wdhs
Western District
Health Service

2014 ANNUAL REPORT

IMPROVING CONSUMER EXPERIENCE, EVERYONE, EVERY TIME

Western District Health Service is a Sub Regional referral service with a proud reputation as one of Victoria's leading and innovative Rural and Regional Health Service providers. We have a strong commitment to our vision in striving for Excellence in Healthcare for Everyone Every Time through a person centred care service model.

wdhs
Western District Health Service

Symbolism of logo

Our logo was developed to represent the mission, vision and values of Western District Health Service, with our ultimate goal to create a more integrated and responsive service system based upon a person centred care model in accord with our 5 to 10 year Service Plan and Model of Care.

The six outer individual circular links of our logo represent the six potential service components of person centred care (acute, sub acute, mental health, wellness and promotion, aged care and primary care). The small inner circle represents our community members, clients and consumers. This inner circle is located near the wellness and promotion circular link to symbolise the ultimate aim of wellness and good health.

Our Mission

To meet the health and wellbeing needs of our community by delivering a comprehensive range of high quality, innovative and valued health services.

Vision

Excellence in healthcare, putting people first

Values

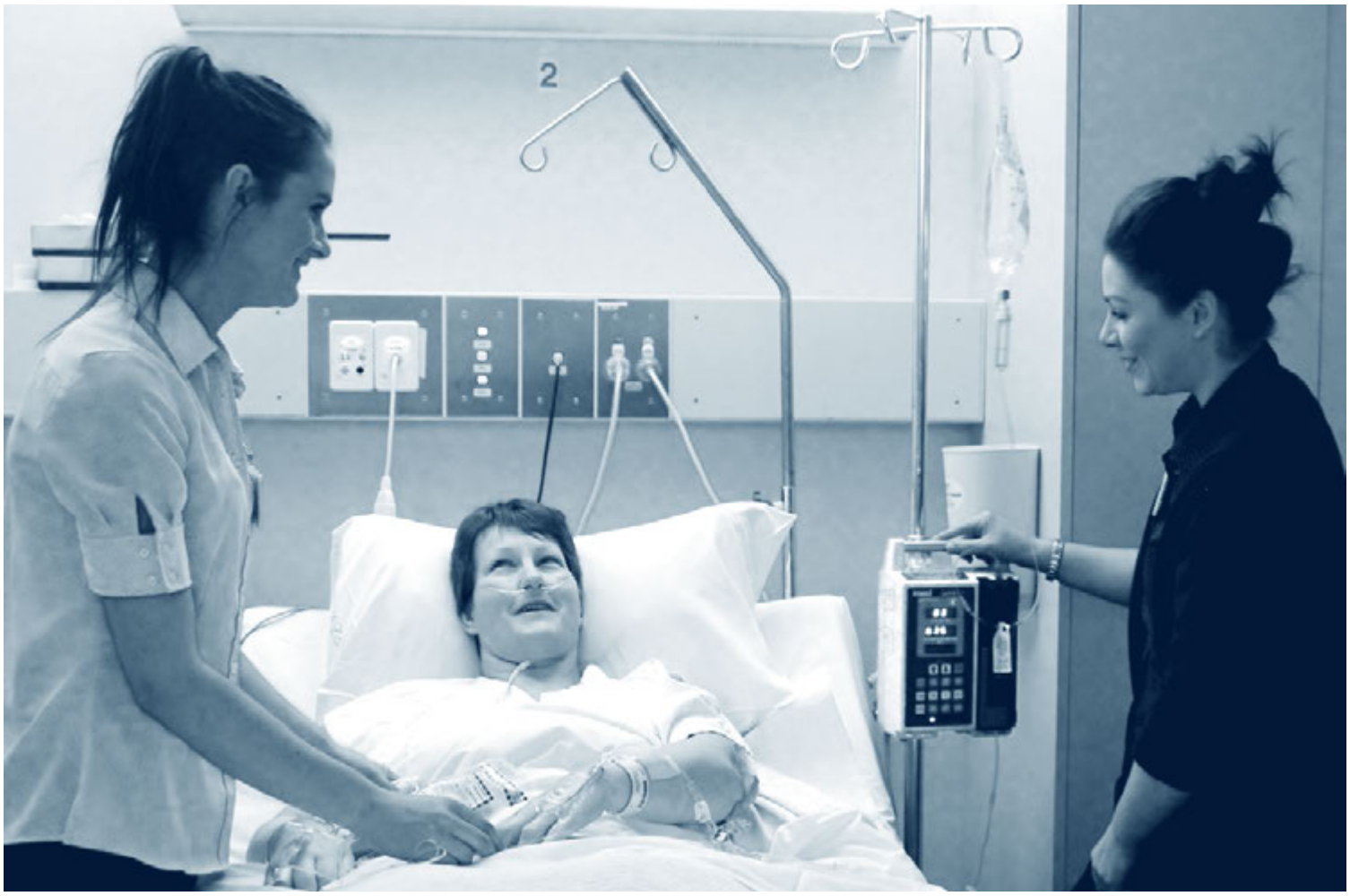
Our community
We recognise their rights, encourage their participation and are committed to their health and wellbeing.

Improving performance
We are committed to a culture of continuous quality improvement and innovation.

Our staff
We are committed to their wellbeing and ongoing education, growth and development.

Strong leadership
We are committed to governance and management that sets sound directions promoting innovation and research.

Safe practice
We are committed to a safe and healthy environment.



→ **Front Cover**
1. L-R: WDHS staff in Theatre Surgical Registrar Enoch Wong, Registered Nurse Helen Thomas and Surgeon Mr Peter Tung.
2. L-R: WDHS Medical Unit Manager Julie Stevens, CEO Jim Fletcher, Mrs Beryll Jeffries with Physiotherapist Prinisha Vijayakumar.
3. L-R: Dylan and Casey Marlow with baby Millie.

→ **Back Cover: Staff, consumers and carers sharing their experience of mental health services at the March Consumer and Friends Network Forum.**

→ **Opposite: Volunteer at The Grange Residential Aged Care Facility, Gail Darling, performing her weekly hairdressing with resident Lesley Holmes.**

→ **Above: L-R: Registered Nurses Kate Nunn & Amy Cowland providing person centred care to patient Deborah Cluse.**

Western District Health Service
Annual Report 2014

The theme of this year's report, 'Improving consumer experience, everyone, every time', reflects our vision, mission and values as well as our goal of embedding our adopted person centred care service model into our culture and daily practice.

- Victorian Premier's Regional Health Service of the Year 2012
- Victorian Premier's Primary Health Service Finalist 2011
- Victorian Premier's Regional Health Service Finalist 2010
- Victorian Premier's Regional Health Service Finalist 2009
- Victorian Premier's Primary Health Service 2008
- Victorian Premier's Regional Health Service 2007

Western District Health Service (WDHS) follows the Victorian State Government Department of Treasury and Finance FRD30 guidelines for its Annual Report, as a public entity under Section 3 of the Financial Management Act 1994 (FMA).

This report

- Covers the period 1 July 2013 to 30 June 2014
- Is the sixteenth annual report for WDHS
- Is prepared for the Minister for Health, the Parliament of Victoria and the community
- Is a public document freely available on our website and from WDHS on request
- Is prepared in accordance with government and legislative requirements and FRD 30 guidelines
- Provides an accurate record of our activities and achievements against key performance measures
- Acknowledges the support of our community
- Is printed on Evolve Laser - 100% Recycled (TCF)

Alternative Format

This Annual Report is also available on the WDHS website at www.wdhs.net

→ Aisling Cunningham, Nurse Unit Manager on the Medical Ward.

→ WDHS Community Liaison Manager, Steve Laidlaw accepted the Australasian Reporting Awards (ARA) Gold Award for the Health Service's 2013 Annual Report at the June presentation in Sydney.

Contents

Year in Brief

→ **L-R: WDHS Chief Executive Officer Jim Fletcher, Coleraine Campus Manager and Director of Nursing Tim Pitt-Lancaster, Coleraine Campus Advisory Committee Chairman Grant Little, Board President Mary-Ann Brown and Member for Western Victoria David Koch officially open the new one stop shop health precinct for Coleraine.**

2013/14 Highlights

- ACHS National Standards and Community Care Standards re-accreditation for 3 years
- Commissioning and opening of the Coleraine Campus one stop shop health precinct
- Commissioning and opening of the Kolor Lodge redevelopment
- Watermark Charity House project completed
- Shire of Southern Grampians Business award for Community Enterprise and Team Achievement
- VHA award for telehealth initiative
- Commonwealth and State Government funding for the National Centre for Farmer Health
- Canadian Government through the Alberta Farm Safety Centre adopts the National Centre for Farmer Health Sustainable Farm Families Program
- 15 students complete the National Centre for Farmer Health Agricultural Health and Medicine course held in Hamilton. A total of 102 students have now completed the course over the 5 years since its inception
- Development of a 3 year Consumer Participation Plan
- Leading Perinatal expert Professor Sue Walker delivers the 15th Handbury Lecture
- Completion of Care Coordination Model for Barwon South West Agencies
- Establishment of new services for orthopaedics, neurosurgery and kidney disease
- Establishment of a Sub Regional Dental Health Service Model
- Establishment of Residential In Reach program
- Commencement of Redesigning Care program for sub acute services
- Baby Friendly re-accreditation for 3 years
- Hosting of the BSW/Grampians Region Allied Health Conference attended by in excess of 100 health professionals
- Excellent external cleaning audit results 98.7% and food safety compliance outcomes
- Gold Medal Award for Annual Report
- Outstanding fundraising result of $1.145m
- Operating budget surplus of $89k and entity budget surplus of $1.146m

→ **Accepting the Non-clinical Excellence & Innovation Award at the WDHS AGM are the Trak Pas Team, L-R Paula Foley, Fran Patterson, Carolyn Gellert, Lorrraine Northcott, Michelle Walkley, Tatum Pretorius, with guest speaker, Glenn Manton.**

→ Penshurst Campus resident Mary Riddle with enrolled nurses Kim Cameron (left) and Sally Teelow (right).

PERFORMANCE AT A GLANCE	2014	2013	2012	2011	2010
FINANCIAL ($000'S)					
Total revenue	65,888	65,598	63,318	61,503	55,429
Total expenditure	65,799	65,482	63,015	61,228	55,317
Surplus (before capital and specific items)	89	116	303	275	112
Total assets	167,613	101,836	91,107	77,356	72,663
Total liabilities	18,850	19,301	20,410	18,137	18,577
Equity	148,763	82,535	70,697		54,086
FUNDRAISING ($000'S)					
Income	1,171	1,120	1,314	1,528	1,162
Expenditure	26	47	19	45	12
Surplus	1,145	1,073	1,295	1,483	1,150
STAFF					
Number of staff employed	785	818	777	760	736
Equivalent full time	547.63	554.12	555.81	553.12	549.47
PERFORMANCE INDICATORS (ACUTE)					
Inpatients treated (separations)	7,196	6,941	7,562	7,695	6,829
Complexity adjusted inpatients (WIES20)*	4,828	4,540	4,959	5,049	4,976
Average stay (days)	2.77	2.89	2.88	3.10	3.20
Inpatient bed days	19,971	20,038	21,799	24,172	21,861
Total occassions of non-admitted patient service	45,148	50,280	54,951	54,822	60,025

* WIES - Weighted Inlier Equivalent Separations

Overview

Reporting against our Strategic Plan

Each year WDHS reports on its major outcomes and proposed future directions against the seven key strategic areas of the 2011-2016 five year strategic plan. A summary of our achievements for 2013/14 together with proposed future directions are outlined below.

Further details can be found throughout this report.

Please refer to the glossary on the inside back cover for abbreviations.

	OBJECTIVE	STRATEGIES	OUTCOMES	FUTURE
LEADERSHIP AND INNOVATION	To be a leader in the provision of Rural Health Services developing innovative service models to meet the population health needs of our community	Lead the planning, development and delivery of innovative health care and support systems in partnership with other service providers	‣ VHA Award for telehealth initiative (p.25) ‣ Shire of Southern Grampians Business award for Community Enterprise and Team achievement (p.25)	
			‣ Joint funding of the National Centre for Farmer Health by Commonwealth and State Governments (p.5) ‣ Director of National Centre for Farmer Health appointed to Victorian Agriculture Advisory Committee (p.28) ‣ Canadian Government adopts the National Centre for Farmer Health Sustainable Farm Families Program for Canadian Farmers (p.28) ‣ 5th Agricultural Health and Medicine unit completed in Hamilton by students from 5 States and Territories (p.28) ‣ 14 students have completed the Graduate Certificate in Agricultural Health and Medicine (p.28) ‣ National Centre for Farmer Health completes Livestock Exchange health assessments and training for QRME staff in Queensland in 4 rural locations (p.28) ‣ 16th Libby Harricks Oration presented by Director National Centre for Farmer Health in Brisbane	‣ Continue to develop the National Centre for Farmer Health as a Centre for Excellence for farmer health
			‣ Completion of Care Coordination Model for Barwon South West Agencies (p.5)	‣ Continued development of innovative models of care
			‣ Participation in the Barwon South Western Region Strengthening Health Services Initiative (p.7) ‣ Commencement of the pilot Telehealth Stroke Rehabilitation project with Barwon Health (p.23, 24)	‣ Further development of regional and sub regional service systems
			‣ Implementation of 5 year Strategic and Service plans (p.2, 55)	‣ Continued implementation of 5 year plans
QUALITY IMPROVEMENT AND RISK MANAGEMENT	To improve performance through a culture of continuous quality improvement and innovation	Achieve all accreditation requirements through ACHS, Aged Care Accreditation Standards, teaching and training posts	‣ ACHS National Standards and Community Care Standards re-accreditation for 3 years (p.21) ‣ Baby Friendly re-accreditation for 3 years (p.5, 21) ‣ Successful Aged Care accreditation reviews (p.11, 21, 56) ‣ Successful National Standards Peer Review for Palliative Care	‣ Successful completion of accreditation requirements
		Increase participation and leadership in research and best practice	‣ Completion and continuation of National Centre for Farmer Health research projects (p.28) ‣ Completion of Tri-Focal Model of Care Best Practice Aged Care project (p.37) ‣ Completion of Emergency Care Improvement and Innovation project for deteriorating patients (p.23)	‣ Continued participation and leadership in research and best practice
		Participate in Statewide and National Consumer Satisfaction Surveys	‣ High peer group ranking for Victorian Patient Satisfaction Monitor (p.56,84)	‣ Ongoing participation in patient, resident and client surveys
	To effectively manage risk and provide a safe environment for the wellbeing and protection of consumers, staff and Health Service assets	Implement safe practice and risk management programs to ensure the wellbeing and safety of consumers, staff and assets	‣ Excellent results for cleaning and food safety audits (p.22,43) ‣ Implementation of VMIA Site Risk Survey (p.21,34)	‣ Ongoing implementation of safe environment and risk management strategies

