capital grants from DHHS to reflect the progressive capitalisation of DHHS managed projects (i.e. Joan Kirner Women's & Children's Hospital and New Footscray Hospital). Recognition of these grants is based on advice provided by DHHS.

Commonwealth grants
Commonwealth grants revenue are recognised on receipt of funding in accordance with AASB 1058.

Patient and Private Practice Fees

Patient and resident fees, including private practice fees, are recognised as revenue on an accrual basis. There is no impact from AASB 15 as revenue continues to be recognised as and when services are performed.

Commercial Activities
Revenue from commercial activities such as car park revenue are recognised on an accrual basis. There is no impact from AASB 15 as revenue continues to be recognised when services are performed.

Note 2.1 (a): Revenue and Income from Transactions (continued)

Previous accounting policy for 30th June 2019

Grant income arises from transactions in which a party provides goods or assets, (or extinguishes a liability), to the Health Service without receiving approximately equal value in return. While grants may result in the provision of some goods or services to the transferring party, they do not provide a claim to receive benefits directly of approximately equal value (and are termed 'non-reciprocal' transfers). Receipt and sacrifice of approximately equal value may occur, but only by coincidence.

Some grants are reciprocal in nature (i.e. equal value is given back by the recipient of the grant to the provider). The Health Service recognises income when it has satisfied its performance obligations under the terms of the grant.

For non-reciprocal grants, the Health Service recognises revenue when the grant is received.

Grants can be received as general purpose grants, which refers to grants which are not subject to conditions regarding their use. Alternatively, they may be received as specific purpose grants, which are paid for a particular purpose and/or have conditions attached regarding their use.

Impact of COVID-19 on revenue and income

As indicated at Note 1, the health service's response to the pandemic included the deferral of elective surgeries and reduced activity. This resulted in the health service incurring lost revenue as well as direct and indirect COVID-19 costs. The Department of Health and Human Services provided funding which was spent due to COVID-19 impacts on the health service.

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 Expenses from Transactions
3.2 Other Economic Flows
3.3 Analysis of Revenue and Expenses by Internally Managed and Restricted Specific Purpose Funds
3.4 Employee Benefits in the Balance Sheet
3.5 Superannuation

Note 3.1: Expenses from Transactions

	2020 $'000	2019 $'000
Salaries and Wages	558,768	492,898
On-Costs	133,589	120,030
Agency Expenses	12,193	9,977
Fee for Service Medical Officer Expenses	2,016	2,863
Workcover Premium	5,227	4,347
Total Employee Expenses	**711,793**	**630,114**
Drugs	33,458	30,041
Medical and Surgical (including Prostheses)	41,476	40,773
Diagnostic and Radiology	13,186	13,667
Other Consumables	31,291	33,008
Total Consumables	**119,411**	**117,489**
Finance Expenses	425	225
Total Finance Expenses	**425**	**225**
Depreciation and Amortisation (refer Note 4.4)	70,471	48,028
Total Depreciation and Amortisation	**70,471**	**48,028**
Other Administrative Expenses	33,175	32,107
Sub-Total Other Administrative Expenses	**33,175**	**32,107**
Energy and Water	8,471	8,408
Repairs and Maintenance (Reactive)	7,644	9,568
Maintenance Contracts (Preventative)	10,449	8,706
Medical Indemnity Insurance	14,385	14,358
Expenditure for Capital Purposes (Minor Equipment)	2,462	6,457
Sub-Total Other Operating Expenses	**43,411**	**47,497**
Total Other Operating Expenses	**76,586**	**79,604**
Total Expenses from Transactions	**978,686**	**875,460**

Note 3.1: Expenses from Transactions (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:
- Salaries and wages (including fringe benefits tax, leave entitlements, termination payments);
- On-costs;
- Agency expenses;
- Fee for service medical officer expenses; and
- Workcover premiums.

Consumables
Supplies and **services costs** 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.

Finance Expenses
Finance expenses include:
- Interest on bank overdrafts and short-term and long-term borrowings (interest expense is recognised in the period in which it is incurred);
- Amortisation of discounts or premiums relating to borrowings;
- Amortisation of ancillary costs incurred in connection with the arrangement of borrowings; and
- Finance charges in respect of finance leases which are recognised in accordance with AASB 16: *Leases.*

Operating Lease Payments (within Other Administrative Expenses)
Operating lease payments up until 30 June 2019 (including contingent rentals) were recognised on a straight line basis

From 1st July 2019, the following lease payments are recognised on a straight-line basis:
- Short-term leases – leases with a term less than 12 months; and
- Low value leases – leases with the underlying asset's fair value, (when new, regardless of the age of the asset being leased), is no more than $10,000.

Variable lease payments not included in the measurement of the lease liability (i.e. variable lease payments that do not

Other Operating Expenses
Other operating expenses represent the day-to-day running costs incurred in normal operations and include such things
- Fuel, light and power;
- Repairs and maintenance;
- Other administrative expenses; and
- Expenditure for capital purposes (the purchase of assets that are below the capitalisation threshold).

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

Impact of COVID-19 on expenses
As indicated at Note 1, the health service's daily activities were impacted by the pandemic. This resulted in direct and indirect costs being incurred, such as increased staffing, increased pathology testing and increased use of PPE (Personal Protective Equipment).

Note 3.2: Other Economic Flows

	2020 $'000	2019 $'000
Net gain/(loss) on non-financial assets		
Net gain on disposal of property, plant and equipment	(59)	-
Total net gain/(loss) on non-financial assets	**(59)**	-
Net gain/(loss) on financial instruments		
Allowance for impairment losses of contractual receivables	(1,130)	(2,611)
Other gains/(losses) from other economic flows	(1,934)	65
Total Net gain/(loss) on financial instruments	**(3,064)**	**(2,546)**
Other gains/(losses) from Other Economic Flows		
Net gain/(loss) arising from revaluation of long service liability	(2,914)	(8,978)
Total other gains/(losses) from other economic flows	**(2,914)**	**(8,978)**
Total other gains/(losses) from economic flows	**(6,037)**	**(11,524)**

Other economic flows are changes in the volume or value of an asset or liability that do not result from transactions. Other gains/(losses) from other economic flows include the gains or losses from:

- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- reclassified amounts relating to available-for-sale financial instruments from the reserves to net result due to a disposal or derecognition of the financial instrument. This does not include reclassification between equity accounts due to machinery of government changes or 'other transfers' of assets.

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; and
- Any gain/(loss) on the disposal of non-financial assets is recognised at the date of disposal.

Net gain/(loss) on financial instruments at fair value

Net gain/(loss) on financial instruments at fair value includes:

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

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 the bond rate movements, inflation rate movements and the impact of changes in probability factors.

Fair Value of Assets, Services 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 receiver obtains control over them.

Note 3.3: Revenue and Expenses for Commercial, Fundraising and Research Activities

	Revenue		Expense	
	2020 $'000	2019 $'000	2020 $'000	2019 $'000
Commercial Activities				
Diagnostic Imaging (Outpatients)	9,429	10,770	7,009	6,606
Car Parking	5,745	4,857	865	750
Property (Rental)	96	76	2	8
Other	3,805	2,819	2,385	1,594
Total Commercial Activities	**19,075**	**18,522**	**10,261**	**8,958**
Other Activities				
Fundraising and Community Support	1,861	2,764	242	418
Research	2,860	2,591	2,860	3,076
Total Other Activities	**4,721**	**5,355**	**3,102**	**3,494**
TOTAL	**23,796**	**23,877**	**13,362**	**12,452**

Note 3.4: Provisions In The Balance Sheet

	2020 $'000	2019 $'000
CURRENT PROVISIONS		
EMPLOYEE BENEFITS (i)		
Unconditional and expected to be settled wholly within 12 months(ii)		
Accrued Days Off	1,475	1,313
Annual Leave	45,020	38,271
Long Service Leave	9,964	9,424
On-Costs	5,651	4,939
	62,110	53,947
Unconditional and expected to be settled wholly after 12 months(iii)		
Annual Leave	7,541	6,344
Long Service Leave	71,970	63,028
On-Costs	8,417	7,344
	87,928	76,716
TOTAL EMPLOYEE BENEFITS - CURRENT PROVISIONS	**150,038**	**130,663**
NON-CURRENT PROVISIONS		
EMPLOYEE BENEFITS (i)		
Long Service Leave	28,457	26,405
On-Costs	3,014	2,797
TOTAL EMPLOYEE BENEFITS - NON-CURRENT PROVISIONS	**31,470**	**29,202**
TOTAL EMPLOYEE BENEFITS PROVISION	**181,508**	**159,865**
(a) EMPLOYEE BENEFITS AND RELATED ON-COSTS		
Current Employee Benefits including On-Costs		
Long Service Leave	90,588	80,108
Annual Leave	57,975	49,241
Accrued Days Off	1,475	1,313
Non-Current Employee Benefits including On-Costs		
Long Service Leave	31,470	29,202
TOTAL EMPLOYEE BENEFITS AND RELATED ON-COSTS	**181,508**	**159,864**

(b) MOVEMENT IN EMPLOYEE BENEFITS AND RELATED ON-COSTS PROVISION	**2020 $'000**	**2019 $'000**
Balance at start of year	**159,864**	**133,061**
Entitlement increment during the year	80,945	74,489
Unwinding of discount and effect of changes in the discount rate	2,977	9,134
Reduction due to transfer out	(62,279)	(56,820)
Balance at end of year	**181,508**	**159,864**

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 3.4: Provisions In The Balance Sheet (continued)

Employee Benefits Recognition

Provision is made for benefits accruing to employees in respect of accrued days off, annual leave and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

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.