	OBJECTIVE	STRATEGIES	OUTCOMES	FUTURE
SERVICE PLANNING AND DEVELOPMENT	Continue to develop a contemporary health care system which focuses on person centred care and improves the health and wellbeing of our community	To enhance our role as a Sub Regional Referral Centre and provide an integrated range of Specialist services to our community	‣ Continued development of sub acute services as a level 3 service provider with the commencement of a Residential In Reach Program and completion of Redesigning Care project (p. 5,19,23,24) ‣ Establishment of visiting neurosurgery and kidney disease specialist services and enhancement of orthopaedic services (p.23,24)	‣ Continue to enhance community access to specialist services
		Provide programs supporting healthy ageing and extend the capacity of services for our ageing population	‣ Integration of District Nursing and Community Palliative Care into the Primary and Preventative Health Division (p.25,26) ‣ Implementation of the Aged Care reform readiness program (p.23,24) ‣ Commencement of Buddy for You program (p.51)	‣ Continue to implement programs to support the health needs of our ageing population
		Develop innovative service models in partnership with consumers to improve person centred care and prevention and management of chronic disease	‣ Implementation of Closing the Gap initiative and signing of MOU with Southern Grampians Shire and Windamara ‣ Establishment of Sub Regional Dental Health Service Model (p. 5,10,25)	‣ Continued implementation of innovative person centred care models for health and wellbeing
HUMAN RESOURCES	Attract and retain high performing staff committed to the Vision, Mission and Values of the Health Service	Develop and implement workforce plans and recruitment strategies to support our Service Plan	‣ Recruitment of Senior Executive staff (p.37,53) ‣ Recruitment of Clinical Managers (p.37,53) ‣ Undergraduate clinical placements for nursing, medical and allied health (p.23,37)	‣ Ongoing development and implementation of workforce plans and strategies
	Provide an environment for motivating and encouraging staff to develop and use their skills to enhance the health, well being and safety of our community	Promote Employer of Choice through work environment, values and culture	‣ Organisational and staff awards including Employee of the Month (p.37,39) ‣ Implementation of Excellence in Healthcare for everyone, every time culture (p.3,10,21) ‣ Implementation of OH & S programs (p.42) ‣ Staff work health and vaccination programs (p.38)	‣ Continued implementation of recognition and healthy workforce initiatives
		Support and encourage education and training of staff directed at optimising skills and enhancing quality of care	‣ Continued development and implementation of education and learning strategy (p.37) ‣ Continuation of Best Practice forums (p.37) ‣ Maternity Services Coordinator undertaking Department of Health Leadership program	‣ Ongoing implementation of education and training plans
		Implementation of the 5 year 2012-2017 Human Resource Strategic Plan	‣ Implementation and evaluation of Year Two Action Plan (p.37)	‣ Continue evaluation and implementation of 5 year Human Resources strategic plan
FACILITIES AND EQUIPMENT	To modernise and maintain facilities, equipment and infrastructure to improve the health and wellbeing of our community	Implement capital master plans to complete the modernisation of facilities across WDHS	‣ Commissioning and opening of the Coleraine Campus one stop shop precinct (p.5,10,11,13) ‣ Commissioning and opening of the Penshurst Campus Kolor Lodge redevelopment (p.5,23,43,46,57) ‣ Stage 2 of trade workshop conversion to Education complex completed (p.43)	‣ Implementation of the 10 year capital blue print for Hamilton and Penshurst campuses
		Continue to modernise and upgrade infrastructure	‣ Commencement of $1.2m fire protection upgrade to Hamilton Base Hospital with Stage 1 completed and Stage 2 to commence October 2014 (p.43) ‣ Completion of 5 year car parking upgrade strategy (p.43) ‣ External upgrade of Hamilton Medical Group building (p.43) ‣ Hamilton Base Hospital Chiller upgrade (p.43) ‣ Replacement of Birches Nurse Call system (p.43) ‣ Demolition of old Coleraine Hospital (p.43)	‣ Completion of fire service upgrade at Hamilton Base Hospital
		Modernisation of major clinical equipment	‣ Purchase of new Theatre equipment for neurosurgery, orthopaedics, urology and general surgery (p.10,12)	‣ Continued modernisation of major clinical equipment

→ Jenny, Morgan, Sandy and Jackie O'Brien gather for the opening of the $520,000 Kolor Lodge Redevelopment (photo Tracy Kruger).

	OBJECTIVE	STRATEGIES	OUTCOMES	FUTURE
COMMUNITY ENGAGEMENT	To enhance community participation and involvement in the development and growth of our Health Service	Foster and encourage consumer participation	‣ Consumer network forums and development of 3 year Consumer Participation Plan (p.21,22) ‣ Hosting of 'Hear Me' consumer play (p.10) ‣ Delta Dog pet visiting program commenced (p.25,26,51) ‣ Volunteer of the Month awards (p.11,49,51)	‣ Foster and encourage participation of consumers and volunteers
		Continue fundraising and donor initiatives and ensure recognition of community support	‣ Construction of Watermark Charity House completed (p.5,10,11,12,32,48,49,51) ‣ Outstanding fundraising result (p.5,6,11,13,34,48) ‣ Hospital Doorknock and Christmas appeals (p.48,49) ‣ Successful Fun Run, Golf Day and Drive In Movie events (p.48,49)	‣ Ongoing implementation of major fundraising and donor initiatives
		Provide regional forums for the community, focusing on education, health and wellbeing	‣ 15th Handbury Lecture (p. 5,10,11) ‣ Hosting of Barwon South West/Grampians Region Allied Health Conference (p.5,10,26)	‣ Provision of regional and educational forums
		Communicate and engage with our community via media, internet, newsletters, brochures, annual reports and promotion of milestones	‣ Gold Award for Annual Report (p.4,5) ‣ Annual and Quality Care Reports, Western Wellbeing publications, International, National and State presentations (p.5,10,21,22,28)	‣ Inform and involve the community via media, internet, newsletters, publications and promotion of milestones
BUSINESS SUSTAINABILITY AND INNOVATION	To develop and implement innovative practices to strengthen our governance, business and financial capacity to deliver efficient and effective high quality healthcare to our community	Support innovation to improve quality and efficiency of clinical, ICT, work practices and business systems	‣ Commence the implementation of a new Community Client Management system (p.21) ‣ Development and implementation of redesign of clinical and business systems (p. 5,10,21,23,43,44)	‣ Continued development of innovative practices and systems
		Continue to maintain financial and health service viability and accountability	‣ Operating and entity budget surplus achieved (p.5,12,16,56,62) ‣ Implementation of Sub Regional Supply project (p.6,13,16,56,62)	‣ Update 3 year budget strategy and implement efficiencies

President and Chief Executive Officer Report

→ **WDHS Board President Mary-Ann Brown and Chief Executive Officer Jim Fletcher, committed to 'Improving consumer experience, everyone, every time'.**

On behalf of the Board of Directors, Management, staff and our community we are pleased to present the 16th Annual Report for Western District Health Service (WDHS).

The year was full of excitement and achievement with the commissioning and opening of major capital developments, the completion of the construction of the Watermark Charity House, accreditation for 3 years under the new National Standards and the announcement of funding for our National Centre for Farmer Health.

It was also a year full of challenges with increasing demand on our financial and human resources.

Our theme for this year's annual report – 'Improving consumer experience for everyone every time' is reflective of our commitment to the implementation of our person centred care service model to enhance the quality of care, health, wellbeing and safety of our patients, clients, residents and carers.

Consistent with our theme we have developed a consumer participation plan in partnership with consumers for implementation over the next three years, continued the quarterly Consumer and Friends Network forums and hosted the ''Hear Me'' consumer play to a full house.

The year was full of achievements and major highlights which we can all be justifiably proud of including:

- Commissioning and opening of the Coleraine Campus one stop shop health precinct, bringing this vision to a reality
- Commissioning and opening of the Penshurst Campus Kolor Lodge redevelopment thanks to the generosity of two long term Penshurst residents Mr Sandy O'Brien and the late Mrs Sheila Harrington
- Completion of the Watermark Charity House thanks to the outstanding support and extraordinary contributions of hundreds of tradespersons, volunteers, business houses, dedicated committee members and onsite project managers; Peter Smith, Max Murray and Rod Papworth to achieve this outstanding community project
- National, State and local awards with an Australasian Reporting Gold Medal Award for our 2013 Annual Report, VHA Award for our telehealth initiatives and Shire of Southern Grampians Business Award for Community Enterprise and Team Achievement
- Establishment of new services for orthopaedics, neurosurgery, kidney disease and a Residential In Reach program
- Adoption of the National Centre for Farmer Health Sustainable Farm Families program by the Canadian Government's Alberta Farm Safety Centre to improve the health, wellbeing and safety of Canadian farm families
- Completion of the fifth year of the National Centre for Farmer Health Agriculture and Medicine course held in Hamilton bringing the total number of students who have attended and completed the course from all states and territories to 102
- Establishment of a Sub Regional Dental Health Service model under the management of South West Healthcare to improve access, continuity and sustainability of dental services for our community
- Completion of the roll out of our Care Coordination Services model to other health agencies in the Barwon South West Region
- Hosting of Barwon South West and Grampians Regions Allied Health Best Practice conference attended by in excess of 100 health professionals
- Professor Sue Walker's inspirational presentation at the 15th Handbury Lecture on the amazing lifesaving developments in perinatal medicine

Quality, Performance, Innovation and Research

We take great pride as a team in our reputation as an innovative and learning organisation that continues to aspire to excellence in healthcare for everyone every time.

The major highlights for continuous improvement towards this aspiration included:

- The outstanding team effort to achieve accreditation under the new National Standards with all 209 core elements fully met with 12 met with merit
- Re-accreditation of our community programs under the Community Care Standards and Maternity Services under the Baby Friendly initiative
- Successful aged care accreditation reviews for all aged care facilities and National Standard peer review for Palliative Care
- High rating for patient satisfaction
- Excellent food safety and cleaning audit outcomes
- Completion of Tri-focal aged care and emergency care improvement and innovation for deteriorating patients best practice projects
- Major research achievements associated with the National Centre for Farmer Health NHRMC – Shh Hearing and organophosphate projects. The results of these projects will facilitate and improve the health, wellbeing and safety of our farming families

Our People

Our staff and volunteers continue to do us proud with their leadership, innovation and dedication to caring for our consumers and recognition through various awards, namely:

- Shire of Southern Grampians Australia Day awards for Young Citizen of the Year for apprentice electrician Matthew Gebert and Community Recognition Award for Cheryle Casey
- Pride of Workmanship awards for Leonie Sharrock, Brigid Kelly, Jen Membrey, Tatum Pretorius and Peter Smith
- Shire Senior Citizen award to Wes Walter for his volunteer work
- Thirteen of our unsung heroes received Employee of the Month awards sponsored by Darriwill Farm and fourteen extraordinary volunteers received the Charlie Watt Volunteer of the Month Award, sponsored by Alexandra House
- The prestigious Clinical and Non Clinical Excellence and Innovation awards to the telehealth services and Trak Pas team with leading gardener, Craig Richardson, awarded the Staff Above and Beyond Award

→ **Accepting the 2013 Powercor Ace Radio Business Achievement Award in Hamilton for the WDHS Primary and Preventative Health Division Manager, Care Co-ordination Usha Naidoo, Primary Care Services Manager Belinda Payne, WDHS CEO Jim Fletcher, Gerard Lucas (Sponsor Hamilton Spectator), WDHS President of the Board Mary-Ann Brown and Speech Pathologist Sue Cameron.**

Our Community

Support from our community knows no bounds and we were privileged and honoured once again to receive outstanding support through volunteering and fundraising activities. WDHS is extremely proud of our army of volunteers who generously give their time to help their fellow citizens.

This year saw the completion of our exciting and innovative Watermark Charity House built by the community for the community. This outstanding family home with stunning views overlooking Lake Hamilton is one of the great achievements in our fundraising history.

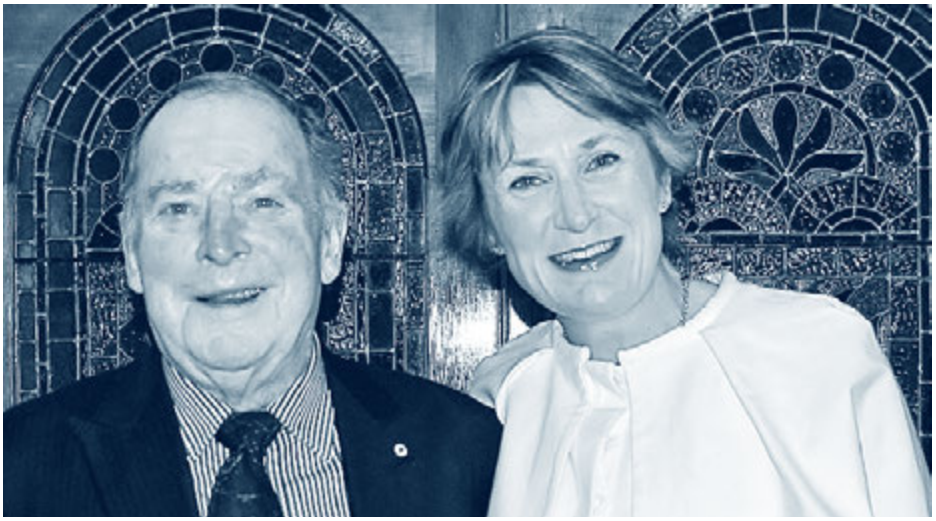
It has created a long lasting legacy in the form of an outstanding housing asset for our community and funds to purchase state of the art equipment for operating theatres, emergency and intensive care needs for our community.

We are extremely grateful to all trades, businesses, volunteers and the Watermark Charity House committee for their support and assistance with this amazing achievement.

Other major and highly successful fundraising activities and events included the Hamilton Vitality Fun Run, WDHS Op Shop Golf Tournament, Annual Door Knock and Christmas Appeals.

We received significant support from the Collier Charitable Fund, Arthur Thomas Trust and Marion Flack Foundation. A very generous bequest of $513,998 was received from the Estate of Alec Scott McBride for Hamilton Base Hospital.

Thanks to these contributions, the success of our fundraising activities and those of our regular supporters including the Hamilton Aged Care Trust; Hamilton, North Hamilton, Coleraine and Penshurst Auxiliaries; Hospital Opportunity Shop, Murray to Moyne, regular benefactor Dr Geoff Handbury and many other businesses and hundreds of individuals our fundraising result for the year was an outstanding $1.145m.



→ **Dr Geoff Handbury AO and Professor Sue Walker at the 15th Annual Handbury Lecture, where Sue gave an inspirational presentation on 'The Fetus as a Patient'.**

Facilities and Equipment

The completion and commissioning of the Coleraine Campus health precinct and Penhurst Campus Kolor Lodge redevelopment saw the conclusion of our $37 million capital development program over the past 3 years.

It is important that we look ahead to our next project on the drawing board, namely the first stage development for the Hamilton Base Hospital and Penshurst campuses. Following an onsite visit by the Department of Health in April 2014, general in-principle agreement was reached on the scope of the first stage of the Hamilton Base Hospital campus redevelopment being in the vicinity of $44m. We look forward to progressing this exciting development through the various planning phases over the next few years and obtaining State Government funding support.

A number of major infrastructure projects were completed during the year with the finalisation of the 5 year car park upgrade strategy and completion of Stage 1 of the $1.2m fire service upgrade at Hamilton Base Hospital, with Stage 2 to be completed by March 2015.

The State Government provided $930k towards these works with the balance funded by Health Service reserves.

The purchase of new equipment for neurosurgery, orthopaedics, urology and general surgery has enhanced existing services and enabled the introduction of some new procedures to reduce the travel burden and costs for our community.

Leadership and Management

WDHS reputation as a leading and innovative Regional and Rural healthcare provider continued to grow with our achievements and service models for farm families health, care coordination, consumer participation and telehealth showcased at international, national and State forums.

We are extremely proud that our National Centre for Farmer Health Sustainable Farm Families program has been adopted by the Canadian Government's Alberta Farm Safety Centre, who describe the program as the "magic" to enhance the health, wellbeing and safety of farm families and their workers; thereby improving productivity. This development together with the last minute funding of $625,000 with $375,000 from the Commonwealth and $250,000 from the State Government underlines the importance of the National Centre for Farmer Health as it continues to provide leadership and deliver programs to improve the health, wellbeing and safety of our farming communities, thereby improving productivity and the business sustainability of the farm.

It also provides WDHS and Victoria with a greater opportunity to build upon its reputation as a national and international leader for farmer health.

→ **Project and Site Managers, Max Murray, Peter Smith and Rod Papworth outside the Watermark Charity House as the project nears completion (photo Hamilton Spectator).**

Our financial performance was again positive with a small operating surplus of $89k and an entity surplus of $1.146m.

Acknowledgments

The support we receive from many individuals, businesses, service clubs, support groups, auxiliaries, Hamilton Aged Care Trust and volunteers is outstanding. Their support is greatly valued and appreciated as it is critical to our ongoing success and development as a Health Service.

We also recognise the outstanding contribution of our Board members, staff, visiting medical officers, development council, local parliamentarians, the Victorian Government, regional and central Department of Health staff, local and Commonwealth Governments and local radio and print media outlets.

Future Outlook

We have finished the year in a strong position and we look ahead with excitement to pursuing our blueprint for the future development of the Hamilton Base Hospital and Penshurst campuses.

We will face many challenges over the next 12 months due to financial and environmental pressures and uncertainty.

WDHS has a strong robust foundation and a commitment to development of our person centred care model for everyone, every time.

We are confident that with the continued outstanding support we are privileged to receive from our community we will meet the challenges ahead and continue to grow our Health Service.

Mary-Ann Brown
President

Jim Fletcher
Chief Executive Officer

Responsible Bodies Declaration

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for the Western District Health Service for the year ending 30 June 2014.

Mary-Ann Brown
President

6 August 2014

Financial Overview

Western District Health Service (WDHS) aims to increase service provision in a financially sustainable way and utilises several key result areas to monitor performance. These key result areas include:

- Operating performance – achieving activity targets and a surplus from operations
- Liquidity – maintenance of sufficient assets to meet commitments as they fall due; a ratio in excess of 0.8
- Asset management – ensuring that sufficient levels of investment are undertaken to maintain the asset base

Financial Overview

The Financial Statements have been prepared in accordance with Standing Direction 4.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards and Australian Accounting Interpretations and other mandatory professional reporting requirements for the year ended 30 June 2014.

WDHS achieved a comprehensive entity surplus of $66.2m for the 2013/14 financial year and expanded the asset base with an investment in fixed assets of $5.2m. The significant comprehensive entity surplus is largely attributable to the impact of a revaluation of land and buildings which contributed $64.9m to the result. Excluding capital grants, the Health Service would have delivered an entity surplus of $1.3m.

Overall liquidity levels declined by $2m during the year as expected, reflecting the drawdown of cash accumulated in prior years to fund the final year of the 3 year $37m capital works program. Liquidity levels remain substantially above target levels.

With the exception of sub-acute inpatient and residential aged care occupancy, all activity targets were achieved. Sub-acute inpatient activity was 17.7% below target with 6.3% of this shortfall directly attributable to bed closures in connection with the fire sprinkler works undertaken during the year. A continued decline in demand for residential aged care services contributed to a decline in occupancy levels to 84.3%; substantially below the target occupancy of 97.7%.

Operating Performance

With the exception of residential aged care, funding provided in funding formulae excludes any contribution towards the cost of depreciation. Funds are traditionally allocated by government capital grants to fund significant asset replacement, and the Health Service continues to rely on community fundraising to provide for equipment replacement.

In reviewing operating performance, capital purpose income comprising capital grants ($3.474m), residential aged care capital contributions ($443,000) and specific purpose donations and bequests ($1.105m) are excluded. These funds are provided for specific capital purposes and are not available to support operations. Depreciation, specific expenditure from capital purpose revenue ($149,000) and the gain on disposal of non-current assets ($84,000) are also excluded, being predominantly funded from capital income sources.

The accepted indicator of performance is the result from continuing operations prior to depreciation and capital purpose income. In the current year the result was a surplus of $89,000 ($116,000 in 2013) which represents 0.14% of operating revenue.

In the 2013/14 financial year depreciation charges of $3.9m were recorded, reflecting the cost associated with the use of buildings and equipment in delivering services. In order to maintain the Health Service asset base, operating surpluses and capital purpose income must exceed depreciation charges and periodic non-current asset valuation changes. In the current year capital income was $1.206m more than the depreciation charges, principally due to capital grants associated with the Coleraine Campus redevelopment. Financial asset fair value gains of $150,000 were recognized in calculating the comprehensive result for the year. During the year all Victorian Public Health Services were involved in a revaluation of land and buildings, undertaken by the Valuer General. This valuation added $64.9m (78.7%) to the net assets of WDHS.

Including all items, the Health Service's net assets increased by $66.231m for the year, which represents an increase of 80.2%. In 2012/13 the increase was $11.835m or 16.7%. Excluding the land and buildings valuation increment, the increase in net assets for the year was a modest $1.302m or 1.6%.

Liquidity Position

During 2013/14 the Health Service generated negative cash flows from operations of $2.759m and received $6.012m in capital purpose income. Of these funds $5.223m was used to purchase property, plant and equipment during the year. The entity generated a negative cash flow of $1.97m for the year after capital items and elimination of cash flows of $273,000 from the purchase of investments.

At the end of the year the ratio of current assets to current liabilities (excluding patient trust funds) was 1.53:1 compared to 1.54:1 in the previous year. This remains considerably in excess of the 0.8 target ratio.

Asset Management

A total of $6.3m was invested during the year comprising building works ($4.8m) and plant, equipment and infrastructure upgrades ($1.5m) in accordance with the capital works budget adopted in August by the Board of Directors. The investment in equipment was equal to the depreciation on equipment items and the investment in buildings was $2.4m greater than the buildings depreciation expense for the year.

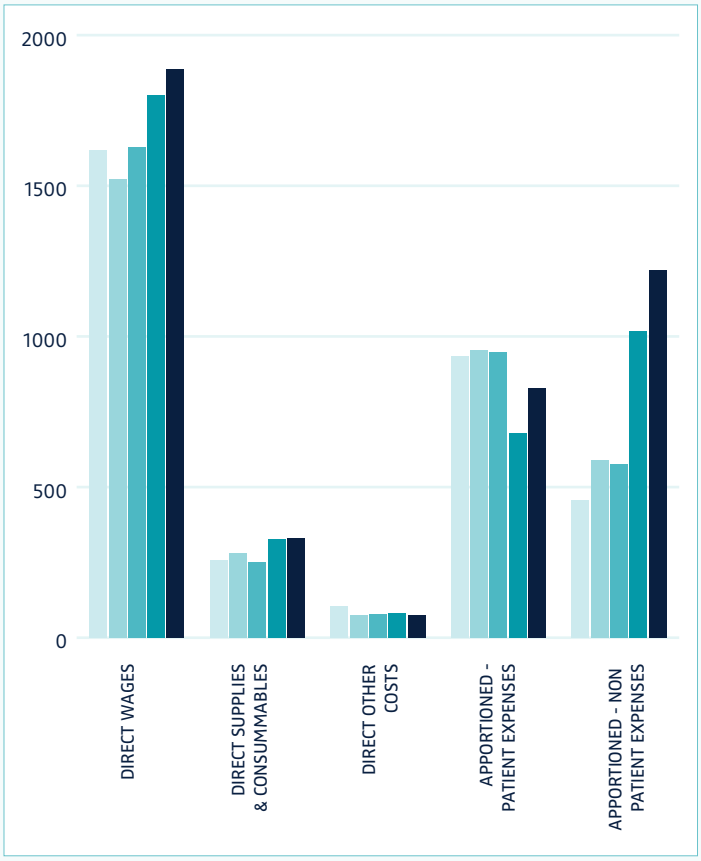
The $4.8m expended on building works represented the finalisation of the multi-year $37m upgrade program commenced in 2010/11. Major components in the current year included the completion of the Coleraine Health Precinct ($3.4m), Hamilton Medical Group Upgrade ($135,000), Kolor Lodge ($224,000) and the completion of the 5 year car park upgrade strategy at the Hamilton Base Hospital and Penshurst campuses ($147,000).

Significant items included in the $1.5m investment in plant, equipment and infrastructure included the Stage 1 of the Fire Ring Main and Sprinkler System upgrade at the Hamilton Base Hospital ($625,000), replacement of the Nurse Call System at the Birches ($105,000), Chiller refurbishment ($104,000) and replacement of the Grange Residential bus ($59,000). Major items of medical equipment replaced during the year included an operating microscope ($88,000) and the purchase of surgical equipment to establish a new neurosurgical service ($130,000).

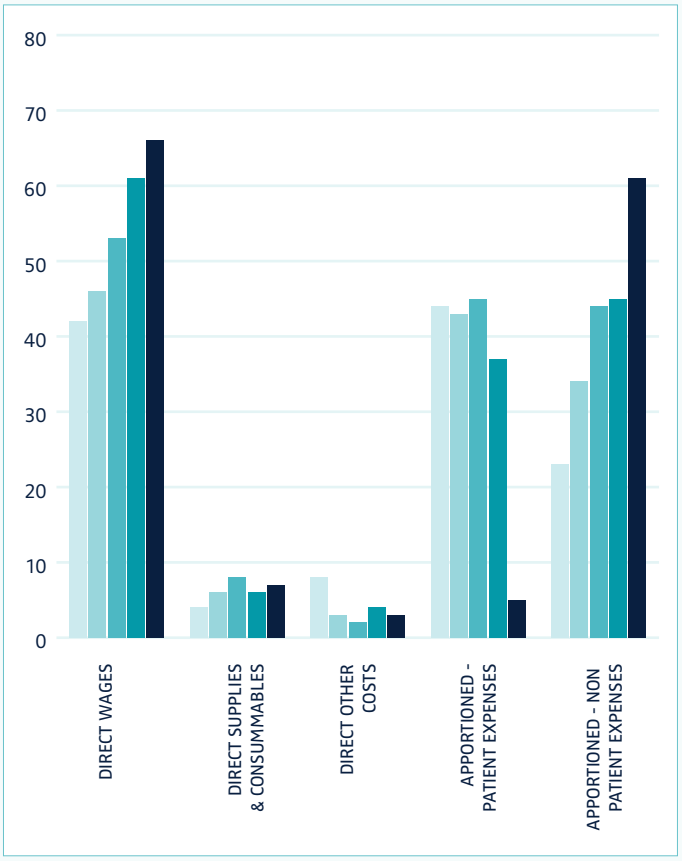
The Future

The continued support of the community, as indicated by the outstanding $1.145m received from donations and bequests in 2013/14, provides the opportunity for WDHS to continue to invest in buildings, medical equipment and technology which would not otherwise be possible. It is important to maintain the level of investment to provide a