Annual Leave and Accrued Days Off

Liabilities for 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 payment of these liabilities.

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

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 (pay) the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months. The unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:
- Nominal 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 following 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.

On-Costs Related to Employee Expense

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

Note 3.5: Superannuation

	Contributions Paid during the Year		Contribution Outstanding at Year End (i)	
	2020 $'000	2019 $'000	2020 $'000	2019 $'000
Defined benefit plans(ii):				
State Superannuation Fund	284	318	24	11
Defined contribution plans:				
First State Super	26,646	26,750	2,692	755
Hesta	15,680	14,558	1,600	504
Other Funds	5,394	3,191	750	270
	48,004	**44,817**	**5,066**	**1,540**

(i) The Contribution Outstanding at Year End refers to the accrual taken up at year end relating to the last pay period in June.

(ii) 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
Defined benefit funds are superannuation funds where contributions are pooled rather than being allocated to particular members. Retirement benefits are determined by a formula based on factors such as an employee's salary and the duration of their employment.

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 Intangible Assets
4.4 Depreciation And Amortisation
4.5 Inventories

Note 4.1: Investments And Other Financial Assets

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	
	2020 $'000	2019 $'000	2020 $'000	2019 $'000	2020 $'000	2019 $'000	2020 $'000	2019 $'000
CURRENT								
Term Deposit								
- Term deposit > 3 months	-	-	450	950	-	-	450	950
Managed Investment								
- VFMC Multi Strategy Funds	-	23,310	-	10,135	24,772	24,261	24,772	57,706
Total Current	**-**	**23,310**	**450**	**11,085**	**24,772**	**24,261**	**25,222**	**58,656**
NON CURRENT								
Investment								
- Cancer Therapeutics CRC	-	-	1	1	-	-	1	1
Total Non Current	**-**	**-**	**1**	**1**	**-**	**-**	**1**	**1**
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**-**	**23,310**	**451**	**11,086**	**24,772**	**24,261**	**25,223**	**58,657**
Represented by:								
Health Service Investments	-	23,310	-	10,135	24,772	24,261	24,772	57,706
Foundation investments	-	-	-	-	-	-	-	-
Jointly Controlled Operations Investments	-	-	451	951	-	-	451	951
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**-**	**23,310**	**451**	**11,086**	**24,772**	**24,261**	**25,223**	**58,657**

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.

The Health Service classifies its other financial assets between current and non-current assets based on the Board'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 including Central Banking System.

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 the 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 the Comprehensive Operating Statement, are subject to annual review for impairment.

In order to determine an appropriate fair value as at the end of the reporting period 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.

Note 4.2: Property, Plant And Equipment

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.

The cost of constructed non-financial physical assets includes the cost of all materials used in construction, direct labour on the project and an appropriate proportion of variable and fixed overheads. The cost of a leasehold improvement is capitalised as an asset and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the improvements.

The initial cost for non-financial physical assets under finance lease, (refer to Note 6.1), is measured at amounts equal to fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

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
Property, plant and equipment as well as right-of-use assets under leases and service concession assets are subsequently measured at fair value less accumulated depreciation and impairment. Fair value is determined with regard to the asset's highest and best use, (considering legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset), and is summarised on the following page by asset category.

Right-of-use asset acquired by lessees (Under AASB 16 – Leases from 1 July 2019)
Initial measurement

The Health Service recognises a right-of-use asset and a lease liability at the lease commencement date. The right-of-use asset is initially measured at cost which comprises the initial amount of the lease liability adjusted for:

- any lease payments made at or before the commencement date; plus
- any initial direct costs incurred; and
- an estimate of costs to dismantle and remove the underlying asset or to restore the underlying asset or the site on which it is located, less any lease incentive received.

Right-of-use asset – Subsequent measurement

The Health Service depreciates the right-of-use assets on a straight line basis from the lease commencement date to the earlier of the end of the useful life of the right-of-use asset or the end of the lease term. The estimated useful life of the right-of-use assets are determined on the same basis as property, plant and equipment, other than where the lease term is lower than the otherwise assigned useful life. The right-of-use assets are also subject to revaluation as required by FRD 103H however as at the end of the reporting period right-of-use assets have not been revalued.

In addition, the right-of-use asset is periodically reduced by impairment losses, if any, and adjusted for certain re-measurements of the lease liability.

Note 4.2: Property, Plant And Equipment (continued)

Revaluations of Non-Current Physical Assets
Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103H 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.

Revaluation 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.

Revaluation decrements are recognised in 'Other Comprehensive Income' to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of property, plant and equipment.

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

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

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

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.

For the purpose of fair value disclosures, the Health Service has determined classes of assets on the basis of the nature, characteristics and risks of the asset 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.

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

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

Valuation Hierarchy
In determining fair values a number of inputs are used. To increase consistency and comparability in the financial statements, these inputs are categorised into three levels, also known as the fair value hierarchy. The levels are as follows:

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

Note 4.2: Property, Plant And Equipment (continued)

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 are used to measure fair value to the extent that relevant observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date. However, the fair value measurement objective remains the same, i.e., an exit price at the measurement date from the perspective of a market participant that holds the asset or owes the liability. Therefore, unobservable inputs shall reflect the assumptions that market participants would use when pricing the asset or liability, including assumptions about risk.

Consideration of highest and best use for non-financial physical assets
Judgements about highest and best use must 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 Health Service has assumed the current use of a non-financial physical asset is its highest and best use unless market or other factors suggest that a different use by market participants would maximise the value of the asset.

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 the Valuer-General Victoria 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 30 June 2020.

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 due 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 although it is adjusted for the community service obligation 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.

Note 4.2: Property, Plant And Equipment (continued)

Specialised Land and Specialised Buildings (continued)
The community service obligation 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 the community service obligation 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 Valuer-General Victoria. The effective date of the valuation was 30 June 2019.

Vehicles
The Health Service acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by the Health Service who set relevant depreciation rates during use to reflect the consumption of the vehicles. As a result, the fair value of vehicles does not differ materially from the carrying amount, (depreciated cost).

Plant and Equipment
Plant and equipment (including medical equipment, computers and communication equipment, and furniture and fittings) are held at carrying amount (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 amount.

There were no changes in valuation techniques throughout the period to the end of the financial year.

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

Note 4.2: Property, Plant And Equipment (continued)

(a) Gross carrying amount and accumulated depreciation

	2020 $'000	2019 $'000
Land		
Land - Crown	129,926	129,926
Total Land at Fair Value	**129,926**	**129,926**
Buildings		
Buildings under Construction at Cost	120,925	67,656
Buildings - Right of use (leased buildings)	143	-
less Accumulated Depreciation	(48)	-
Buildings at Fair Value	676,259	644,575
less Accumulated Depreciation	(42,222)	(651)
Total Buildings	**755,056**	**711,580**
Plant and Equipment		
Plant and Equipment at Fair Value	36,843	37,981
less Accumulated Depreciation	(15,972)	(14,688)
Total Plant and Equipment	**20,871**	**23,293**
Motor Vehicles		
Motor Vehicles at Fair Value	93	262
less Accumulated Depreciation	(93)	(97)
Total Motor Vehicles	**-**	**165**
Medical Equipment		
Medical Equipment at Fair Value	125,502	110,245
less Accumulated Depreciation	(89,749)	(80,703)
Total Medical Equipment	**35,753**	**29,542**
Non Medical Equipment		
Non Medical Equipment at Fair Value	8,026	7,202
less Accumulated Depreciation	(5,669)	(5,136)
Total Non Medical Equipment	**2,357**	**2,066**
Computers and Communication		
Computers and Communication at Fair Value	31,978	20,762
less Accumulated Depreciation	(22,916)	(18,239)
Total Computers and Communications	**9,062**	**2,523**
Furniture and Fittings		
Furniture and Fittings at Fair Value	8,104	7,925
less Accumulated Depreciation	(6,280)	(5,562)
Total Furniture and Fittings	**1,824**	**2,363**
Right of use - plant, equipment, furniture, fittings and vehicles (leases)	2,509	-
less Accumulated Depreciation	(686)	-
TOTAL RIGHT OF USE - PLANT, EQUIPMENT, FURNITURE, FITTINGS AND VEHICLES	**1,823**	**-**
TOTAL PROPERTY, PLANT & EQUIPMENT	**956,673**	**901,458**

Share of jointly controlled assets included in property, plant and equipment are separately disclosed in Note 8.8 Jointly Controlled Operations.