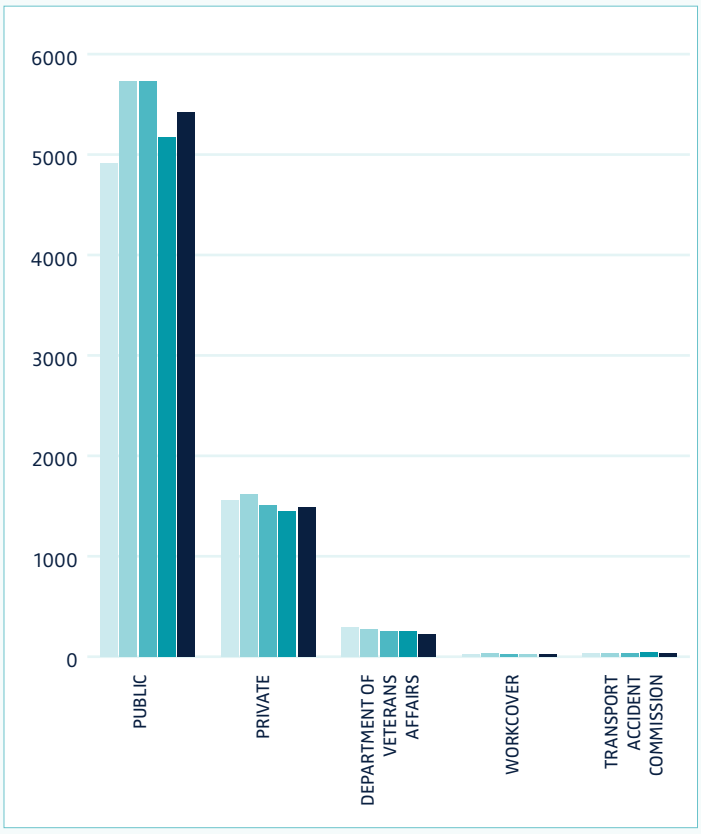
AVERAGE COST ACUTE INPATIENT



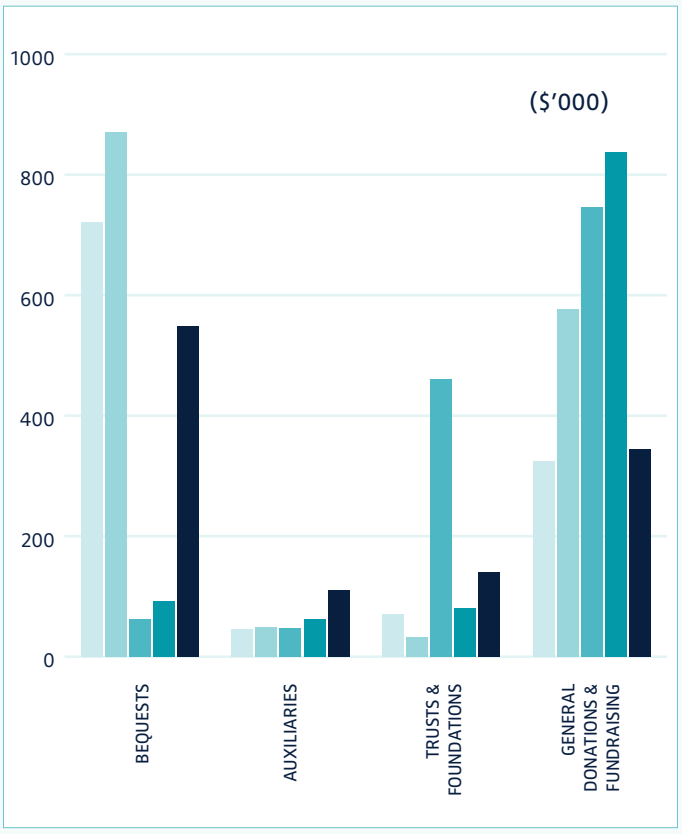
AVERAGE COST NON-ADMITTED OCCASION OF SERVICE



INPATIENTS TREATED BY PATIENT CLASSIFICATION

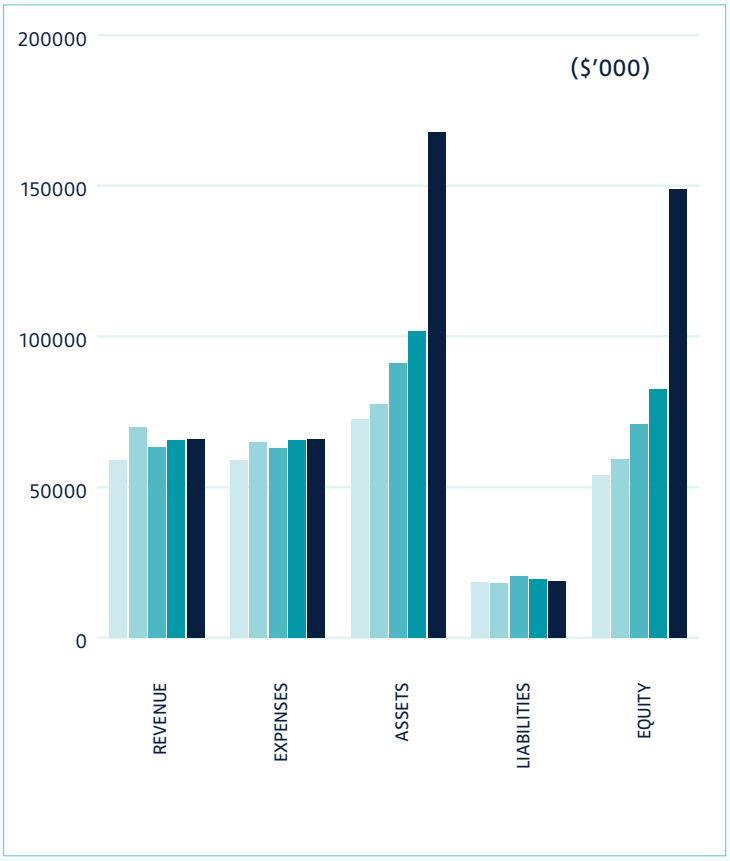


DONATIONS AND BEQUESTS

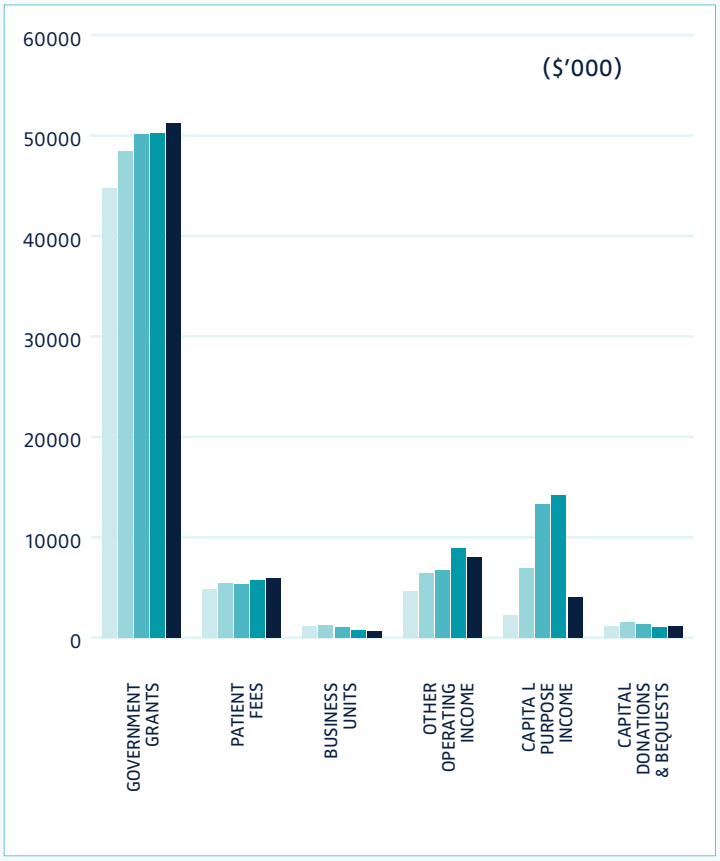


2010 2011 2012 2013 2014

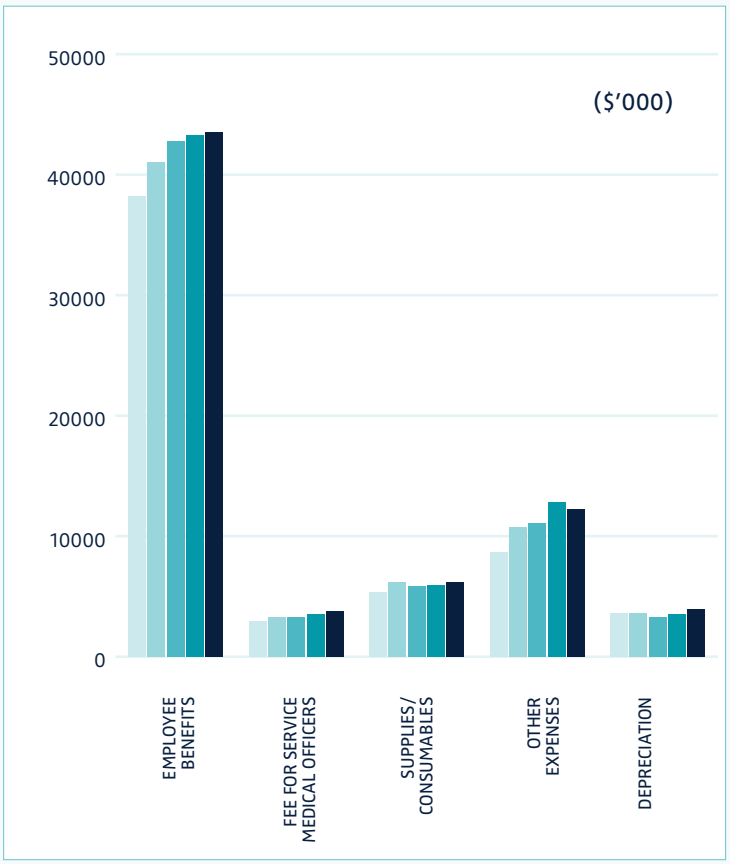
ANALYSIS OF FINANCIAL POSITION 30 JUNE



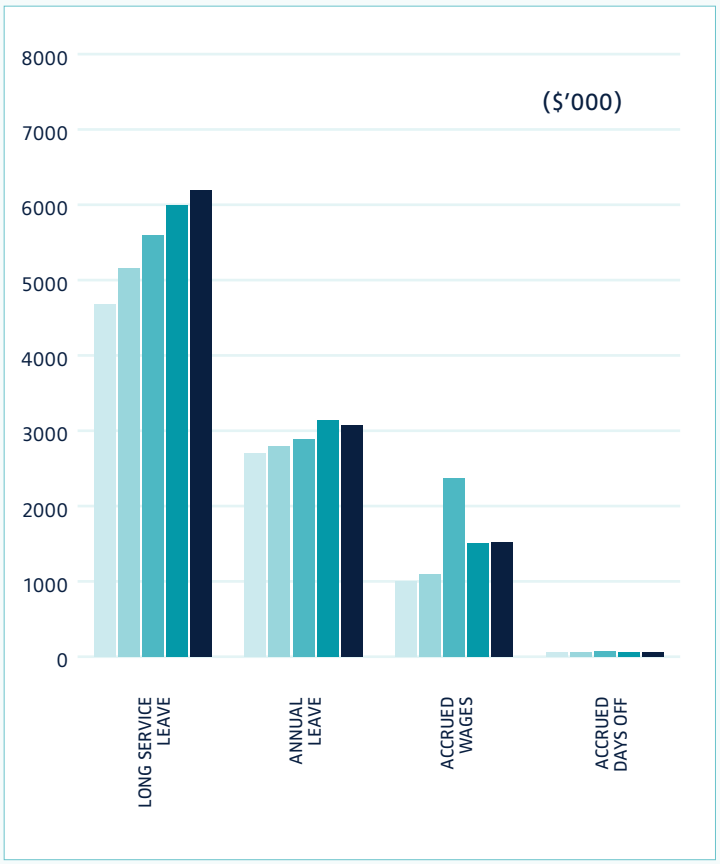
INCOME BY CATEGORY



EXPENDITURE BY CATEGORY



EMPLOYEE BENEFITS AS AT 30 JUNE



strong base for the Health Service to improve service delivery and efficiency and comply with increasingly rigorous service standards.

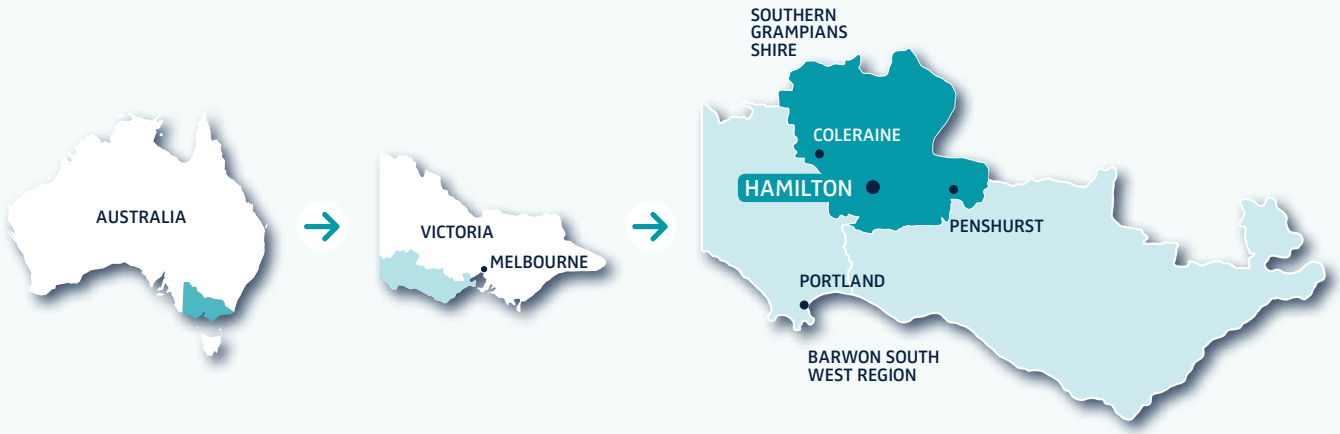
This extensive and unprecedented reform agenda in a challenging economic environment with increased productivity demands, the continued implementation of new clinical information systems and medical technology and constantly increasing demand for high quality services will challenge the Health Service as it strives to continually improve service provision in a financially sustainable way.

Financial analysis of operating revenue and expenses

REVENUE	2014 ($000S)	2013 ($000S)	2012 ($000S)	2011 ($000S)	2010 ($000S)
SERVICES SUPPORTED BY HEALTH SERVICE AGREEMENT					
Government grants	51,137	49,596	50,030	46,923	43,645
Indirect contributions by Department of Human Services	67	662	142	1,494	1,137
Patient fees	5,947	5,700	5,358	5,414	4,828
Other revenue	730	732	950	957	683
	57,881	**56,690**	**56,480**	**54,788**	**50,293**
SERVICES SUPPORTED BY HOSPITAL/COMMUNITY INITIATIVES					
Business Units	655	734	1,048	1,235	1,193
Property income	858	803	708	672	642
Other revenue	6,494	7,371	5,082	4,808	3,301
	8,007	**8,908**	**6,838**	**6,715**	**5,136**
Total revenue	**65,888**	**65,598**	**63,318**	**61,503**	**55,429**
EXPENDITURE					
SERVICES SUPPORTED BY HEALTH SERVICE AGREEMENT					
Employee entitlements	42,756	42,651	41,620	39,618	36,752
Fee for service medical officers	3,785	3,501	3,298	3,311	2,981
Supplies and consumables	6,083	5,763	5,740	6,008	5,192
Other expenses	12,082	12,487	10,716	10,362	8,341
	64,706	**64,402**	**61,374**	**59,299**	**53,266**
SERVICES SUPPORTED BY HOSPITAL/COMMUNITY INITIATIVES					
Employee entitlements	799	604	1,166	1,400	1,487
Supplies and consumables	130	131	150	155	163
Other expenses	164	345	325	374	401
	1,093	**1,080**	**1,641**	**1,929**	**2,051**
Total Expenditure	**65,799**	**65,482**	**63,015**	**61,228**	**55,317**
SURPLUS FOR THE YEAR BEFORE CAPITAL PURPOSE INCOME					
Depreciation and specific items.	**89**	**116**	**303**	**275**	**112**
Capital Purpose Income	3,474	13,258	11,646	5,513	1,318
Donations and bequests	1,105	1,073	1,314	1,528	1,162
Residential Aged Care - Capital Purpose Income	443	848	1,575	1,387	1,124
Surplus/(Loss) on disposal of fixed assets	84	75	34	(416)	(59)
Impairment of Financial Assets			(14)	(12)	**(54)**
Assets Provided Free of Charge				459	
Expenditure using capital purpose income	(149)	(173)			
Depreciation	(3,900)	(3,512)	(3,302)	(3,618)	(3,575)
Depreciation	(3,512)	(3,302)	(3,618)	(3,575)	(2,354)
Entity surplus for the year	**1,146**	**11,685**	**11,556**	**5,116**	**28**

* See page 13 for Financial Overview

About Our Organisation



WDHS has played a central role in its community for more than 150 years, since the Hamilton Base Hospital and Benevolent Asylum was first established in 1862 to provide care for people suffering from illness and accidents and for victims of personal tragedy and social distress.

Today, WDHS remains a reflection of the community and major centre it continues to serve in a prosperous rural environment, looking forward to a positive future.

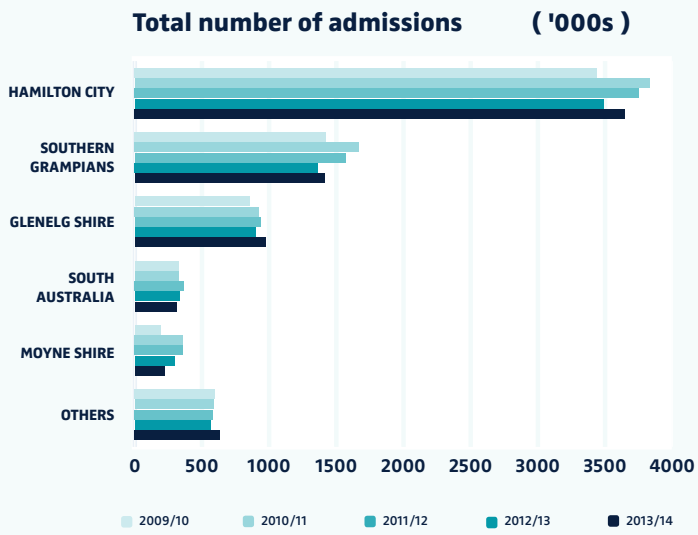
WDHS is based in Hamilton with campuses at Coleraine and Penshurst in the Southern Grampians Shire (SGS) and Merino in the Glenelg Shire (GS). WDHS incorporates the Frances Hewett Community Centre (FHCC), Grange Residential Care Service, Hamilton Base Hospital (HBH), Coleraine District Health Service (CDHS), Penshurst and District Health Service (PDHS), Merino Community Health Centre, the National Centre for Farmer Health (NCFH) and Youth Services.

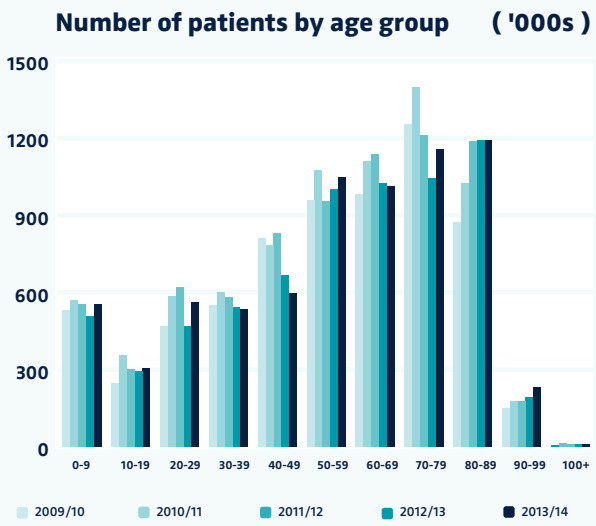
The Health Service provides 91 acute and subacute beds, 175 high and low level extended care and residential aged care beds, 35 independent living units, primary care, community and allied health services, and youth services.

WDHS is a member of the Southern Grampians Glenelg Sub Region of the Department of Health's Barwon South West Region. Other member health services are Casterton Memorial Hospital, Heywood Rural Health, Portland District Health, Balmoral and Dartmoor Bush Nursing Centres.

Southern Grampians Shire is centrally located in Victoria's Western District. The Shire has a resident population of 16,200 people, with approximately 9,800 living in Hamilton. The remainder are serviced by smaller townships and local farming communities.