Note 4.2: Property, Plant And Equipment (continued)

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

Consolidated	Land $'000	Buildings $'000	Buildings Under Construction $'000	Buildings Right of Use $'000	Plant and Equipment $'000	Motor Vehicles $'000	Medical Equipment $'000	Non Medical Equipment $'000	Computers & Communications $'000	Furniture and Fittings $'000	Right of Use - PPE, F&V $'000	Total $'000
Balance at 1 July 2018	**90,180**	**432,481**	**109,079**	**-**	**41,667**	**-**	**36,126**	**2,071**	**939**	**2,700**	**-**	**715,243**
Additions		93,027	69,194	-	2,085	170	1,209	303	1,302	271	-	167,561
Disposals	-	-	-	-	-	-	-	-	-	-	-	-
Revaluation increments/ (decrements)	39,746	39,662	-	-	-	-	-	-	-	-	-	79,408
Net transfers between classes (i)	-	110,617	(110,617)	-	(19,259)	-	193	181	1,342	88	-	(17,455)
Depreciation and amortisation (note 4.4)	-	(31,863)	-	-	(1,200)	(5)	(7,986)	(489)	(1,060)	(696)	-	(43,299)
Balance at 1 July 2019	**129,926**	**643,924**	**67,656**	**-**	**23,293**	**165**	**29,542**	**2,066**	**2,523**	**2,363**	**-**	**901,458**
Additions	-	25,484	64,498	143	13,989	-	8,347	459	1,405	126	2,509	116,960
Disposals	-	-	-		-	-	(60)	(5)	(19)	-	-	(84)
Revaluation increments/ (decrements)	-	-	-	-		-	-	-	-	-	-	-
Net transfers between classes (i)	-	6,200	(11,229)	-	(15,127)	(165)	7,125	375	9,830	53	(5)	(2,943)
Depreciation and amortisation (note 4.4)	-	(41,571)	-	(47)	(1,284)	-	(9,203)	(537)	(4,677)	(718)	(681)	(58,718)
Balance at 30 June 2020	**129,926**	**634,037**	**120,925**	**96**	**20,871**	**-**	**35,752**	**2,357**	**9,062**	**1,824**	**1,823**	**956,673**

(i) The total of net transfers between classes is usually zero as it is a 'net' figure, however in this instance there was a transfer to Intangible Assets from the Plant and Equipment category. This value is included in note 4.3(b) Intangible Assets in the 'Additions' line.

Land and Buildings and Leased Assets Carried At Valuation

The Valuer-General Victoria undertook to re-value all of the Health Service's owned land and buildings to determine their fair value. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation is 30 June 2019.

In compliance with FRD 103H, in the reporting period, the Health Service's management conducted an annual assessment of the fair value of land and buildings and leased buildings. To facilitate this, management obtained from the Department of Treasury and Finance the Valuer General Victoria indices for the financial year ended 30 June 2020.

The VGV indices, which are based on data to March 2020, indicate an average increase of 8% across all land parcels and an average increase of 2.5% in buildings.

Management regards the VGV indices to be a reliable and relevant data set to form the basis of their estimates. Whilst these indices are applicable at 30 June 2020, the fair value of land and buildings will continue to be subjected to the impacts of COVID-19 in future accounting periods.

As the accumulative movement was less than 10% for land and buildings no managerial revaluation was required.

Note 4.2: Property, Plant And Equipment (continued)

(c) Fair value measurement hierarchy for assets

	Consolidated Carrying amount	Fair value measurement at end of reporting period using:		
		Level 1[(i)]	Level 2[(i)]	Level 3[(i)]
	$'000	$'000	$'000	$'000
Balance at 30 June 2020				
Land at fair value				
Specialised Land	127,146	-	-	127,146
Non-Specialised Land	2,780	-	2,780	-
Total Land at fair value	**129,926**	**-**	**2,780**	**127,146**
Buildings at fair value				
Specialised Buildings	633,285	-	-	633,285
Non-Specialised Buildings [(ii)]	752	-	752	-
Total Buildings at fair value	**634,037**	**-**	**752**	**633,285**
Buildings under construction at fair value	120,925	-	-	120,925
Buildings - Right of use (leased buildings)	95	-	-	95
Plant and Equipment at fair value	20,871	-	-	20,871
Motor Vehicles at fair value	-	-	-	-
Medical Equipment at fair value	35,753	-	-	35,753
Non-Medical Equipment at fair value	2,357	-	2,357	-
Computers and Communication at fair value	9,062	-	9,062	-
Furniture and Fittings at fair value	1,824	-	1,824	-
Right of use PPE, furniture, fittings and vehicles	1,823	-	1,823	-
Total other plant and equipment at fair value	**192,710**	-	**15,067**	177,643
TOTAL PROPERTY, PLANT & EQUIPMENT	**956,673**	**-**	**18,599**	**938,074**

(i) Classified in accordance with the fair value hierarchy.

(ii) Non specialised buildings are buildings that might have an alternative use that would generate higher and therefore better use. For Western Health, this relates to the Drug and Alcohol addiction centres (WestAdd)

	Consolidated Carrying amount	Fair value measurement at end of reporting period using:		
		Level 1[(i)]	Level 2[(i)]	Level 3[(i)]
	$'000	$'000	$'000	$'000
Balance at 30 June 2019				
Land at fair value				
Specialised Land	127,146	-	-	127,146
Non-Specialised Land	2,780	-	2,780	-
Total Land at fair value	**129,926**	**-**	**2,780**	**127,146**
Buildings at fair value				
Specialised Buildings	643,024	-	-	643,024
Non-Specialised Buildings	900	-	900	-
Total Buildings at fair value	**643,924**	**-**	**900**	**643,024**
Buildings under construction at fair value	67,656	-	-	67,656
Plant and Equipment at fair value	23,293	-	-	23,293
Motor Vehicles at fair value	165	-	165	-
Medical Equipment at fair value	29,542	-	-	29,542
Non-Medical Equipment at fair value	2,066	-	2,066	-
Computers and Communication at fair value	2,523	-	2,523	-
Furniture and Fittings at fair value	2,363	-	2,363	-
Total other plant and equipment at fair value	**127,607**	**-**	**7,117**	**120,491**
TOTAL PROPERTY, PLANT & EQUIPMENT	**901,458**	**-**	**10,797**	**890,661**

(i) Classified in accordance with the fair value hierarchy.

Note 4.2: Property, Plant And Equipment (continued)

(d) Reconciliation of Level 3 Fair Value [(i)]

Consolidated	Land $'000	Buildings $'000	Buildings Right of Use $'000	Buildings Under Constrct'n $'000	Plant and Equipment $'000	Medical Equipment $'000	Total $'000
Balance at 1 July 2019	**127,146**	**643,024**	**-**	**67,656**	**23,293**	**29,542**	**890,661**
Additions/(disposals)		25,484	143	64,498	13,989	8,287	112,401
Net transfers between classes		6,200	-	(11,229)	(15,127)	7,125	(13,031)
Gains/(losses) recognised in net result							
- Depreciation		(41,423)	(47)	-	(1,284)	(9,203)	(51,957)
	127,146	**633,285**	**96**	**120,925**	**20,871**	**35,751**	**938,074**
Items recognised in other comprehensive income							
- Revaluation	-	-		-	-	-	-
Balance at 30 June 2020	**127,146**	**633,285**	**96**	**120,925**	**20,871**	**35,751**	**938,074**

Consolidated	Land $'000	Buildings $'000	Buildings Right of Use $'000	Buildings Under Constrct'n $'000	Plant and Equipment $'000	Medical Equipment $'000	Total $'000
Balance at 1 July 2018	**81,714**	**432,133**	**-**	**109,079**	**41,667**	**36,126**	**700,719**
Additions/(disposals)	-	93,027	-	69,194	2,085	1,209	165,515
Net transfers between classes	5,730	110,617	-	(110,617)	(19,259)	193	(13,336)
Gains/(losses) recognised in net result							
- Depreciation	-	(31,861)	-	-	(1,200)	(7,986)	(41,047)
	87,444	**603,916**	**-**	**67,656**	**23,293**	**29,542**	**811,851**
Items recognised in other comprehensive income							
- Revaluation	39,702	39,108	-	-	-	-	78,810
Balance at 30 June 2019	**127,146**	**643,024**	**-**	**67,656**	**23,293**	**29,542**	**890,661**

(i) Classified in accordance with the fair value hierarchy, refer Note 4.2 (c)

Note 4.2: Property, Plant And Equipment (continued)

(e) Fair Value Determination

Asset Class	Likely Valuation Approach	Significant Inputs (Level 3 only)
Non-Specialised Land	Market approach	N/A
Specialised Land	Market approach	Community Service Obligation adjustments (b)
Non-Specialised Buildings	Market approach	N/A
Specialised Buildings(a)	Depreciated replacement cost approach	-Cost per square metre -Useful life
Infrastructure	Depreciated replacement cost approach	-Cost per square metre -Useful life
Vehicles	Market approach Depreciated replacement cost approach	N/A - Cost per unit - Useful life
Plant and Equipment(a)	Depreciated replacement cost approach	- Cost per unit - 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) Community service obligations 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 reporting period

(f) Property, Plant and Equipment Revaluation Surplus

	Note	2020 $'000	2019 $'000
Property, Plant and Equipment Revaluation Surplus			
Balance at the beginning of the reporting period		438,474	359,066
Revaluation Increment			
- Land	4.2 (b)	-	39,746
- Buildings	4.2 (b)	-	39,662
Balance at the end of the reporting period		438,474	438,474
Represented by:			
- Land		115,087	115,087
- Buildings		323,387	323,387
		438,474	**438,474**

Note 4.3: Intangible Assets

(a) Intangible assets - Gross carrying amount and accumulated amortisation

	2020 $'000	2019 $'000
Intangible Produced Assets - Software [(i)]	51,766	44,710
less Accumulated Amortisation	(29,719)	(17,965)
Total Intangible Assets	**22,047**	**26,745**

(i) Additions during the year related to the Electronic Medical Record Software.

(b) Intangible assets - Reconciliation of the carrying amount by class of asset

	Note	Software $'000	Total $'000
Balance at 1 July 2018		**5,099**	**5,099**
Additions [(i)]		26,375	26,375
Amortisation	4.4	(4,729)	(4,729)
Balance at 1 July 2019		**26,745**	**26,745**
Additions [(i)]		7,055	7,055
Amortisation	4.4	(11,753)	(11,753)
Balance at 30 June 2020		**22,047**	**22,047**

(i) Includes a transfer from Plant and Equipment. This value is shown in note 4.2(b) in the net total of 'Net Transfers Between Classes'.

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.

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

a) the technical feasibility of completing the intangible asset so that it will be available for use or sale;
b) an intention to complete the intangible asset and use or sell it;
c) the ability to use or sell the intangible asset;
d) the intangible asset will generate probable future economic benefits;
e) the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and
f) the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Note 4.4: Depreciation And Amortisation

	2020 $'000	2019 $'000
Depreciation		
Buildings	41,571	31,863
Plant and Equipment	1,284	1,200
Motor Vehicles	-	5
Medical Equipment	9,203	7,986
Non Medical Equipment	537	489
Computers and Communication	4,677	1,060
Furniture and Fittings	718	696
Right of use assets (leases)		
- Right of use buildings	47	-
- Right of use plant, equipment and vehicles	681	-
Total Depreciation	**58,718**	**43,299**
Amortisation		
Intangible Assets - Software	11,753	4,729
Total Amortisation	**11,753**	**4,729**
Total Depreciation and Amortisation	**70,471**	**48,028**

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 generally 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)* .

Right-of use assets are depreciated over the shorter of the asset's useful life and the lease term. Where the Health Service obtains ownership of the underlying leased asset or if the cost of the right-of-use asset reflects that the entity will exercise a purchase option, the entity depreciates the right-of-use asset overs its useful life.

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

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.

	2020	2019
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	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.

Note 4.5: Inventories

	2020 $'000	2019 $'000
Medical and surgical consumables at cost	245	236
Pharmacy supplies at cost	3,745	2,116
Total Inventories	**3,990**	**2,352**

Inventories
Inventories include goods and other property for consumption or for distribution at nil or nominal cost in the ordinary course of business operations. It excludes depreciable assets.

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

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

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 and contract assets
5.2 Payables and contract liabilities
5.3 Other Liabilities

Note 5.1 (a): Receivables and contract assets

	Note	2020 $'000	2019 $'000
CURRENT			
Contractual			
Inter Hospital Debtors		333	2,069
Trade Debtors		2,229	3,033
Patient Fees		5,936	6,528
Accrued Revenue [(i)]		3,189	4,581
Trade Debtors	7.1 (c)	(282)	(393)
Patient Fees	7.1 (c)	(2,160)	(3,159)
Sub-Total Contractual Receivables		**9,245**	**12,659**
Statutory			
GST Receivable		895	1,194
Accrued Revenue - Department of Health and Human Services		140	5,635
Sub-Total Statutory Receivables		**1,035**	**6,829**
TOTAL CURRENT RECEIVABLES		**10,280**	**19,488**
NON CURRENT			
Statutory			
Long Service Leave - Department of Health and Human Services		39,518	35,103
TOTAL NON CURRENT RECEIVABLES		**39,518**	**35,103**
TOTAL RECEIVABLES		**49,798**	**54,592**

(i) Represents uninvoiced debtors and interest not yet received relating to the VFMC investment

Note 5.1 (b): Movement in allowance for impairment losses of contractual receivables

	2020 $'000	2019 $'000
Balance at beginning of year	3,553	2,435
Reversal of allowance written off during the year as uncollectable	(2,241)	(1,493)
Increase in allowance recognised in net result	1,130	2,611
Balance at end of year	**2,442**	**3,553**

Receivables

Receivables consist of:

- contractual receivables, which consists of debts in relation to goods and services and accrued investment income. These receivables are classified as financial instruments and are categorised as 'financial assets at amortised cost'. They are initially recognised at fair value plus any directly attributable transaction costs. The Health Service holds the contractual receivables with the objective to collect the contractual cash flows and therefore subsequently measured at amortised cost using the effective interest method, less any impairment; and
- statutory receivables, which predominantly includes amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. The Health Service applies AASB 9 for initial measurement of the statutory receivables and as a result statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition.

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.*

The Health Service is not exposed to any significant credit risk exposure to any single counterparty or any group of counterparties having similar characteristics. Trade receivables consist of a large number of customers in various geographical areas. Based on historical information about customer default rates, management consider the credit quality of trade receivables that are not past due or impaired to be good.

Impairment losses of contractual receivables

Refer to Note 7.1 (c) Contractual receivables at amortised costs for the Health Service's contractual impairment losses.

Note 5.2: Payables and Contract Liabilities

	Note	2020 $'000	2019 $'000
CURRENT			
Contractual			
Trade Creditors		3,805	15,738
Accrued Salaries and Wages		26,830	21,805
Accrued Expenses		13,158	21,722
Deferred grant revenue	5.2 (a)	10,681	-
Contract liabilities - income received in advance	5.2 (b)	5,425	-
Salary Packaging		2,197	2,213
Amounts Payable to Governments and Agencies		4,435	10,900
Other		9	10
		66,540	**72,388**
Statutory			
Repayable Grants - Department of Health and Human Services	5.2 (b)	1,701	-
		1,701	**-**
TOTAL CURRENT PAYABLES		**68,241**	**72,388**
NON-CURRENT			
Deferred grant revenue	5.2 (a)	5,074	**-**
TOTAL NON-CURRENT PAYABLES		**5,074**	**-**
TOTAL PAYABLES		**73,315**	**72,388**

Payables consist of:

- contractual payables, classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to the Health Service prior to the end of the financial year that are unpaid, and arise when the Health Service becomes obliged to make future payments in respect of the purchase of those goods and services.
- statutory payables, that are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

The credit terms for accounts payable are usually Net 60 days.

Note 5.2 (a): Deferred Grant Revenue

	2020 $'000
Grant consideration for capital works recognised that was included in the deferred grant liability balance (adjusted for AASB 1058) at the beginning of the year	12,457
Grant consideration for capital works received during the year	13,061
Grant revenue for capital works recognised consistent with the capital works undertaken	(9,763)
Closing balance of deferred grant consideration received for capital works	**15,755**
Represented by	
Current contract liabilities	**10,681**
Non-current contract liabilities	**5,074**

Grant consideration was received during the financial year for the Linear Accelerator Program. The Health Service receives grant revenue each year over the useful life of the linear accelerator, being ten years. This grant consideration is deferred each year until the program has expired. At the expiration of the program, grant revenue is recognised in its tenth and final year at which the Health Service will acquire new linear accelerators which will be subject to the grant deferment and recognition as previously outlined.

Note 5.2 (b): Contract Liabilities

	2020 $'000
Opening balance brought forward from 30 June 2019 adjusted for AASB 15	-
Add: Payments received for performance obligations yet to be completed during the period	87,412
Add: Grant consideration for sufficiently specific performance obligations received during the year	804,649
Less: Revenue recognised in the reporting period for the completion of a performance obligation	(81,847)
Less: Grant revenue for sufficiently specific performance obligations works recognised consistent with the performance obligations met during the year	(802,948)
Total contract liabilities	**7,126**

Maturity Analysis of payables
Please refer to Note 7.1(b) for the aging analysis of payables

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 Borrowings
6.2 Cash and Cash Equivalents
6.3 Commitments for Expenditure

Note 6.1: Borrowings

	2020 $'000	2019 $'000
CURRENT		
TCV loan (i)	888	850
Lease Liability (ii)	627	24
DHHS Cash Advance (iii)	23,530	-
Total Current Borrowings	**25,045**	874
NON CURRENT		
TCV loan (i)	18,869	19,350
Lease Liability (ii)	1,286	141
Total Non-Current Borrowings	**20,155**	19,491
Total Borrowings	**45,200**	20,365

(i) This is an unsecured loan with the Treasury Corporation of Victoria (TCV) and has an annualised weighted average interest rate of 1.805%. The loan finances the Sunshine Hospital multi-deck car park. The approved loan limit is $20.4M.
(ii) Secured by the motor vehicle assets leased. Finance leases are effectively secured as the rights to the leased assets revert to the lessor in the event of a default.
(iii) DHHS Cash Advance received in June 2020.

Maturity analysis of borrowings

Please refer to Note 7.1(c) for the ageing analysis of borrowings.

Defaults and breaches

During the current and prior year, there were no defaults and breaches of any of the loans.

Note 6.1: Borrowings (continued)

Lease Liabilities

Repayments in relation to leases are payable as follows:

	Minimum future lease payments		Present Value of minimum future lease payments	
	2020	2019	2020	2019
Lease Liabilities	**$'000**	**$'000**	**$'000**	**$'000**
Not later than one year	751	31	627	24
Later than 1 year and not later than 5 years	1,238	146	1,286	141
Later than 5 years	-	-	-	-
Minimum lease payments	**1,989**	177	**1,913**	165
Less future finance charges	(76)	(12)	**-**	-
	1,913	165	**1,913**	165

	2020	2019
	$'000	**$'000**
Included in the financial statements as:		
Current borrowings finance lease liability	627	24
Non-current borrowings finance lease liability	1,286	141
Total Finance Lease Liability	**1,913**	165

The weighted average interest rate implicit in the finance lease is 1.9% (2019: 3.25%).

Leases

A lease is a right to use an asset for an agreed period of time in exchange for payment. All leases are recognised on the balance sheet, with the exception of low value leases, (less than $10,000), and short term leases of less than 12 months.

Western Health Service's leasing activities

For any new contracts entered into on or after 1 July 2019, the Health Service considers whether a contract is, or contains a lease. A lease is defined as 'a contract, or part of a contract, that conveys the right to use an asset, (the underlying asset), for a period of time in exchange for consideration'. To apply this definition the Health Service assesses whether the contract meets three key evaluations which are whether:

- the contract contains an identified asset, which is either explicitly identified in the contract or implicitly specified by being identified at the time the asset is made available to the Health Service and for which the supplier does not have substantive substitution rights;
- the Health Service has the right to obtain substantially all of the economic benefits from use of the identified asset throughout the period of use, considering its rights within the defined scope of the contract and the Health Service has the right to direct the use of the identified asset throughout the period of use; and
- the Health Service has the right to take decisions in respect of 'how and for what purpose' the asset is used throughout the period of use.