Patient Demographics





→ **Theatre and Executive staff celebrating International Nurses Day (L-R) Julie Schultz, Sarah Roberts, Coryn Meyers, Michelle Walkley, Jim Fletcher, Kavel Lyons, Janet Kelsh, Judy Esson, Kylie Pearce and Peta Dietrichs.**

Our Past, Present & Future

WDHS was established in 1998, with the amalgamation of Hamilton Base Hospital, Southern Grampians Community Health Services and Penshurst and District War Memorial Hospital, now Penshurst and District Health Service (PDHS). In 2005 CDHS amalgamated with WDHS.

The HBH site is also the location for the Birches Extended Care facility, which provides 45 beds for mainly high-care use and also caters for people with special needs.

The Penshurst Hospital was built in 1957 and provides acute care, residential aged accommodation, community services and manages independent living units at Penshurst and Dunkeld.

The Coleraine District Health Service commenced in 1935. On 6 December 2013 the new $27 million Coleraine Campus development was officially opened. The service is now a magnificent one stop shop health precinct which provides acute care, residential aged accommodation and primary care services from the Thomas Hodgetts Centre including medical, dental and maternal and child health. There are also 25 independent living units in Coleraine and a Community Health Centre at Merino.

Frances Hewett Community Centre joined WDHS in 1998, and provides a broad range of primary care and community based services.

The Grange was built as a private hospital in 1927 and became an aged care hostel in 1956. Redevelopments occurred in 2002 and 2012, and it now provides 50 beds of modern aged residential care accommodation and 28 Community Aged Care packages (CACPs).

Youth Services were established in 1997 by Southern Grampians Community Health Services Inc, which amalgamated with HBH in 1998. The Youth program was managed as a drop in centre model until 2011, when it was redeveloped as an outreach service and renamed youth4youth, now known as Youth Services. The Youth Services program provides a wide range of health and recreational services for young people in various locations throughout our community.

WDHS took over management of Dental Services in July 2000 and a new public dental clinic building on the Frances Hewett Community Centre site was completed in June 2009. WDHS transferred the Dental Service to South West Healthcare in January 2014 as part of a new sub-regional Dental Service for South West Victoria.

National Centre for Farmer Health

The National Centre for Farmer Health (NCHF) is a partnership between WDHS and Deakin University, which commenced operations in October 2008 with funding from the Victorian Government and the Handbury Trust.

Launched by the Premier of Victoria, it was established to provide national leadership to improve the health, wellbeing and safety of farmers, farm workers and their families across Australia through research, service delivery and education.

Since then it has developed the only Graduate Certificate of Agricultural Health and Medicine in Australia and holds its core unit Agricultural Health and Medicine at WDHS annually. Supporting the research and service delivery is www.farmerhealth.org.au which has been accredited by Health On Net Code for providing quality and reliable health information. Research has been undertaken into hearing loss, mental health and depression, organophosphate exposures, the role of exercise in improving mental health, and delivery of the award winning Sustainable Farm Families program to over 2300 farm men and women across Australia. The work of the NCFH has been presented and published both nationally and internationally. Further development of the NCFH is envisaged as demand for this service delivery, expertise and education grows.

→ **Dialysis Nurse at Hamilton Base Hospital, Leonie Eales with patient Mrs Betty Moyle.**

Our Services

Acute/Sub-acute Services

- Anaesthetics
- Chemotherapy
- Coronary Care
- Day Procedure
- Ear, Nose and Throat
- Emergency
- Endoscopy
- General Medicine
- General Surgery
- Geriatric Evaluation Management (GEM)
- Gynaecology
- Haemodialysis
- High Dependency Care
- Hospital in the Home
- Infection Control
- Intensive Care
- Maxillofacial Surgery
- Nephrology
- Neurosurgery
- Obstetrics
- Oncology
- Operating Suite
- Ophthalmology
- Oral Surgery
- Orthopaedics
- Paediatrics
- Pre-admission Service
- Pharmacy
- Psychiatry
- Rehabilitation
- Specialist Medicine
- Specialist Nursing
- Transition Care
- Urology
- Wound Care
- Private Services - Pathology, Radiology and Sleep Clinic

Extended Care

(The Grange, The Birches, Kolor Lodge, Penshurst Nursing Home, Valley View Nursing Home, Wannon and Mackie Hostels)

- Community Aged Care Packages
- Dementia Specific Residential Aged Care
- Lifestyle and Leisure
- Men's Out & About activities
- Palliative Care
- Psycho Geriatric Care
- Residential Aged Care
- Residential Extended Care
- Respite

Primary & Preventative Health

- Active Script
- Audiology
- Breast Cancer Support Group
- Cancer Link Nurse
- Cancer Support Group
- Cancer Support Services
- Cardiac Rehabilitation
- Cardiac Support Group
- Carer's Support Group
- Chronic Disease Management

→ **The WDHS 'Person Centred Care Service Model' is representative of a planning framework, which aims to deliver person centred health care that is integrated and coordinated around the needs of people rather than service types, professional boundaries, organisational structure, funding and reporting requirements. Implementation of this model in partnership with our consumers will enhance health outcomes for our community.**

- Coordinated Care
- Community Falls and Balance
- Community Rehabilitation Centre (CRC)
- Continence Service
- Counselling
- Dermatology
- Dental Services
- Diabetes Education
- District Nursing Service
- Domiciliary Midwifery
- Family Planning
- Hamilton Community Transport
- HARP (Hospital Admission Risk Program)
- Home Referral
- Hospital in the Home
- Maternity Enhancement
- Meals on Wheels
- Men's Health
- Nutrition and Dietetics
- Occupational Therapy
- Palliative Care
- Physical Activity Programs
- Physiotherapy
- Planned Activity Group
- Podiatry
- Post Acute Care
- Pulmonary Rehabilitation
- Quit Fresh Start
- Rehabilitation in the Home
- Residential In Reach
- Respiratory Education
- Respiratory Support Group
- Sexual and Reproductive Health
- Social Work
- Speech Pathology
- Stomal Therapy
- Women's Health
- Work Health
- Youth Health

National Centre for Farmer Health

- Agri-Safe
- Applied Research and Development
- Information and Knowledge Hub
- Professional Training and Education
- Sustainable Farm Families

Administrative

- Auxiliaries
- Business Support and Innovation
- Community Liaison
- Facility Management
- Finance
- Health Information
- Hotel Services
- Human Resources
- Learning and Education
- Library
- Linen Services
- Occupational Health and Safety
- Quality Improvement
- Reception
- Security
- Volunteer Program

Service Performance at a Glance

	2014	2013	2012	2011	2010
INPATIENT STATISTICS (ACUTE PROGRAM)					
Inpatients Treated	**7,196**	6,941	7,562	7,695	6,829
Average Complexity (DRG Weight)	**0.67**	0.66	0.67	0.68	0.73
Complexity adjusted inpatients (WIES 20)*	**4,828**	4,540	4,959	5,049	4,976
Inpatient Bed Days	**19,971**	20,038	21,799	24,172	21,861
Average Length of Stay (days)	**2.77**	2.89	2.88	3.10	3.20
HITH bed days	**631**	776	492	758	678
Nursing Home Type Bed Days	**1,553**	1,808	1,823	2,544	2,385
Operations	**2,895**	2,882	2,764	3,014	3,029
Births	**210**	201	219	235	223
Available Bed Days	**28,613**	26,915	27,854	27,191	27,191
Occupancy Rate	**75.2%**	81.1%	84.8%	98.2%	89.2%
Average Cost per inpatient	**$3,958**	$3,906	$3,476	$3,420	$3,366
AGED CARE STATISTICS - (AGED PROGRAM)					
HIGH CARE					
Residents Accommodated	**185**	227	211	178	158
Resident Bed Days	**39,639**	50,247	51,696	49,268	40,547
LOW CARE					
Residents Accommodated	**62**	35	45	26	80
Resident Bed Days	**11,803**	5,968	7,137	10,070	18,071
RESPITE					
Residents Accommodated	**139**	129	138	151	133
Resident Bed Days	**2,077**	1,506	1,967	1,629	1,755
Occupancy Rate	**84.27%**	90.88%	97.72%	98.25%	97.30%
Community Aged Care Package (CAPs) clients	**44**	39	40	39	39
CAPS occassions of service	**9,654**	10,396	10,891	10,857	10,908
ACCIDENT/EMERGENCY OCCASIONS OF SERVICE	**7,155**	**6,841**	**7,221**	**6,693**	**5,949**
OUTPATIENT (NON-ADMITTED) OCCASIONS OF SERVICE					
Physiotherapy	**7,131**	9,284	11,087	8,552	7,567
Rehabilitation & Day Centre	**3,502**	3,637	3,872	4,566	4,605
Speech Pathology	**737**	759	681	873	851
Podiatry	**2,568**	2,365	2,321	2,884	2,810
Social Welfare	**664**	524	510	520	2,946
Occupational Therapy	**4,642**	4,636	4,857	4,417	4,053
Palliative Care	**1,942**	2,162	3,693	2,065	1,893
District Nursing Service	**23,962**	26,913	27,930	30,945	35,300
Total non-admitted occasions of service	**45,148**	50,280	54,951	54,822	60,025
Cost per non-admitted occasion of service	**$192**	$153	$152	$132	$122
Meals on Wheels	**26,933**	30,733	32,346	35,309	37,770
QUALITY ASSURANCE					
Full Accreditation Status	**YES**	YES	YES	YES	YES

* WIES - (Weighted Inlier Equivalent Separations) are based on the Australian Refined - Diagnostic Groups (AR-DRG) further refined in Victoria by the addition of a few additional DRGs by the Vic-DRG version 52.

* Our Target WIES for 2013/14 (excluding those funded under the Small Rural Health Services Program) was 4,772. The health service was 56.37 WIES above target (1.18%).

Improving Performance

→ **Accepting the WDHS Clinical Excellence & Innovation Award are WDHS clinicians involved in Telehealth (L-R) Stuart Willder, Jane Sharp, Janine Huf, Sue Cameron & Director of Primary & Preventative Health, Rosie Rowe with AGM guest speaker Glenn Manton.**

Strategy

To pursue best practice through a culture of continuous quality improvement and increased consumer participation in health care and evaluation.

Achievements

- Implementation of the National Standards
- Successful Australian Council on Healthcare Standards (ACHS) organisation wide accreditation survey conducted in October 2013, with all core Standards Met; twelve Met with Merit and 3 years accreditation achieved against the National Safety and Quality Health Service Standards
- Successful Home and Community Care (HACC) accreditation achieved against the Common Care Community Standards
- Successful Baby Friendly accreditation achieved
- Successful Aged Care accreditation support visits at all WDHS Aged Care facilities
- Implementation of the Risk Management Framework
- Consumer participation in the development of a 3 year plan
- Participation and completion of research and best practice projects
- Implementation of Infection Control and Environmental Strategies
- Quality of Care Report completed

The Future

- Establishment of the sustainability framework for the National Safety and Quality Health Service Standards
- Implementation of risk management framework strategies
- Participation in research and best practice projects
- Implementation of environmental and infection control strategies
- Victorian Healthcare Experience Survey to commence in May 2014
- Evaluation of the Community Advisory Committee

Implementation of the National Standards

The Australian Commission on Safety and Quality in Healthcare developed the National Safety and Quality Health Service Standards, which were implemented from 1 January 2013. Extensive education programs and promotional activities have been undertaken to heighten the awareness and embed the changes into our quality improvement culture. A sustainability framework has been established to maintain compliance and embed the National Safety and Quality Health Service Standards into our daily practice to continually monitor and improve performance.

Accreditation

The Australian Council on Healthcare Standards (ACHS) conducted an on-site full accreditation audit against the 10 National Safety and Quality Health Service Standards in October 2013. The Standards provide nationally consistent and uniform measures of safety and quality across a wide variety of health care services. There are 209 Core Actions which must be 'Satisfactorily Met'. In addition there are 47 Developmental Actions which required a demonstration that there were processes in place for completing these actions. WDHS 'Satisfactorily Met' all 209 Core Actions and 12 of these were 'Met with Merit'. 'Met with Merit' requires that in addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This means a culture of safety, evaluation and improvement is evident throughout the hospital in relation to the action or standard under review. We 'Satisfactorily Met' 38 of the 47 Developmental Actions, and received 12 low risk recommendations which included 9 'Not Met' Developmental Actions. We have an action plan in place and are working towards implementing these recommendations.

A Home and Community Care accreditation survey was also conducted in October 2013 and we successfully achieved reaccreditation for a further 3 years. A peer review of Palliative Care under the National Standards was completed successfully during the year.

In November 2013 our Baby Friendly Accreditation Survey achieved 3 years reaccreditation.

During the year Aged Care Accreditation Support visits at the Birches, Grange, Coleraine and Penshurst were completed with full compliance achieved.

Risk Management

The Board, Executive and all staff are aware that the identification, assessment, and prioritisation of risks are critical to the safety of patients, residents, clients, visitors and staff at WDHS. The team works towards monitoring, minimising and controlling the probability and impact of unplanned events.

The Risk Register has been upgraded and is monitored regularly by the Executive team who review the controls that are in place, to minimise our risks and maximise our opportunities. A risk management framework has been developed and reviewed to embed the principles of the risk management standard AS/NZS ISO 31000:2009. The four recommendations from the VMIA site risk survey have been progressed with 2 recommendations fully implemented and the remaining 2 in progress for completion by March 2015.

Consumer Participation, Feedback and Satisfaction

Feedback from the community is received via internal and external processes and includes the active involvement of the Community

→ **Members of the Hamilton Base Hospital Cleaning team who helped achieve the cleaning standards audit result of 98.7% (L-R) Leeanne Ryan, Gary Meyers, Jill Jackson and Troy Young.**

Advisory Committee and the Quality Improvement Coordinating Committee.

Feedback from our internal processes enables us to monitor the quality of care from our patient, resident and client experiences, and assists us to implement improvements to our practices, systems, facilities and equipment. The internal process is complemented by the six monthly external Victorian Satisfaction Monitor (VPSM) Report where we have continued to be rated highly by patients. As a result of feedback this year, several improvements were made to the Emergency Department, Medical, Surgical and Preadmission areas.

The VPSM has now been superseded by the Victorian Healthcare Experience Survey which commenced in May 2014.

Consumer and Friends Network

The Consumer and Friends Network was established in March 2013 to hear and learn from consumers and carers about their experience with the Health Service. This initiative has been a positive way to connect consumers, carers and staff in identifying how service access, quality and safety can be enhanced.

A Forum is held each quarter with an open invitation to the community to attend. Specific topics are discussed with an average attendance of 9 consumers and 10 staff. In the last 12 months, forums have been held on enhancing services in Aged Care, improving access for people with disability, improving Mental Health services and Advanced Care Planning.

Actions as a result of the Forums include:

- New initiatives within Aged Care including a new café at the Birches, revised leisure activities and mealtimes
- Increased access to information regarding services for people with disabilities on the WDHS website and on brochures
- Inclusion of a client's care plan developed with a disability agency on the WDHS Medical Record when available from the client
- Consumers with a disability telling their stories at staff orientation and ward meetings
- Progress on initiatives to address Mental Health service gaps in partnership with Medicare Local, Primary Care Partnership and South West Healthcare

A 3 year consumer participation plan has been adopted by the Health Service and the implementation will not only assist in improving the consumer experience for 'everyone, every time' but also further embed our Person Centred Care Service Model into our daily practice.

Community Advisory Committee

It is acknowledged that actively encouraging and involving consumers in health care improves safety and quality of services, improves health outcomes, encourages an active role for consumers in managing their own health and provides more equitable, effective and accessible health services.

The Community Advisory Committee promotes consumer involvement in healthcare planning, delivery and evaluation throughout WDHS. It also provides input into service needs, feedback on performance indicators relating to service quality and represents the community by making consumer perspectives known to staff, management and the Board of Directors. Members of the Committee have participated in hospital tours to develop a better understanding of the day-to-day operations of the organisation. A review of the needs of the consumer representation has been undertaken to further improve the involvement of our community.

Research and Best Practice Projects

The National Centre for Farmer Health has increased our participation in research projects across WDHS. These projects include research into farmer hearing loss, alcohol intervention programs and arthritis.

Currently our areas of research are looking at the socio-economic impacts of travel for surgery for rural citizens and the use of Skype and Telehealth for perioperative assessments.

Infection Control and Environment

Our infection control program promotes awareness of correct behaviour and practice, and monitors outcomes through auditing and analysis of any related incidents. The program endeavours to educate and provide correct principles of infection prevention to all healthcare workers, monitoring outcomes through auditing and analysing incidents. It is also responsible for providing a consultancy service to other health services in the Southern Grampians/Glenelg sub region.

Food safety, cleanliness of facilities, hand hygiene and correct use of antibiotics are core to an effective infection control program.

WDHS continues to rate well with catering facilities achieving full compliance with food safety certification, 98.7% for cleaning standards and achieving well above the State benchmark average for hand hygiene and compliance with antibiotics use.

Quality of Care Report

WDHS is required to produce an annual Quality of Care Report as a means of providing the extended community with information on systems, processes and outcomes in our endeavour to ensure delivery of the highest possible quality of care and services.

The report includes information on consumer feedback, external reviews and clinical practice as well as data on the outcomes of quality improvement activities.

The Quality of Care Report is reviewed by the Department of Health with feedback available to WDHS on opportunities for improvement.

Further information on improving performance is available in our Quality of Care Report, which is available in either printed or audio formats at all campuses and at www.wdhs.net

Clinical Services

→ **Pictured with the new surgical microscope purchased through the Alec McBride bequest are Theatre nurses Julie Schultz, Donna McCallum, Surgeon Dr. Caroline Tan and Foong Micropotics representatives John & Andrew Foong.**

Strategy

To enhance our Sub Regional role providing an integrated range of high quality services to meet the population health needs of our community.

Achievements

- Establishment of new services for orthopaedics, neurosurgery and kidney disease
- Completion of Emergency Care Improvement and Innovation project for deteriorating patients
- Completion of Stroke Telehealth project with Barwon Health
- Completion of the Redesigning Care project for sub-acute services
- Establishment of a Residential In Reach program
- Implementation of the Aged Care Reform Readiness program
- Completion of the Theatre Supply Chain project
- Completion of the Coleraine Campus one stop shop health precinct and redevelopment of the Penshurst Campus Kolor Lodge

The Future

- Enhancement of bariatric services
- Enhancement of Advanced Care planning
- Continued implementation of systems to embed changes to practice and enhance care through telehealth
- Completion of the Aged Care Reform strategy
- Implementation of IV pump strategy across all campuses
- Upgrade of 2nd Theatre to install a new tower for digital technology
- Implementation of Theatre Supply Strategy Project
- Progress Hamilton Base Hospital master plan

At Western District Health Service (WDHS) our staff are committed to providing everyone every time with a positive experience through their health care journey. Our staff are mindful of the apprehension faced by some patients during hospital stays and treat each with respect and care. There were 7,196 inpatients treated during the past 12 months, and 45,148 outpatient occasions of service provided.

The Operating Theatres at WDHS served by leading medical and surgical proceduralists and nursing staff, assisted by state of the art equipment operated on 2,895 patients this past year. In our Midwifery Unit we shared the joy of welcoming 210 babies in 2013/14, while our staff provided support and care for 7,155 patients who attended both the HBH Emergency Department and those who attended the Primary Care treatment service provided at CDHS and PDHS for minor injuries and illnesses.

We are proud of our staff and facilities which allow us to extend this care across the geographic region we serve. The 75 acute beds at Hamilton Base Hospital provide Emergency, Medical, Surgical, Sub Acute, Midwifery, Paediatrics and Intensive Care services, together with a broad range of Allied Health services. Penshurst Campus 6 acute beds and Coleraine Campus 10 acute beds both provide general medical care.

Our sub acute services GEM, rehabilitation, palliative and transition care provided care to 4,576 patients.

WDHS' 6 aged care facilities, The Birches and The Grange in Hamilton; Penshurst Nursing Home and Kolor Lodge in Penshurst; Valley View Nursing Home and Wannon Court and Mackie Hostels in Coleraine cater for residential needs of the elderly. Twenty eight Community Aged Care Packages (CACPs) are administered from the Grange. The staff who support our residents and their carers in these facilities are predominantly Division 1 and Division 2 nurses supported by Personal Care Workers and Hotel Services staff

We accommodated 185 high care residents, 62 low care residents, 139 respite residents and our occupancy rate in our aged care facilities was 84.27%. We serviced 44 CACPs clients.

Specialist Services

Our role as a Sub Regional Service provider together with our aim of enhancing access to a comprehensive range of appropriate and safe services has continued to expand during the year with three new specialists visiting our Health Service.

Orthopaedic services have been enhanced with the appointment of Mr. Alastair Sutherland as a visiting specialist which has resulted in an increased range of surgical procedures, particularly in relation to knee surgery.

Dr. Caroline Tan a Neurosurgeon, commenced a monthly consulting clinic and operating theatre service for spinal surgery which is the

→ Graduate Registered Nurse Kate Nunn and Clinical Support Nurse Amy Holmes checking medications.

only service of this kind west of Melbourne. The purchase of equipment to facilitate the introduction of the new service was made possible through a bequest from the Estate of Alec McBride.

We were also fortunate to have Professor Steve Holt, Director of Nephrology at Royal Melbourne Hospital Kidney Care, establish a three monthly consulting clinic for community members with kidney disease and also to support our dialysis service.

The introduction of these new services and procedures for Hamilton Base Hospital Campus has reduced the travel burden and costs for our community.

Emergency Care

To ensure we continue to provide best practice care for patients presenting to our Emergency Department we have completed our participation in the evidence based best practice project for the recognition and response to deteriorating patients through the Emergency Care Improvement and Innovative Clinical network. This has facilitated improved outcomes through the implementation of a:

- Formal track and trigger observation chart designed with specified periodic measurement criteria
- Multiple parameter system with two different escalation pathways for different physiology parameters
- Comprehensive education and awareness plan
- Improved response and escalation pathways and management of patients presenting with unstable and deteriorating conditions

Sub-Acute Services

Our role as a level 3 sub-acute service continues to develop and grow with the completion of a redesigning care project to improve the coordination and integration of the care pathways for our rehabilitation patients and patients with functional decline.

We have also completed a stroke rehabilitation telehealth project in partnership with Barwon Health to enhance the level of stroke care provided to our community and to minimise the need to transfer patients to higher level centres.

The introduction of a Residential In Reach program which aims to assist all aged care facilities in the Southern Grampians and Northern Glenelg Shire to prevent presentation to emergency departments through a specialist nurse working in partnership with General Practitioners and residential care providers, has resulted in 42 aged care residents being assisted with this program. The outcome of this assistance has either successfully prevented admission or supported the admission pathways through the Emergency Department for treatment and return to home or to their residential aged care facility.

Aged Care Reform

In response to the continued implementation of the Commonwealth Government's Living Longer, Living Better Age Care reforms, WDHS along with other aged care providers was required to develop a comprehensive aged care reform readiness plan to implement reform changes from 1 July 2014.

This included participation in the Victorian Healthcare Association Aged Care Readiness project and the development of our own implementation plan. Our implementation plan has included the publication of our pricing structure for all our aged care facilities, the application of additional infrastructure funding for eligible newly built and significantly refurbished facilities namely Coleraine, Grange and Penshurst, engagement of a specialist group to embed care plans and resident centred care into daily practice to sustain resident outcomes and subsidy payment for care provided and the development of marketing and promotional strategy.

The finalisation of the Aged Care Reform Readiness Project will be a major change for WDHS and our community over the next year.

Theatre Supply Chain Reform

A major business improvement project undertaken by the Health Service to improve the efficiency and reduce costs has been our Theatre Supply Chain Project. The aim of this project is to change the supply chain to a real time system thereby reducing the need to have excess stock in storage and reduce duplication, double handling and costs through the disposal of out of date stock. The second component of the project is to ensure the billing of all prosthetic supplies. It is anticipated that as a result of the supply chain reform project we will achieve savings of around $130,000 in 2014/15 and $100,000 recurrently in future years.

Clinical Services Capital Improvements

The official opening of the new $27m one stop shop health precinct for Coleraine in December 2013 saw this vision become a reality. The new precinct will ensure the acute health, residential aged care and primary health needs of the Coleraine community will be served into the next century and beyond.

The generosity of two long term Penshurst residents Mr. Sandy O'Brien and the late Shelia Harrington enabled the modernisation of the 10 bed Penhurst Campus Kolor Lodge aged care facility to improve the comfort and homely environment for current and future residents for the next 20 years.

Primary and Preventative Health

→ Rosie Rowe, Director of Primary and Preventative Health and Usha Naidoo, Manager Care Coordination receiving the 2013 VHA Award on behalf of WDHS. Pictured with Susan Williams, CEO Hardy Group International, Hon David Davis, Minister for Health, Kevin Hardy, Principal and Founder of Hardy Group International and Anthony Graham, VHA Chair.

→ WDHS OT team and Physio staff celebrate Occupational Therapy Week with a morning tea.

Achievements

- Victorian Healthcare Association Award and Member's Choice Award for Telehealth services
- Southern Grampians Powercor ACE Radio Business Achievement Award – Community Enterprise and Judge's Team Leadership Award
- WDHS Clinical Excellence and Innovation Award
- Continued development of Telehealth
- Establishment of new Services, including:
  - Sub Regional Dental Health Service Model
  - Residential In Reach program
  - Delta Dog Visiting Service
  - Podiatry Service
  - Men's Health Nurse Practitioner
  - Electronic Care Plan
  - Occupational Therapy Paediatric Service
- Integration of District Nursing into the Primary and Preventative Health Division
- Hosting of the Inaugural Rural Health Conference
- Extending work place health and wellbeing programs
- Improving oral health care through Top Teeth project
- Expanding youth programs

Awards

- Shire Business Awards - the 2013 Powercor ACE Radio Business Achievement Award is recognition of the Division's innovation, team culture and focus on meeting community needs. Particular recognition was noted for Telehealth services and the award winning Care Coordination model.

The Division was also awarded the Judge's 'Team Leadership' Award recognizing the Division's initiatives to develop staff and achieve a high performing culture.

- Telehealth Service Awards - leadership in telehealth was recognised by the Primary and Preventative Health team being awarded the WDHS Clinical Excellence and Innovation Award and the prestigious 2013 Victorian Healthcare Association (VHA) Award reflecting outstanding innovation to address community needs. The team also won the inaugural Member's Choice Award, voted by delegates at the annual VHA conference.

Telehealth initiatives include:

- Men's Health - over 180 patients use this service each year with reduced waiting times, improved access and travel times and reduced economic hardship.
- Speech Pathology has supported over 30 Telehealth sessions with five regional clients. This has saved the clients and their families over 4000 kilometres of travel from outlying areas into Hamilton.
- Pain Management– 35 pain clients have accessed clinics coordinated by the HARP team and Dr Malcolm Hogg at the Royal Melbourne Hospital.
- Cancer –Telehealth consultations are offered weekly with specialists at the Andrew Love Cancer Centre in Geelong.

Telehealth has recently been expanded into Palliative Care, Residential In Reach, Respiratory and Physiotherapy. This has been assisted by a $17,300 grant from the Department of Health.

New Services

South West Dental Service

A new Sub Regional Dental Service was established in January, resulting in the public dental service in Hamilton being managed by South West Healthcare. The service aims to improve the recruitment and retention of dentists, thereby improving access, continuity and service sustainability. This has been positive for the Hamilton community with full-time dentists and dental therapists available and enhanced peer and professional support for staff.

Residential In Reach

This service aims to assist aged care facilities to prevent presentations to Emergency Departments. A specialist nurse supports the provision of care within the facility, working closely with the resident's GP. Since commencing in December 2013, 42 patients have been assisted, with the provision of intravenous antibiotics and catheter changes.

Delta Dogs Program

A new canine volunteer has commenced visiting as a result of a partnership with The Delta Dog Society, local Cox Street Veterinary Clinic and volunteer handlers. The program aims to enhance health and wellbeing, with research showing that interaction with dogs lowers blood pressure and increases endorphins. Visits occur in outpatient areas, Planned Activity Groups, acute wards and aged care.

→ Delta Dogs Volunteer Stan Dean, HARP Chronic Care Nurse Janine Huf, Director, Primary and Preventative Health, Rosie Rowe, Vet Kristabel Lewis and Planned Activity Group (PAG) clients Cliff Everett & Joan King enjoy a pat of Delta Dogs Jill and Tessa at a celebration to kick off the program.

New Podiatry Services

Enhancements to podiatry have enabled a 90% reduction in the waitlist. The benchmark includes:

- A new assistant role to support clinicians
- A new self-management group to support low risk clients to become more confident and competent in managing their own foot care
- A new fast track clinic for selected clients who have no medical complications. Teamwork between the podiatrist and assistant has increased throughput by 30%
- Expansion of weekly services with funding from Great South Coast Medicare Local

Feedback on the new podiatry services was gathered by WDHS volunteers, Jenny Groves and Heather Wilkinson. Clients were excited to provide feedback to volunteers and praised the improvements to the Podiatry Service.

Men's Health Nurse Practitioner

Stu Willder is now an endorsed Nurse Practitioner, enabling him to expand his clinical services to men and boys. Stu works in partnership with visiting Urologist Mr Richard Grills to manage patients requiring Urological surgery. Stu also works in partnership with the Hamilton Medical Group to provide a Men's Health Clinic. This collaborative service provides support for over 150 men per year. Clinical services are bulk billed and are coordinated in collaboration with General Practitioners.

Electronic Care Plan improves Coordination of Care

The challenge of how clinicians can share real time information to enable coordination of care for clients with multiple services has been resolved by the establishment of an electronic care plan. This replaces multiple paper based care plans in different agency files. Health professionals use a web portal to access the care plan, including WDHS and Shire staff. Forty five care plans have been shared to date, enabling the client's care team to better coordinate client support.

Occupational Therapy Paediatric Service

Over 20 children have received support since a paediatric OT service commenced in 2013. This service, while supported by limited funding, enables families to access much needed therapy locally. WDHS continues to look at ways to enhance our paediatric services and to meet unmet demand.

Integration of District Nursing

In December 2013 the District Nursing and Community Palliative Care Service were integrated into the Primary and Preventative Health Division to improve coordination of community and home based services provided by WDHS and the Southern Grampians Shire.

Inaugural Rural Allied Health Conference

The inaugural Barwon South West and Grampians Regional Allied Health Conference was hosted by WDHS involving 100 Allied Health professionals from Geelong, Ballarat and Western Victoria. Presentations included WDHS Occupational Therapy and Speech Therapy Department managers, with the WDHS presentation on Telehealth in Speech Pathology winning a Presenter's Award.

Workplace Health and Wellbeing Programs

In the last 12 months, workplace programs were provided to Iluka Resources (Hamilton and Ouyen), Wannon Water, Ryan's Freighters, Murray Goulburn, Watpac (civil and mining) and Powercor.

Programs are individually designed for each industry group to support health awareness, screening and preventative practices in the workplace. Apart from government funding for Ryan's Freighters, all programs were delivered on a fee for service basis.

Top Teeth

In 2013, WDHS developed the 'Top Teeth' Pilot Project, aimed at improving our engagement with disadvantaged families to promote oral health practices and dental clinic access from an early age.