This policy is applied to contracts entered into, or changed, on or after 1 July 2019.

Separation of lease and non-lease components

At inception or on reassessment of a contract that contains a lease component, the lessee is required to separate out and account separately for non-lease components within a lease contract and exclude these amounts when determining the lease liability and right-of-use asset amount.

Note 6.1: Borrowings (continued)

Recognition and measurement of leases as a lessee (under AASB 16 from 1 July 2019)
Lease Liability – initial measurement
The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease if that rate is readily determinable or the Health Services incremental borrowing rate.

Lease payments included in the measurement of the lease liability comprise the following:
- fixed payments (including in-substance fixed payments) less any lease incentive receivable
- variable payments based on an index or rate, initially measured using the index or rate as at the commencement date;
- amounts expected to be payable under a residual value guarantee; and
- payments arising from purchase and termination options reasonably certain to be exercised

Lease Liability – subsequent measurement

Subsequent to initial measurement, the liability will be reduced for payments made and increased for interest. It is remeasured to reflect any reassessment or modification, or if there are changes in-substance fixed payments.

When the lease liability is remeasured, the corresponding adjustment is reflected in the right-of-use asset, or profit and loss if the right of use asset is already reduced to zero.

Short-term leases and leases of low value assets

The Health Service has elected to account for short-term leases and leases of low value assets using the practical expedients. Instead of recognising a right of use asset and lease liability, the payments in relation to these are recognised as an expense in profit or loss on a straight line basis over the lease term.

Presentation of right-of-use assets and lease liabilities
The Health Service presents right-of-use assets as 'property, plant and equipment' unless they meet the definition of investment property, in which case they are disclosed as 'investment property' in the balance sheet. Lease liabilities are presented as 'borrowings' in the balance sheet.

Recognition and measurement of leases (under AASB 117 until 30 June 2019)
In the comparative period, leases of property, plant and equipment were classified as either finance leases or operating leases.

The Health Service determined whether an arrangement was or contained a lease based on the substance of the arrangement and required an assessment of whether fulfilment of the arrangement is dependent on the use of the specific asset(s); and the arrangement conveyed a right to use the asset(s).

Leases of property, plant and equipment where the Health Service as a lessee had substantially all of the risks and rewards of ownership were classified as finance leases. finance leases were initially recognised as assets and liabilities at amounts equal to the fair value of the leased property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The leased asset is accounted for as a non-financial physical asset and depreciated over the shorter of the estimated useful life of the asset or the term of the lease. Minimum finance lease payments were apportioned between the reduction of the outstanding lease liability and the periodic finance expense, which is calculated using the interest rate implicit in the lease and charged directly to the consolidated comprehensive operating statement.

Note 6.1: Borrowings (continued)

Recognition and measurement of leases (under AASB 117 until 30 June 2019) (continued)
Contingent rentals associated with finance leases were recognised as an expense in the period in which they are incurred.
Assets held under other leases were classified as operating leases and were not recognised in the Health Services balance sheet. Operating lease payments were recognised as an operating expense in the Statement of Comprehensive Income on a straight-line basis over the lease term.

The impact of initialling applying AASB15: *Revenue from Contracts with Customers* and AASB 1058: *Income of not-for-profit entities* to the Health Service's grant revenue is described in Note 8.13. Under application of the modified retrospective transition method chosen in applying AASB 15 and AASB 1058 for the first time, comparative information has not been restated to reflect the new requirements. The adoption of AASB 15 and AASB 1058 did have an impact on Other Comprehensive Income and the Statement of Cash flows for the financial year.

Operating lease payments up until 30 June 2019 (including contingent rentals) are recognised 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.

From 1 July 2019, the following lease payments are recognised on a straight-line basis:
- Short-term leases – leases with a term less than 12 months; and
- Low value leases – leases with the underlying asset's fair value (when new, regardless of the age of the asset being leased) is no more than $10,000.

Variable lease payments not included in the measurement of the lease liability (i.e. variable lease payments that do not depend on an index or a rate, initially measured using the index or rate as at the commencement date). These payments are recognised in the period in which the event or condition that triggers those payments occur.

Other leasing arrangements in 2019: The other leases relate to equipment with lease terms of up to seven years. The Health Service has options to purchase the equipment at the conclusion of the lease agreements. Some leases provide for additional rent payments based on changes in a local price index.

Note 6.2: Cash And Cash Equivalents

	2020 $'000	2019 $'000
Cash on Hand (excluding monies held in trust)	15	15
Cash at Bank (excluding monies held in trust)	43,484	22,089
Total Cash and Cash Equivalents	**43,499**	**22,104**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	43,499	22,104
Total Cash and Cash Equivalents	**43,499**	**22,104**

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

For the purposes of the Cash Flow Statement, Cash Assets includes cash on hand, at bank and short-term deposits.

Note 6.3: Commitments For Expenditure

	2020 $'000	2019 $'000
Capital Expenditure Commitments		
less than 1 year	13,543	26,352
Longer than 1 year but not longer than 5 years	5,895	4,444
5 years or more	-	-
Total Capital Expenditure Commitments	**19,438**	**30,796**
Operating Expenditure Commitments		
less than 1 year	39,862	75,005
Longer than 1 year but not longer than 5 years	23,282	42,095
5 years or more	4	4
Total Operating Expenditure Commitments	**63,148**	**117,104**
Non-cancellable Operating Lease Commitments		
less than 1 year	751	671
Longer than 1 year but not longer than 5 years	1,238	339
5 years or more	-	-
Total Non-cancellable Lease Commitments	**1,989**	**1,010**
Total Commitments for expenditure (inclusive of GST)	**84,575**	**148,910**
less: GST recoverable from the Australian Tax Office (i)	(5,816)	(8,107)
Total Commitments for expenditure (exclusive of GST)	**78,759**	**140,803**

Future finance lease payments are recognised on the balance sheet, refer to Note 6.1 Borrowings.

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

Commitments
Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed 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.

The Health Service has entered into commercial leases on certain medical equipment, computer equipment and property where it is not in the interest of the Health Service to purchase these assets. These leases have an average life of between 1 and 7 years with renewal terms included in the contracts. Renewals are at the option of the Health Service. There are no restrictions placed upon the lessee by entering into these leases.

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 judgement to be applied, which for the Health Service is related mainly to fair value determination.

Structure

7.1 Financial Instruments
7.2 Contingent Assets and Contingent 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.*

Note 7.1 (a): Categorisation of Financial Instruments

2020	Financial Assets at Amortised Cost $'000	Financial Assets at Fair Value Through Net Result $'000	Financial Assets at Fair Value Through Other Comprehensive Income $'000	Financial Liabilities at Amortised Cost $'000	Total $'000
Contractual Financial Assets					
Cash and Cash Equivalents	43,499	-	-	-	43,499
Receivables					
- Trade Debtors	2,562	-	-	-	2,562
- Patient Fees	5,936	-	-	-	5,936
- Other Receivables	3,189	-	-	-	3,189
Other Financial Assets					
- Term Deposit	450	-	-	-	450
- Managed Funds	-	24,772	-	-	24,772
- Shares in Other Entities	-	1	-	-	1
Total Financial Assets [(i)]	**55,636**	**24,773**	-	-	**80,410**
Financial Liabilities					
Payables	-	-	-	50,434	50,434
Borrowings	-	-	-	45,200	45,200
Total Financial Liabilities [(i)]	-	-	-	**95,635**	**95,635**

Note 7.1: Financial Instruments (continued)

Note 7.1 (a): Financial Instruments: Categorisation (continued)

2019	Financial Assets at Amortised Cost $'000	Contract-ual financial assets - available-for-sale $'000	Contract-ual financial liabilities at amortised cost $'000	Total $'000
Financial Assets				
Cash and Cash Equivalents	22,104	-	-	22,104
Receivables				
- Trade Debtors	5,103	-	-	5,103
- Patient Fees	6,528	-	-	6,528
- Other Receivables	4,581	-	-	4,581
Other Financial Assets				
- Term Deposit	950	-	-	950
- Managed Funds	-	57,706	-	57,706
- Shares in Other Entities	-	1	-	1
Total Financial Assets [(i)]	**39,266**	**57,707**	**-**	**96,973**
Financial Liabilities				
Payables	-	-	72,388	72,388
Borrowings	-	-	20,365	20,365
Total Financial Liabilities [(i)]	-	-	**92,753**	**92,753**

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

Categories of financial assets under AASB 9

Financial assets at amortised cost

Financial assets are measured at amortised costs if both of the following criteria are met and the assets are not designated as fair value through net result:

- the assets are held by the Health Service to collect the contractual cash flows; and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interests.

These assets are initially recognised at fair value plus any directly attributable transaction costs and subsequently measured at amortised cost using the effective interest method less any impairment.

The Health Service recognises the following assets in this category:

- cash and deposits;
- receivables (excluding statutory receivables);
- term deposits; and
- certain debt securities.

Note 7.1: Financial Instruments (continued)

Financial assets at fair value through other comprehensive income
Debt investments are measured at fair value through other comprehensive income if both of the following criteria are met and the assets are not designated as fair value through net result:

- the assets are held by the Health Service to achieve its objective both by collecting the contractual cash flows and by selling the financial assets, and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interests.

Equity investments are measured at fair value through other comprehensive income if the assets are not held for trading and the Health Service has irrevocably elected at initial recognition to recognise in this category.