Forty six children were screened/assessed at 2 local Kindergartens (of which 69% were healthcare card holders). Evaluation showed:

- 39% needed treatment
- 65% accessed the clinic via the program; 70% of these were new clients to the clinic
- 90% remained engaged and completed their treatments

WDHS has commenced delivering the program to a greater number of Kindergartens in the Southern Grampians Shire, utilising the 'Top Teeth' method.

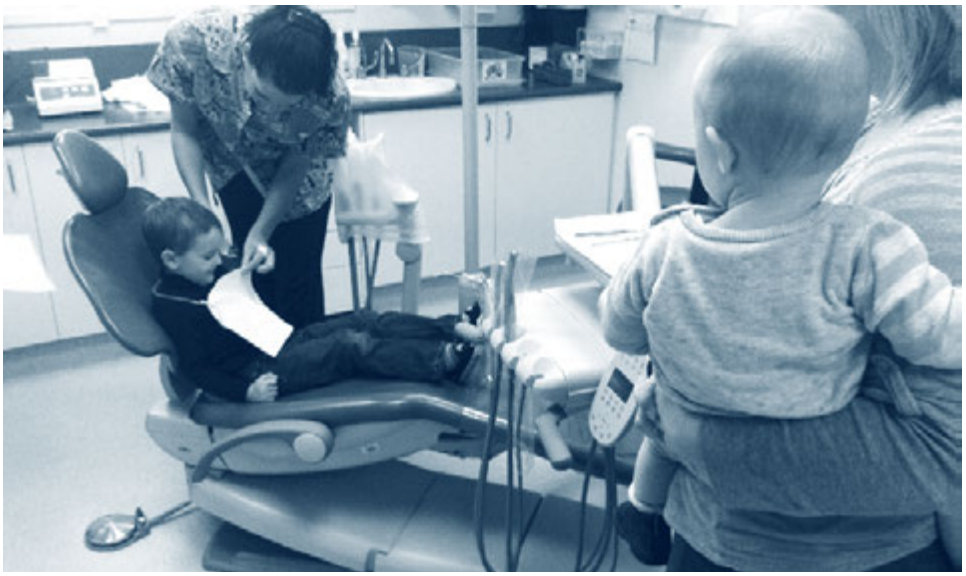
→ WDHS Allied Health Department Managers host the Allied Health conference pictured with staff from other Agencies, Department of Health and key note speaker centre front, Rosalie Boyce, Associate Professor, University of Southern Queensland.

Youth Services

Key highlights of this year's programs include:

- **Holiday Program** - twenty activities with over 500 young people participating in activities such as paintballing, fishing charter off Portland, Melbourne Show, Luna Park, Adventure Park and horse riding on the beaches of Warrnambool. The program is funded by a generous donation from Dr Geoff Handbury, AO.
- **Hamilton Young Mother Network** – over 40 young mothers have participated in the program since it commenced in 2011. This aims to build the social, emotional, education, services access and parenting capacity.
- **Southern Grampians FReeZA Program** - over 2000 young people participated in diverse events including the Hamilton Battle of the Bands; Hamilton Hard-Core Music Night; Balmoral Pool Party and Family Fun Day; Australia Day Pool Party Dunkeld; Highland Games in Glenthompson and the Hamilton Winter Pool Party.
- **Southern Grampians Youth Achievement Awards** – establishment of monthly Awards in partnership with a range of local agencies to recognise young people who have demonstrated excellence and have contributed to the community.
- The Awards commenced in February 2014 as a partnership between **Western District Health Motov8** and the **Butterfly Foundation** - Motov8 and the Butterfly Foundation provided workshops to over 200 students focussing on body image and positive friendships.

→ Southern Grampians Youth Achievement Awards supported by WDHS and other local community groups.



→ A kindergarten student receives treatment through the 'Top Teeth Project'.

National Centre for Farmer Health

→ Visitors from Alberta, Canada learning about Australian wool during a farm visit to Nick and Yvonne Falkenberg's farm, Coleraine.

The National Centre for Farmer Health (NCFH) is a Hamilton-based partnership between WDHS and Deakin University encompassing university research, service delivery and education and provides leadership to improve the health, wellbeing and safety of farm men and women, farm workers and their families.

The NCFH was established in 2008 through a partnership with the Victorian State Government Future Farming Strategy and the Helen and Geoff Handbury Trust. This core funding ceased in 2012 and the last 24 months have seen the centre work through completing programs and applying for ongoing funding to continue its work.

Despite the difficult funding circumstances, achievements over the past year include finalisation of the Sustainable Farm Families Flood Recovery program, continuation of new research projects, supporting students through Australia's only Graduate Certificate in Agricultural Health and Medicine, expansion of www.farmerhealth.org.au and Health and Lifestyle assessments in partnership with Queensland Rural Medical Education.

The NCFH also continues to play an active role in promoting farmer health, wellbeing and safety at many events from local major events such as the Lucindale and SunGold Field days, the Warwick Rodeo and Kingaroy show in Queensland to speaking at conferences, remote medical education days and university research symposia.

Sustainable Farm Families™

The most important aspect of a healthy Australian farm? A healthy farming family.

Achievements

The final Sustainable Farm Families Flood Recovery workshop was delivered in Cavendish in July 2013. As the SFF program came to a close we hosted a delegation from Alberta, Canada who travelled across the world to see the SFF program in action, talk to farmers and consider how to repeat and transfer the program to Alberta. The SFF Program had been running for 10 years and it is very exciting to see this award winning and much loved program adopted by another country.

Health and Lifestyle Assessments

Health and Lifestyle Assessments (HLA's) are currently being delivered in partnership with Queensland Rural Medical Education. The partnership delivered successful programs in Toowoomba, Warwick, Charleville and Kingaroy to complete the program. This program offers an opportunity for junior doctors and medical students to have a holistic experience in the assessment of metabolic risk within rural communities. This is not something that is covered in the hospital setting and is essential for effective general practice. Recently we have also partnered with Primary Producers South Australia and Country South SA Medicare Local to deliver a similar program in South East South Australia at the Lucindale Field Days. The NCFH provided over 600 health and lifestyle assessments at agricultural events during 2013-2014. Support was also provided to the SunGold Field days in collaboration with GMHBA Limited, Meat for Profit Day held in Hamilton, the Grasslands conference in Ballarat and the VFF conference at the Melbourne showgrounds along with other initiatives.

Professional Training and Education

Achievements

Commencing in 2010, the only Agricultural Health and Medicine subject (HMF701) in Australia has seen 102 postgraduate students undertake this important and new area of study. These students have come from every State and mainland territory in Australia to undertake the week long intensive course based at WDHS Hamilton Base Hospital Campus. In 2012, an additional online unit Healthy and Sustainable Agricultural Communities (HMF 702) commenced and to date 27 students have completed this subject. These subjects provide credit towards the Post Graduate Certificate in Agricultural Health and Medicine, Masters of Public Health, Nursing, Health Promotion or Agriculture. This has added to its appeal and helps to broaden the knowledge of agricultural health into other disciplines. The NCFH is committed to continuing to provide professional training for people working and providing services to farmers and their families. Future activities will include the growth and expansion of professional training and education at all levels to improve skills, knowledge and competencies in farmer health, wellbeing and safety, to the highest level.

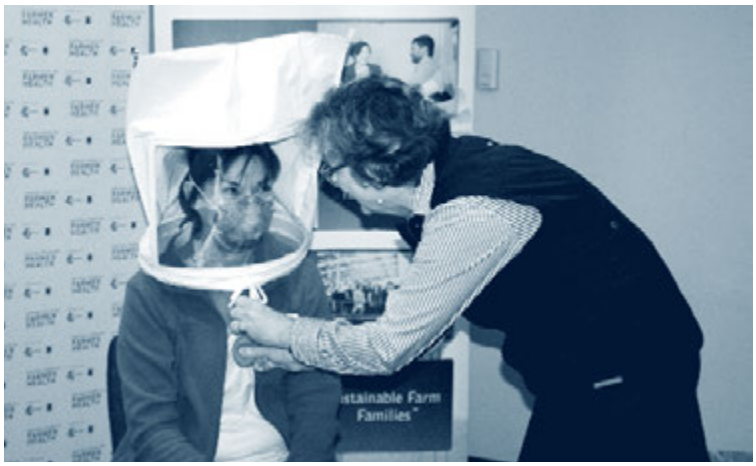
Applied Research and Development

Achievements

This year has been busy with a number of research projects moving towards completion.

Projects that have been completed and reported on include:

- Department of Environment and Primary Industries - Sustainable Farm Families Flood Recovery
- Australian Research Council Linkage Grant - Implementation and evaluation of a program to reduce alcohol and related problems among farm men and women.



→ Tricia Kinsey RN from Kerang having a fit test undertaken as part of HMF 701 Agricultural Health and Medicine course held at WDHS in February 2014.

→ Dr. Jacquie Cotton conducting an on- farm noise audit on Catryne and Judy Van Der Vlugt's farm in Gippsland as part of the 'Shhh hearing in a farming environment' funded by a National Health and Medical Research Council Project Grant.

Projects that are in progress include:

- 'Shhh hearing in a farm environment' (National Health and Medical Research Council Project Grant GNT 1033151) is being delivered in partnership with the University of Canberra and National Acoustic Laboratories. This projects looks at early intervention hearing services to farmers with a self-reported hearing loss in Victoria and Queensland. Data collection is complete and undergoing analysis. To date there has been some conference presentations and two publications are currently under review. The study is registered with Australian New Zealand Clinical Trials and is due for completion December 2014.
- Cholinesterase Research Outreach Project (CROP) – measuring organophosphate exposure in Western Victorian farmers, which is associated with chronic neurological diseases such as Parkinson's disease in sheep farmers. The pilot study included 41 South West farmers and 14 non farmers (control). Data collection is complete and is undergoing analysis, with the study's first publication currently under review with BMC Public Health. The study was registered with Australian New Zealand Clinical Trials.
- Farming Families Wellbeing and Bereavement Study - this study is being done as doctoral research through a partnership with University of New England and NCFH. Data collection is almost complete and the studies literature review has been published.

Farmer Health Website www.farmerhealth.org.au

Achievements

In 2014 the Farmer Health website was updated to a new platform to reflect the changing nature of user behaviour, allowing the website to be viewed on mobile devices.

During the past year the Farmer Health topic pages remain the most popular content. Farmer Health topic pages contain health and safety information specifically looking at the health and safety issues faced by farmers and their work circumstances. The five most viewed topic pages were: eye injury – flash burns, parsnip rash, scabby mouth, farm succession planning and farmers lung.

In 2013-2014 Farmer Health had over 25,000 unique visitors, an 11% increase on the previous year, with Australia accounting for the majority of visits followed by the United States, United Kingdom and Canada.

Our web presence also extended to social media sites such as Facebook and Twitter with over 600 Facebook and 566 Twitter followers.

In 2013, in collaboration with WDHS, both the Farmer Health and WDHS websites provided the opportunity for people to show their support for funding the National Centre for Farmer Health by downloading a letter of support to send to Members of Parliament, and by adding their name to the list of supporters.

Commitment to providing quality health information online with our continued partnership with Better Health Channel as a content partner ensures the maintenance of accreditation from the international Geneva based, non-profit, non-governmental organisation, Health on the Net (HON).

The Farmer Health website has continued to grow with 83,991 unique visitors (an increase of 39% on the same time last year), viewing more than 314,453 pages since the website first went live in 2010.

Peer reviewed manuscripts published this year included:

1. Brumby S, (2014). Making Connections: The 2014 Libby Harricks Memorial Oration [Monograph] (pp. 7-34). Sydney: Deafness Forum Limited. Retrieved from www.deafnessforum.org.au/images/pdf/2014 Libby Harricks Memorial Oration.pdf
2. Cotton J, Brumby S, Lewandowski P, Calvano A, (2014). Cholinesterase Research Outreach Project (CROP) – Measuring Cholinesterase Activity of Australian Farmers, Journal of Agromedicine, vol. 19, no. 2, pp. 210-211
3. Brumby S, Newell M, Chandrasekara A, Calvano A & Atcheson M, Health Checks in the Saleyards – Bringing the Health Professional to the Farmer, Journal of Agromedicine, vol. 19, no. 2, pp. 210-211.
4. Brumby S, Hogan A, Williams W, Mercer-Grant C, & Calvano A, Careful – They Can't Hear You: Intervention of Vulnerable Populations Working in Agriculture . Journal of Agromedicine, vol. 19, no. 2, pp. 204-205
5. Kennedy AJ, Maple MJ, McKay K, Brumby SA (2014). Suicide and accidental death in Australia's rural farming communities: a review of the literature. Rural and Remote Health 14: 2517.
6. Rogers M, Barr N, O'Callaghan Z, Brumby S, Warburton J, (2013), Healthy ageing: Farming into the twilight. Rural Society Journal, vol. 22, Work and Environment, pp. 251-262. doi: 10.5172/rsj.2013.22.3.251
7. Brumby S, Chandrasekara A, Kremer P, Torres S, McCoombe S and Lewandowski P (2013), The effect of physical activity on psychological distress, cortisol and obesity: results of the farming fit intervention program, BMC Health, vol.13, no.1018
8. Lunner Kolstrup C, Kallioniemi M, Lundqvist P, Kymalainen H. R, Stallones L, & Brumby S (2013). International perspectives on psychosocial working conditions, mental health, and stress of dairy farm operators. J Agromedicine, 18(3), 244-255. doi: 10.1080/1059924X.2013.796903

Southern Grampians Glenelg Primary Care Partnership (SGGPCP)

→ The Southern Grampians Glenelg Primary Care Partnership Team L-R: Clinton Thomas - Project Officer, Jo Brown - Health & Wellbeing Manager, Claire Nailon - Project Officer, Robyn Holcombe - Office Coordinator, Neil Gunn - Project Officer.

Southern Grampians Glenelg Primary Care Partnership is a voluntary partnership that has formed to enhance the health and wellbeing of our community by helping organisations work together.

Our Vision is to collectively achieve greater improvements in the health and wellbeing of our community by building strong partnerships and capacity to respond to local health and wellbeing needs of our community.

Our Primary Care Partnership (PCP) Partners are:

- ASPIRE, a Pathway to Mental Health Inc
- Balmoral Bush Nursing Centre Inc
- Brophy Family & Youth Services Inc
- Casterton Memorial Hospital
- Dartmoor & District Bush Nursing Centre Inc
- Dhauward Wurrung Elderly & Community Health Services Inc
- Glenelg Shire Council
- Hamilton Community House Inc
- Heywood Rural Health
- Kyeema Centre Inc
- Mulleraterong Centre Inc
- Old Courthouse Community Centre Inc
- OzChild
- Great South Coast Medicare Local
- Portland District Health
- Portland Neighbourhood House Inc
- Southern Grampians Shire Council
- South West Healthcare (Psychiatric Services)
- WDHS Hamilton, Coleraine and Penshurst campuses
- Winda-Mara Aboriginal Corporation

Partnering Achievements

Partnerships – Great South Coast Medicare Local (GSCML) and South West PCP (SWPCP)

Following a joint meeting of the Boards/ Executive Committees of GSCML, SWPCP and SGGPCP, the Executive Officers have been meeting regularly to determine and document how the three organisations are to work on various issues to maximise the use of resources in the region. This has resulted in various partnering approaches, from a single lead agency within a defined scope through to full collaborative approaches such as Local Voices Shaping Local Futures project (highlighted below). Some of the key early outcomes of this partnership include GSCML working with Deakin University to share promising practices in health promotion around alcohol. SGGPCP then facilitates these practices at a local level in Portland with SWPCP and SGGPCP, working together to develop a Great South Coast approach to obesity prevention, and GSCML leading (in consultation with SGGPCP and SWPCP) the development of a robust evaluation framework for health and wellbeing outcomes. A framework to explain what are the common strategies, who is leading them and the partnership approach is being finalised to communicate this partnership approach to stakeholders.