These assets are initially recognised at fair value with subsequent change in fair value in other comprehensive income.

Upon disposal of these debt instruments, any related balance in the fair value reserve is reclassified to profit or loss. However, upon disposal of these equity instruments, any related balance in fair value reserve is reclassified to retained earnings.

The Health Service recognises certain unlisted equity instruments within this category.

Financial assets at fair value through net result

Equity instruments that are held for trading as well as derivative instruments are classified as fair value through net result. Other financial assets are required to be measured at fair value through net result unless they are measured at amortised cost or fair value through other comprehensive income as explained above.

However, as an exception to those rules above, the Health Service may, at initial recognition, irrevocably designate financial assets as measured at fair value through net result if doing so eliminates or significantly reduces a measurement or recognition inconsistency ('accounting mismatch') that would otherwise arise from measuring assets or liabilities or recognising the gains and losses on them on different bases.

Categories of financial liabilities
Financial assets and liabilities at fair value through net result

Financial assets and liabilities at fair value through net result are categorised as such 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 net result on the basis that the financial assets form part of a group of financial assets that are managed based on their fair values 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 unless the changes in fair value relate to changes in the the Health Service's own credit risk. In this case, the portion of the change attributable to changes in the Health Service's own credit risk is recognised in other comprehensive income with no subsequent recycling to net result when the financial liability is derecognised. The Health Service recognises some debt securities that are held for trading in this category and designated certain debt securities as fair value through net result in this category.

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); and
- borrowings (including lease liabilities).

Note 7.1: Financial Instruments (continued)

Derivative financial instruments

Derivative financial instruments are classified as held for trading financial assets and liabilities. They are initially recognised at fair value on the date on which a derivative contract is entered into. Derivatives are carried as assets when their fair value is positive and as liabilities when their fair value is negative. Any gains or losses arising from changes in the fair value of derivatives after initial recognition are recognised in the consolidated comprehensive operating statement as an 'other economic flow' included in the net result.

Offsetting financial instruments:

Financial instrument assets and liabilities are offset and the net amount presented in the consolidated balance sheet when, and only when, the Health Service has a legal right to offset the amounts and intend either 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.

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.

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.

Reclassification of financial instruments:
Subsequent to initial recognition reclassification of financial liabilities is not permitted. Financial assets are required to reclassified between fair value through net result, fair value through other comprehensive income and amortised cost when and only when the Health Service's business model for managing its financial assets has changes such that its previous model would no longer apply.

Note 7.1 (b): Maturity Analysis of Financial Liabilities

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

				Maturity Dates				
	Note	Carrying Amount	Nominal Amount	Less than 1 Month	1-3 Months	3 Months-1 Year	1-5 Years	over 5 Years
2020		**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Financial Liabilities								
At amortised cost								
Payables [(i)]	5.2	50,434	50,434	69,766	14,998	5,306	-	-
Borrowings	6.1	45,200	45,200	8	112	24,926	5,145	15,009
Total Financial Liabilities		**95,634**	**95,634**	**69,773**	**15,110**	**30,232**	**5,145**	**15,009**
2019								
Financial Liabilities								
At amortised cost								
Payables [(i)]	5.2	72,388	72,388	72,388	-	-	-	-
Borrowings	6.1	20,365	20,365	2	89	783	4,221	15,270
Total Financial Liabilities		**92,752**	**92,752**	**72,389**	**89**	**783**	**4,221**	**15,270**

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

Note 7.1 (c) Contractual receivables at amortised cost

1 July 2019	**Current**	**Less than 1 month**	**1–3 months**	**3 months –1 year**	**1–5 years**	**Total**
Expected loss rate	0.8%	11.0%	70.6%	97.5%	0%	
Gross carrying amount of contractual receivables	10,947	1,472	1,481	2,313	-	**16,212**
Loss allowance	**88**	**162**	**1,046**	**2,257**	**-**	**3,553**

30 June 2020	**Current**	**Less than 1 month**	**1–3 months**	**3 months –1 year**	**1–5 years**	**Total**
Expected loss rate	1.5%	4.7%	60.2%	93.6%	100.0%	
Gross carrying amount of contractual receivables	7,437	1,430	1,161	1,498	163	**11,688**
Loss allowance	**110**	**67**	**699**	**1,402**	**163**	**2,442**

Impairment of financial assets under AASB 9: *Financial Instruments*
The Health Service records the allowance for expected credit loss for the relevant financial instruments, in accordance with AASB 9: *Financial Instruments* 'Expected Credit Loss' approach. Subject to AASB 9: *Financial Instruments*, impairment assessment includes the Health Service's contractual receivables, statutory receivables and its investment in debt instruments.

Equity instruments are not subject to impairment under AASB 9: *Financial Instruments*. Other financial assets mandatorily measured or designated at fair value through net result are not subject to impairment assessment under AASB 9: *Financial Instruments*. While cash and cash equivalents are also subject to the impairment requirements of AASB 9: *Financial Instruments*, any identified impairment loss would be immaterial.

Note 7.1 (c) Contractual receivables at amortised cost

Contractual receivables at amortised cost
The Health Service applies AASB 9 simplified approach for all contractual receivables to measure expected credit losses using a lifetime expected loss allowance based on the assumptions about risk of default and expected loss rates. The Health Service has grouped contractual receivables on shared credit risk characteristics and days past due and select the expected credit loss rate based on the past history, existing market conditions, as well as forward-looking estimates at the end of the financial year.

On this basis, the Health Service determines the opening loss allowance and the closing loss allowance at end of the financial year as disclosed above.

Reconciliation of the movement in the loss allowance for contractual receivables

	Note	2020 $'000	2019 $'000
Balance at beginning of the year ($'000s)		3,553	2,435
Opening retained earnings adjustment on adoption of AASB 9		-	-
Opening Loss Allowance	5.1	**3,553**	**2,435**
Increase in provision recognised in the net result	5.1	1,130	2,611
Reversal of unused provision recognised in the net results		(2,241)	(1,493)
Balance at end of the year	5.1	**2,442**	**3,553**

Credit loss allowance is classified as other economic flows in the net result. Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

In prior years, 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. A provision is made for estimated irrecoverable amounts from the sale of goods when there is objective evidence that an individual receivable is impaired. Bad debts considered as written off by mutual consent.

Statutory receivables and debt investments at amortised cost [AASB2016-8.4]

The Health Service's non-contractual receivables arising from statutory requirements are not financial instruments. However, they are nevertheless recognised and measured in accordance with AASB 9 requirements as if those receivables are financial instruments.

Both the statutory receivables and investments in debt instruments are considered to have low credit risk, taking into account the counterparty's credit rating, risk of default and capacity to meet contractual cash flow obligations in the near term. As a result, the loss allowance recognised for these financial assets during the period was limited to 12 months expected losses.

Note 7.2 Contingent Assets and Contingent Liabilities

There are no contingencies to report (2019: nil).

Note 8: Other Disclosures

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

Structure

8.1 Reconciliation Of Net Result For The Year To Net Cash Flow From Operating Activities
8.2 Responsible Persons Disclosures
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Note 8.1: Reconciliation Of Net Result For The Year To Net Cash Flow From Operating Activities

	2020 $'000	2019 $'000
Net Result For The Year	**13,282**	**81,723**
Non-cash movements:		
Depreciation and amortisation	70,471	48,028
Revaluation of long service leave	2,914	8,978
Provision for doubtful debts	(999)	-
Allowance for impairment losses of contractual receivables	1,130	2,611
Net gain on revaluation of managed funds	1,934	(65)
Movements included in investing and financing activities:		
Net (gain)/loss from disposal of non financial physical assets	60	-
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/decrease in Receivables	4,663	(16,768)
(Increase)/decrease in Prepayments	(270)	(762)
Increase/(decrease) in Payables	(21,953)	19,181
Increase/(decrease) in Provisions	18,729	17,826
Increase/(decrease) in Inventories	(1,638)	(103)
Increase/(decrease) in Other Liabilities	(4,432)	1,217
Increase/(decrease) in Non-Current Other Liabilities	619	-
NET CASH INFLOW FROM OPERATING ACTIVITIES	**84,510**	**161,865**

Note 8.2: Responsible Persons Disclosures

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

	Period
Responsible Ministers	
The Honourable Jenny Mikakos, Minister for Health and Minister for Ambulance Services	1/07/2019 - 30/06/2020
The Honourable Martin Foley, Minister for Mental Health	1/07/2019 - 30/06/2020
The Honourable Luke Donnellan, Minister for Child Protection, Minister for Disability, Ageing and Carers	1/07/2019 - 30/06/2020
Governing Board	
Ms Bronwyn Pike (Chair)	1/07/2019 - 30/06/2020
Professor Colin Clark	1/07/2019 - 30/06/2020
Mrs Elleni Bereded-Samuel	1/07/2019 - 19/11/2019
Mr David Shaw	1/07/2019 - 18/02/2020
Dr Catherine Hutton	1/07/2019 - 30/06/2020
Ms Patricia Malowney	1/07/2019 - 30/06/2020
Ms Nicole Bartholomeusz	1/07/2019 - 19/11/2019
Ms Robyn Batten	1/07/2019 - 30/06/2020
Mr Andrew Conway	12/05/2020 - 30/06/2020
Ms Sheree Proposch	1/07/2019 - 30/06/2020
Accountable Officer	
Mr Russell Harrison	1/07/2019 - 30/06/2020

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

	2020 No.	2019 No.
Income Band		
$0 - $9,999	1	0
$10,000 - $19,999	1	0
$20,000 - $29,999	2	1
$30,000 - $39,999	0	2
$40,000 - $49,999	3	4
$50,000 - $59,999	2	2
$60,000 - $69,999	0	0
$70,000 - $79,999	0	0
$80,000 - $89,999	0	0
$90,000 - $99,999	1	1
$310,000 - $319,999	0	0
$400,000 - $409,999	0	0
$440,000 - $449,999	0	1
$480,000 - $489,999	1	0
Total Numbers	**11**	**11**

	2020 $'000	2019 $'000
Total remuneration received, or due to, Responsible Persons (excluding Responsible Ministers) from the reporting entity amounted to:	**$907**	**$966**

Note: The remuneration above includes payments made up to 30 June 2020 to Directors that have resigned as at 30 June 2020.

Payments to Responsible Ministers are excluded and are reported within the Department of Parliamentary Services Financial Report.

Note 8.3: Remuneration of Executive Officers

The number of Executive Officers, (excluding Responsible Persons), and their total remuneration during the reporting period is shown in the table below. Total annualised employee equivalent provides a measure of full time equivalent Executive Officers over the reporting period.

All Executive Officers are considered to be Key Management Personnel of the Health Service and are therefore included in note 8.4 below.

Remuneration of Executive Officers	**Total Remuneration**	
	2020 ($'000)	**2019 ($'000)**
Short-term employee benefits	1,766	1,955
Post-employment benefits	123	166
Other long-term benefits	146	150
Termination benefits	40	-
Total remuneration [(i)]	**2,075**	**2,271**
Total number of executives	6	7
Total annualised employee equivalent [(ii)]	**6**	**7**

(i) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the Health Services under AASB 124: Related Party Disclosures and are also reported within Note 8.4 Related Parties.

(ii) Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

Remuneration comprises employee benefits in all forms 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.

Note 8.4: 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
- Controlled Entities – Western Health Foundation Limited and Western Health Foundation Trust Fund; and
- Jointly Controlled Operation – A member of the Victorian Comprehensive Cancer Centre; 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	Ms 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 Catherine Hutton	Board Member
Western Health	Ms Patricia Malowney	Board Member
Western Health	Ms Nicole Bartholomeusz	Board Member
Western Health	Ms Robyn Batten	Board Member
Western Health	Mr Andrew Conway	Board Member
Western Health	Ms Sheree Proposch	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	Mr Paul Eleftheriou	Chief Medical Officer
Western Health	Ms Suellen Bruce	Executive Director People, Culture & Communications
Western Health	Mr Shane Crowe	Executive Director Nursing & Midwifery
Western Health	Ms Susan Wardle	Executive Director Strategy & 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	2020 ($'000)	2019 ($'000)
Short-term employee benefits	2,582	2,826
Post-employment benefits	174	224
Other long-term benefits	187	187
Termination benefits	40	-
Total[(i)]	**2,983**	**3,237**

(i) KMPs are also reported in Note 8.2 Responsible Persons or Note 8.3 Remuneration of Executives.

Note 8.4: Related Parties (continued)

Significant Transactions with Government Related Entities
The Health Service received funding from the Department of Health and Human Services of $769 million (2019: $743 million), including indirect contributions of $5 million (2019: $7 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 the Victorian Managed Insurance Authority.

The Standing Directions of the Assistant Treasurer require the Health Service to hold cash, (in excess of working capital), in accordance with the State's centralised banking arrangements. All borrowings are required to be sourced from Treasury Corporation Victoria unless an exemption has been approved by the Minister for Health and Human Services and the Treasurer.

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 arm's length transactions similar to other members of the public, in relation to 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 Health Service, there were no related party transactions that involved key management personnel, their close family members and their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2020. There were no related party transactions with Cabinet Ministers required to be disclosed in 2020.

There were no related party transactions required to be disclosed for the Health Service Board of Directors, Chief Executive Officer and Executive Directors in 2020.

Controlled entity related party transactions
Western Health Foundation

The transactions between the entities relate to donations transferred to Western Health from the Foundation and reimbursements to Western Health from the Foundation for the costs of fundraising activities.

	2020 ($'000)	2019 ($'000)
Distribution and reimbursements of funds by Western Health Foundation	3,331	890
Total	**3,331**	**890**

Note 8.5: Remuneration Of Auditors

	2020 $'000	2019 $'000
Victorian Auditor-General's Office		
Audit of financial statements	136	143
Protiviti		
Internal Audit services [(i)]	71	304
Total Remuneration of Auditors	**207**	**447**

(i) $100K of accrued Internal Audit fees from the 2018/19 year was reversed in 2019/20 as it was not required.

Note 8.6: Events Occurring After The Balance Sheet Date

The Health Service has acquired a local-government owned enterprise, Regional Kitchen Pty Ltd. The date of this acquisition was 7 August 2020.

The COVID-19 pandemic has created unprecedented economic uncertainty. Actual economic events and conditions in the future may be materially different from those estimated by the health service at the reporting date. As responses by government continue to evolve, management recognises that it is difficult to reliably estimate with any degree of certainty the potential impact of the pandemic after the reporting date on health service, its operations, its future results and financial position. The state of emergency in Victoria was extended on 16 August 2020 until 13 September 2020 and the state of disaster still in place.

No other matters or circumstances have arisen since the end of the financial year which significantly affected or may affect the operations of the health service, the results of the operations or the state of affairs of the health service in the future financial years.

Note 8.7: Controlled Entities

The Health Service's interest in the controlled entity is detailed below. The amounts are included in the consolidated financial statements under their respective categories:

Name of Entity	Principal Activity	Ownership Interest %	Country of Incorporation	Equity Holding
Western Health Foundation Trust Fund		100%	Australia	100%
Western Health Foundation Limited	Fundraising and philanthropic activities on behalf of the Health	100%	Australia	Limited by Guarantee

The Health Service's interest in revenues and expenses resulting from this is detailed below:

Controlled entity contributions to the consolidated results

Net Result For The Year	2020 ($'000)	2019 ($'000)
Western Health Foundation Trust Fund [(i)]	(1,470)	1,899
Western Health Foundation Limited	-	-
	(1,470)	**1,899**

(i) In the current financial year, the Foundation received $1.8M of donations and subsequently donated $3.1M to Western Health for Medical Equipment, Salaries & wages and the Williamstown Project, and reimbursed $0.2M of fundraising expenditure. In the previous financial year, the Foundation received $2.8M of donations and subsequently donated $0.5M, and reimbursed $0.4M of fundraising expenditure.

Contingent Liabilities and Capital Commitments

There are no known contingent liabilities or capital commitments held by the controlled entity at balance date.

Note 8.8: Jointly Controlled Operations

Name of Entity	Principal Activity	Ownership Interest 2020 %	Ownership Interest 2019 %
Victorian Comprehensive Cancer Centre Joint Venture (VCCC)	Cancer research, education, 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.

	2020 $'000	2019 $'000
Current Assets		
Cash and cash equivalents	607	507
Investments and other financial assets	450	950
Receivables	31	20
Prepayments	34	122
Total Current Assets	**1,122**	**1,599**
Non-Current Assets		
Investments and other financial assets	1	1
Property, plant and equipment	10	14
Intangible Assets	7	8
Total Non-Current Assets	**18**	**23**
TOTAL ASSETS	**1,140**	**1,622**
Current Liabilities		
Payables	88	95
Accrued expenses	54	38
Provisions	41	25
Total Current Liabilities	**183**	**158**
Non-Current Liabilities		
Provisions	10	10
Total Non-Current Liabilities	**10**	**10**
TOTAL LIABILITIES	**193**	**168**
NET ASSETS	**947**	**1,454**
EQUITY		
Accumulated surplus	947	1,454
TOTAL EQUITY	**947**	**1,454**

Note 8.8: Jointly Controlled Operations (continued)

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

	2020 $'000	2019 $'000
Revenue		
Grants	872	850
Members Contribution	152	150
Other Income	93	26
Interest Income	14	32
Total Revenue	**1,131**	**1,058**
Expenses		
Employee Benefits	502	410
Operating Expenses	1,129	838
Depreciation	7	5
Total Expenses	**1,638**	**1,253**
NET RESULT	**(507)**	**(195)**

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

Contingent liabilities and capital commitments
There are no known contingent liabilities or capital commitments held by the jointly controlled operation 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 (2019: 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.

Note 8.8: Jointly Controlled Operations (continued)

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 8.9: Economic Dependency

The Health Service is dependent on the Federal and State Governments for the majority of its revenue used to operate the entity. At the date of this report, the Board of Directors has no reason to believe the Federal and State Governments will not continue to support the Health Service.

Note 8.10: Changes in accounting policy, revision of estimates and corrections of prior period errors

Changes in accounting policy
Leases
This note explains the impact of the adoption of AASB 16: *Leases* on the Health Service's financial statements.

The Health Service has applied AASB 16 with a date of initial application of 1 July 2019. The Health Service has elected to apply AASB 16 using the modified retrospective approach, as per the transitional provisions of AASB 16 for all leases for which it is a lessee. The cumulative effect of initial application is recognised in retained earnings as at 1 July 2019. Accordingly, the comparative information presented is not restated and is reported under AASB 117 and related interpretations.

Previously, the Health Service determined at contract inception whether an arrangement is or contains a lease under AASB 117 and Interpretation 4 – 'Determining whether an arrangement contains a Lease'. Under AASB 16, the Health Service assesses whether a contract is or contains a lease based on the definition of a lease as explained in note 6.1.

On transition to AASB 16, the Health Service has elected to apply the practical expedient to grandfather the assessment of which transactions are leases. It applied AASB 16 only to contracts that were previously identified as leases. Contracts that were not identified as leases under AASB 117 and Interpretation 4 were not reassessed for whether there is a lease. Therefore, the definition of a lease under AASB 16 was applied to contracts entered into or changed on or after 1 July 2019.

Leases classified as operating leases under AASB 117
As a lessee, the Health Service previously classified leases as operating or finance leases based on its assessment of whether the lease transferred significantly all of the risks and rewards incidental to ownership of the underlying asset to the Health Service. Under AASB 16, the Health Service recognises right-of-use assets and lease liabilities for all leases except where exemption is availed in respect of short-term and low value leases.

On adoption of AASB 16, the Health Service recognised lease liabilities in relation to leases which had previously been classified as operating leases under the principles of AASB 117: *Leases* . These liabilities were measured at the present value of the remaining lease payments, discounted using the Health Service's incremental borrowing rate as of 1 July 2019. On transition, right-of-use assets are measured at the amount equal to the lease liability, adjusted by the amount of any prepaid or accrued lease payments relating to that lease recognised in the balance sheet as at 30 June 2019.

Note 8.10: Changes in accounting policy, revision of estimates and corrections of prior period errors (continued)

The Health Service has elected to apply the following practical expedients when applying AASB 16 to leases previously classified as operating leases under AASB 117:

- Applied a single discount rate to a portfolio of leases with similar characteristics;
- Adjusted the right-of-use assets by the amount of AASB 137 onerous contracts provision immediately before the date of initial application, as an alternative to an impairment review;
- Applied the exemption not to recognise right-of-use assets and liabilities for leases with less than 12 months of lease term;
- Excluded initial direct costs from measuring the right-of-use asset at the date of initial application; and
- Used hindsight when determining the lease term if the contract contains options to extend or terminate the lease.

For leases that were classified as finance leases under AASB 117, the carrying amount of the right-of-use asset and lease liability at 1 July 2019 are determined as the carrying amount of the lease asset and lease liability under AASB 117 immediately before that date.

Leases as a Lessor

The Health Service is not required to make any adjustments on transition to AASB 16 for leases in which it acts as a lessor. The Health Service accounted for its leases in accordance with AASB 16 from the date of initial application.

Impacts on financial statements
On transition to AASB 16, the Health Service recognised $2,508,753 of right-of-use assets and $1,913,255 of lease liabilities.

When measuring lease liabilities, the Health Service discounted lease payments using its incremental borrowing rate at 1 July 2019. The weighted average rate applied is 3.25%.

	1/07/2019
Total Operating lease commitments disclosed at 30 June 2019	1,219
Discounted using the incremental borrowing rate at 1 July 2019	1,181
Finance lease liabilities as at 30 June 2019	**165**
Recognition exemption for:	
Short-term leases	-
Leases of low-value assets	-
Lease liabilities recognised at 1 July 2019	**1,346**

Revenue from Contracts with Customers

In accordance with FRD 121 requirements, the Health Service has applied the transitional provision of AASB 15, under modified retrospective method with the cumulative effect of initially applying this standard against the opening retained earnings at 1 July 2019. Under this transition method, the Health Service applied this standard retrospectively only to contracts that are not 'completed contracts' at the date of initial application. The Health Service has not applied the fair value measurement requirements for right-of-use assets arising from leases with significantly below-market terms and conditions principally to enable the entity to further its objectives as allowed under temporary option under AASB 16 and as mandated by FRD 122.

Comparative information has not been restated.

Note 2.1 (a) – Income from tranactions includes details about the transitional application of AASB 15 and how the standard has been applied to revenue transactions.

Income of Not-for-Profit Entities
The adoption of AASB 1058 did not have an impact on Other comprehensive income and the Statement of Cash flows for the financial year.

Note 8.10: Changes in accounting policy, revision of estimates and corrections of prior period errors (continued)

Transition impact on financial statements

This note explains the impact of the adoption of the following new accounting standards for the first time, from 1st July 2019:

- AASB 15: *Revenue from Contracts with Customers;*
- AASB 1058: *Income of Not-for-Profit Entities;* and
- AASB 16: *Leases.*

Impact on Balance Sheet due to the adoption of AASB 15, AASB 1058 and AASB 16 is illustrated with the following reconciliation between the restated carrying amounts at 30 June 2019 and the balances reported under the new accounting standards (AASB 15 and AASB 16) at 1 July 2019:

Balance Sheet	Notes	Before new accounting standards Opening 1st July 2019	Impact of new accounting standards - AASB 16, 15 & 1058	After new accounting standards Opening 1st July 2019
Property, Plant and Equipment	4.2 (a)	901,458	1,287	902,746
Other Assets		167,571	-	167,571
Total Assets		**1,069,029**	**1,287**	**1,070,317**
Payables and Contract Liabilities	5.2	86,624	12,458	99,082
Other Liabilities		180,230	-	180,230
Total Liabilities		**266,854**	**12,458**	**279,312**
Accumulated surplus/(deficit)		152,410	(11,171)	141,239
Physical Revaluation Surplus		438,474	-	438,474
Other Equity Items		211,291	-	211,291
Total Equity		**802,175**	**(11,171)**	**791,004**

Note 8.10: Changes in accounting policy, revision of estimates and corrections of prior period errors (continued)

Statement of changes in equity – changes for AASB 1058 and AASB 15 adoption

	Notes	Physical asset revaluation surplus	Available for sale financial asset revaluation surplus	Financial assets at fair value through other comprehensive income revaluation reserve	Own credit risk revaluation reserve relating to financial liabilities designated at fair value through profit or loss	Restricted Specific Purpose Surplus	Accumulated surplus	Contributed Capital	Total
Balance at 1 July 2018 [(a)]		359,066	1,286	-	-	6,606	71,106	202,980	641,044
Net result for the year		-	-	-	-	-	81,723	-	81,723
Other comprehensive income for the year		79,408	-	-	-	-	-	-	79,408
Opening balance adjustment on adoption of AASB9		-	(1,286)	-	-	-	1,286	-	-
Transfer to accumulated surplus		-	-	-	-	-	-	-	-
Capital appropriations		-	-	-	-	-	-	-	-
Balance at 30 June 2019		**438,474**	**-**	**-**	**-**	**6,606**	**154,115**	**202,980**	**802,175**
Change in accounting policy (due to AASB 15, 1058)		**-**	**-**	**-**	**-**	**-**	**(11,171)**	**-**	**(11,171)**
Restated balance at 1 July 2019		**438,474**	**-**	**-**	**-**	**6,606**	**142,944**	**202,980**	**791,004**
Net result for the year		**-**	**-**	**-**	**-**	**-**	13,282	**-**	13,282
Other comprehensive income for the year		**-**	**-**	**-**	**-**	(1,977)	1,977	-	**-**
Receipt/(return) of contributed capital		**-**	**-**	**-**	**-**	-	-	311	311
Transfer to contributed capital (a)		**-**	**-**	**-**	**-**	**-**	**-**	-	**-**
Capital appropriations		**-**	**-**	**-**	**-**	**-**	**-**	-	**-**
Balance at 30 June 2020		**438,474**	**-**	**-**	**-**	**4,629**	**158,203**	**203,291**	**804,597**

Note 8.11: AASBs Issued That Are Not Yet Effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2020 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 30 June 2020, 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 and/or Impacts	Effective date
AASB 17 Insurance Contracts	*The new Australian standard eliminates inconsistencies and weaknesses in existing practices by providing a single principle based framework to account for all types of insurance contracts, including reissuance contract that an insurer holds. It also provides requirements for presentation and disclosure to enhance comparability between entities.* *This standard currently does not apply to the not-for-profit public sector entities. No material impact is expected.*	*1 January 2021*
AASB 2018-7 Amendments to Australian Accounting Standards – Definition of Material	*This Standard principally amends AASB 101 Presentation of Financial Statements and AASB 108 Accounting Policies, Changes in Accounting Estimates and Errors. The amendments refine and clarify the definition of material in AASB 101 and its application by improving the wording and aligning the definition across AASB Standards and other publications. The amendments also include some supporting requirements in AASB 101 in the definition to give it more prominence and clarify the explanation accompanying the definition of material. No material impact is expected.*	*1 January 2020*
AASB 2020-1 Amendments to Australian Accounting Standards - Classification of Liabilities as Current or Non-Current	*This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. It initially applied to annual reporting periods beginning on or after 1 January 2022 with earlier application permitted however the AASB has recently issued ED 301 Classification of Liabilities as Current or Non-Current – Deferral of Effective Date with the intention to defer the application by one year to periods beginning on or after 1 January 2023. No material impact is expected.*	*1 January 2023*

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2019-20 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

AASB 2018-6: *Amendments to Australian Accounting Standards – Definition of a Business.*
AASB 2019-1: *Amendments to Australian Accounting Standards – References to the Conceptual Framework.*
AASB 2019-3: *Amendments to Australian Accounting Standards – Interest Rate Benchmark Reform.*
AASB 2019-4 *Amendments to Australian Accounting Standards – Disclosure in Special Purpose Financial Statements of Not-for-Profit Private Sector Entities on Compliance with Recognition and Measurement Requirements.*
AASB 2019-5: *Amendments to Australian Accounting Standards – Disclosure of the Effect of New IFRS Standards Not Yet Issued in Australia.*
AASB 2020-2: *Amendments to Australian Accounting Standards – Removal of Special Purpose Financial Statements for Certain For-Profit Private Sector Entities.*
AASB 1060: *General Purpose Financial Statements – Simplified Disclosures for For-Profit and Not-for-Profit Tier 2 Entities* (Appendix C).

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WESTERN CENTRE FOR HEALTH RESEARCH AND EDUCATION
Sunshine Hospital
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