Partnerships with Victorian Centre for Climate Change Adaptation and Research (VCCCAR)

SGGPCP were selected as one of three PCPs to participate in the 'VCCCAR Implementing tools to increase adaptive capacity in the community and natural resource management sectors project' in 2013. SGGPCP worked closely with the VCCCAR research team to identify a tool to increase adaptation in the community health sector. The project chose to implement the Adaptation Navigator in a facilitated discussion with PCP partner agencies. This discussion enabled sharing, learning and provided a strategic direction across the catchment. The project enabled an opportunity to increase partnerships with research agencies and to provide a valuable opportunity for the research sector to connect with a community agency. Primary Care Partnerships are well placed to further work in adaptation and to work closely with their partner agencies to increase adaptive knowledge and capacity. Project outcomes have been documented in a case study and research papers, and presented at State and National forums which will be used for future international conferences.

Highlights

Heywood Food Access Project

Accessing fresh fruit and vegetables in small rural communities serviced by one general store can have significant impacts on health and wellbeing. The Heywood Food Access Project worked in partnership with the community to increase access to fresh fruit

and vegetables, particularly for families with young children. Families with young children were encouraged to grow their own fruit and vegetables and were supported to do this by linking closely with the Heywood Food Swap which provided a platform to learn new skills through workshops, increased networks and opportunities to swap food. Basic vegetable growing workshops were also conducted at the Heywood Kindergarten resulting in the construction of garden beds and development of vegetable recipe cards. Families with young children were also provided with portable garden beds and a vegie growing kit to start growing food at home. As a result 15 new families started growing vegetables at home and five new families were regular attenders at the Heywood Food Swap.

Glenelg Seniors Achieving Valuable Energy Savings (SAVES)

SGGPCP has been successful in obtaining funding from the Low Income Energy Efficiency Program (LIEEP) through the Australian Department of Industry to improve energy efficiency in the homes of Home and Community Care (HACC) clients in the Glenelg Shire. This project is a collaboration between SGGPCP, the Glenelg Shire Council and Federation University. Through an innovative participatory training approach, 35 HACC staff will learn about household energy efficiency and complete adaptations to improve the efficiency in their own homes. Staff will then work with HACC clients to complete household energy efficiency assessments and prioritise areas for action. Community education sessions will add to the knowledge of the general community to further support change. Federation University will lead data collection and project evaluation. Glenelg SAVES began in 2013 and will conclude in 2016.

Barwon South West Enhancing Care Coordination

The Barwon South West Enhancing Care Coordination Project was created to improve the capacity of primary care services to provide more appropriate care coordination to consumers throughout the Barwon South West (BSW) region. A small Project Working Group comprising of the SGGPCP, SWPCP, G21, the Department of Health and WDHS has developed the project to date, incorporating information gained from agencies.

The first phase of the project focussed on 'internal organisational change' and has so far been delivered in workshops throughout the region, based on the Studer Group's Hardwiring Excellence Framework.

→ **The Hamilton Breast Cancer Support Group helped to raise breast cancer awareness by joining the spectacular 'Field of Women' on the MCG before an AFL football match in 2014.**

Phase two of the project will focus on 'System Excellence' improving care coordination at the local systems level through to the regional systems level.

As of January 2014 there were 304 active participants from 27 regional organisations.

Local Voices Shaping Local Services

Local Voices Shaping Local Services is an exciting ongoing initiative led by Great South Coast Medicare Local (GSCML) which aims to develop a shared understanding of the health priority areas for the Great South Coast. SGGPCP and SWPCP are working closely with GSCML to gather a range of quantitative and qualitative data to help ensure our health system is responsive to local need through service improvement. The iterative process involves community consultation, health professional consultation, best practice and literature reviews, prioritisation and recommendations. The first iteration is focusing on three areas:

- Mental Health / Alcohol and Other Drugs
- Obesity / Type 2 Diabetes
- Respiratory / Smoking

Future Direction

Obesity Prevention

It is anticipated that in the coming year, a joint approach between Southern Grampians Glenelg Primary Care Partnership, South West Primary Care Partnership, Department of Health and the World Health Organisation's Collaborating Centre for Obesity Prevention, Deakin University will be undertaken which will drive the Obesity Prevention efforts at a Great South Coast level.

It is the intention to implement a highly integrated community driven approach to tackling the obesity problem in this region. Central to this approach is understanding the inter-relationships of local systems and how they impact on the community regarding physical activity levels and healthy eating. Additionally, enhancing community capacity to analyse these systems and to create, implement and monitor a community specific action plan is a further objective of this approach.

An undertaking of this magnitude would be a world's first and presents a tremendous opportunity to ensure the obesity prevention efforts in this region are based on the most current research and promising intervention strategies to achieve a meaningful and sustained approach when tackling the overweight and obesity statistics.

Culture of Responsibility of Drinking

Our goal over the next four years is to develop a community culture of responsible drinking and reduced harm from smoking. This will include increasing our knowledge, capacity and ownership of the problem, workplace initiatives, community driven action on alcohol and the expansion of smoke free environments. The PCP will work in partnership particularly with agencies which have identified alcohol and tobacco as priorities in their plans and which have identified capacity. Part of our focus includes the PCP and partners working in partnership with Deakin University in Portland, with an initial focus on reducing alcohol consumption by underage young people. This will include working with secondary students and parents, underage alcohol sales monitoring and social marketing and communication. Key stakeholders include Portland District Health, Dhauwurd-Wurrung Elderly & Community Health Service Inc, Department of Education and Early Childhood Development, Victoria Police and Glenelg Shire.

For further information regarding the SGG PCP, go to www.sggpcp.com

Corporate Governance

→ WDHS Board Members L-R: Back Row: Ian Whiting, Jen Hutton, Mark McGinnity, Front Row: Darren Barber, Mary-Ann Brown (President) and Hugh Macdonald.

WDHS was incorporated in July 1998 under The Health Services Act 1988 and is governed by a seven member Board of Directors (BOD), appointed by the Governor in Council upon the recommendation of the Minister for Health.

Board Structure, Role and Responsibilities

BOD terms of appointment are usually three years, with one third of terms expiring in June each year. Members are eligible for reappointment.

BOD members serve in a voluntary capacity. The balance of skills and experience within the BOD is kept under continual review. The BOD orientation and evaluation process introduced in 2003 was continued during 2013-14 and has assisted significantly in evaluating the effectiveness and performance of the Board Chair, individual Directors and the Board as a team. All current Board Members have undertaken additional governance training.

The BOD is responsible for the governance and strategic direction of the Health Service and is committed to ensuring that the services WDHS provides comply with their legislative requirements and the Objectives, Mission and Vision of the Service, within the resources provided. In the course of their duties, the BOD and Executive may seek independent advice from a range of sources. The BOD reviews governance information monthly in order to continually assess the performance of WDHS against its objectives and is also responsible for appointing and evaluating the performance of the Chief Executive Officer. In order to ensure the effective operation of the BOD, the Board has membership on 10 committees, which meet as required and report back to the BOD.

Board of Directors

Mary-Ann Brown

BEcs(Tas),GradDipLibSc(KCAE), MBA (Newcastle)

Mary-Ann lives on a farm at Dunkeld and is the principal of Mary-Ann Brown & Associates, an insurance services business. She is Chairperson of the Dunkeld Community Centre Committee and President of the Dunkeld Progress Association, member of the Performing Arts Centre Advisory Committee and a Dunkeld Visitor Information Centre volunteer. Appointed to WDHS Board in November 2002, current term expires 30 June 2015.

Jenny Hutton B.Ed

Jen is Director of Community Relations and Development at The Hamilton and Alexandra College. She is actively involved in fundraising in the community having been involved recently in the Grange, Watermark Charity House and Mulleraterong fundraising appeals. She is a Fellow of Educateplus (Network of Advancement Professionals in Education) and was the regional representative of the Vic/Tas Executive Committee from 2006-2012. Appointed to WDHS Board in November 2002, current term expires 30 June 2015.

Hugh Macdonald BBacc

Hugh has worked in the finance industry since 1982. He is Relationship Manager for the Rural Bank in Western Victoria and also runs a farming enterprise at Hamilton. Hugh is a Director of The Hamilton and Alexandra College Foundation, a trustee for The Hamilton and Alexandra College Old Collegians and a board member of the National Centre for Farmer Health since its inception. He is a past President of the Hamilton Racing Club, and the Hamilton Junior Basketball Association. He chaired the fundraising committee for the Hamilton Indoor Leisure and Aquatic Centre, and is Chair of the WDHS Watermark Charity House Committee. Appointed to WDHS Board in November 2006, current term expires 30 June 2015.

Mark McGinnity

BA (Behav Sc), Dip Teach (Science), Dip Rel Ed, M Ed (Teach & Curric), MACE, MACEL.

Mark is the Principal of Monivae College and a member of the College's Board of Directors. He is Chair of the Advisory Committee for the Hamilton District Skills Centre and a member of the Parish Pastoral Council of St Mary's Parish Hamilton. Mark is also a member of the Association of Heads of the Independent Schools of Australia and the Principals' Association of the Victorian Catholic Secondary Schools. Appointed July 2011, current term expires 30 June 2014.

Ian Whiting

Ian is Managing Director of Bassett Estate Pty Ltd and a Director of Club Solutions Australia Pty Ltd, Charity Bid Pty Ltd and Clubbid.com.au. Ian is President of the Morven CFA Rural Fire Brigade, past Chair of the Top of the Town Charity Ball 2010 and the Branxholme Progress Development Group Fundraising Committee. Ian was Deputy Chair of the South West Academy of Sport, VCFL Regional Manager South West Border and was Chair of the VCFL South West Border Regional Board. He is a past President of the Hamilton Junior Football League and College Magpies Junior Football Club, a past Founding President of the Smokey River Land Management Group and past Captain of the Morven CFA RFB.

Appointed to the WDHS Board on 1 July 2011, current term expires 30 June 2014.

Mark Stratmann BA Dip T, LLB, JP
Mark is principal of Stratmann & Co Lawyers. He has a background in education and has been practicing law since 1999. Mark and his wife Sally have four sons and a daughter. He is a past Board Member of the WestVic Division of General Practice and Monivae College. Mark and his family have lived in Hamilton for thirteen years after relocating from Melbourne. Appointed to the WDHS Board on 1 July 2010, Mark resigned on 19 November 2013 to take up a Magistrate's Court appointment.

Darren Barber Master HRM
CSU – in progress, Cert IV Training & Assessment.

Darren is a partner of SED Advisory, a regional Victorian professional services firm. He has over 14 years experience in Human Resource Management and specialises in regional workforce development in a business and regional context.

Darren and his wife Katherine have 3 children, he was born and bred in Hamilton and has been actively involved in the community with roles on the Gray Street Primary School council, Show Us Your Toys committee, South West TAFE Hamilton Campus Advisory Committee, Mitchell Park Kindergarten committee and acted as a regional delegate for the VECCI Business and Employment forum. Appointed on 1 July 2013, current term expires 30 June 2016.

Governance Statement

"The Board is a strong advocate of corporate and clinical governance and seeks to ensure that the Health Service fulfils its governance obligations and responsibilities to all its stakeholders."

The Board is committed to:

- Sound, transparent corporate governance and accountable management
- Provision of high quality and innovative care, reflective of its Mission and Vision
- Conduct that is ethical and consistent with the Health Service values and community values and standards
- Management of risk and protection of health service staff, clients and assets
- Due diligence in complying with statutory requirements, acts, regulations and codes of practice
- Continuous quality improvement, innovation and research

Ethics
Board members are required by the Health Services Act, 1988 to act with integrity and objectivity at all times. They are required to declare any pecuniary interest or conflict of interest during Board debate and to withdraw from proceedings if necessary.

There were no instances requiring declaration this year.

Executive Role
The members of the Executive Team are Chief Executive Officer, Deputy CEO/Director of Corporate Services, Director of Medical Services, Director of Nursing, Director of Primary and Preventative Health, Human Resources Manager, Manager/Director of Nursing, Coleraine Campus, Manager/Director of Nursing, Penshurst Campus, Director, National Centre for Farmer Health.

The Executive met 25 times during the year, providing regular reports to the BOD.

Attestation on Compliance with Australian/New Zealand Risk Management Standard

I, Jim Fletcher, certify that the WDHS has risk management processes in place consistent with the Australian/New Zealand Risk Management Standard and an internal control system is in place that enables the executive to understand, manage and satisfactorily control risk exposures. The audit committee verifies this assurance and that the risk profile of the WDHS has been critically reviewed within the last 12 months.

Jim Fletcher
CHIEF EXECUTIVE OFFICER

Hamilton
6 August 2014

BOARD MEMBER	BOARD MEETINGS ATTENDED	COMMITTEE MEMBERSHIP AS AT 30 JUNE 2014	COMMITTEE MEETINGS ATTENDED
Mary-Ann Brown	**11 of 11**	Audit & Compliance	4 of 5
		Board Executive	1 of 1
		Medical Appointments Advisory	2 of 2
		Medical Consultative	4 of 4
		Quality Improvement	1 of 1
		Remuneration	1 of 1
Jenny Hutton	**11 of 11**	Community Advisory	4 of 4
		Development Council	6 of 6
		Medical Appointments Advisory	2 of 2
		Penshurst Advisory	5 of 5
Hugh Macdonald	**10 of 11**	Board Executive	1 of 1
		Development Council	6 of 6
		Project Control	7 of 8
		Quality Improvement	1 of 1
		Remuneration	1 of 1
Mark McGinnity	**11 of 11**	Audit & Compliance	1 of 1
		Development Council	4 of 6
		Medical Appointments Advisory	2 of 2
		Quality Improvement	4 of 6
Darren Barber	**11 of 11**	Community Advisory	4 of 4
		Project Control	6 of 8
		Quality Improvement	4 of 6
Mark Stratmann	**5 of 6**	Audit & Compliance	2 of 2
Resigned 19 November 2013		Quality Improvement	2 of 3
		Remuneration	1 of 1
Ian Whiting	**10 of 11**	Audit & Compliance	5 of 5
		Project Control	8 of 8

→ WDHS Executive members L-R Hilary King, Tim Pitt-Lancaster, Janet Kelsh, Jim Fletcher, Rosie Rowe, Nic van Zyl, Bronwyn Roberts, Patrick Turnbull and Sue Brumby.

Risk Management
Risk management is an all of organisation activity and requires appropriate action to be taken to minimise or eliminate risk that could result in personal injury, damage to, or loss of assets.

During the year two of the four recommendations from our 2013 VMIA site risk survey were implemented with the remaining 2 recommendations relating to the HBH fire service upgrade in progress, with Stage 1 of this upgrade completed and Stage 2 due for completion in March 2015.

Progress with the implementation of the 2012-2017 Security Continuous Improvement Plan also continued with 6 recommendations now fully implemented, 2 partially completed and 2 in early progress.

Committees of the Board

Audit and Compliance Committee
Advises the BOD on all aspects of internal and external audits, financial and asset risk, accounting procedures, financial reporting, and compliance with statutory requirements.

Jim Bailey and Jodie Missen were the external Committee representatives. The Committee received internal audit reports on the financial management compliance framework and reviewed the Victorian Auditor General's Office reports and recommendations on infection control and occupational health and safety risks, recommendations and their application to WDHS.

The Committee also developed and completed a self - assessment evaluation to assess the operation and performance of the Committee.

Five meetings were held during the year.

Medical Appointments Advisory Committee
Advises the BOD on appointments, reappointments, suspensions and terminations of visiting medical practitioners.

Two meetings were held during the year.

Medical Consultative Committee
Makes recommendations on matters relating to medical staff and clinical services provided and ensures effective communication between the Board, Senior Executive Staff, and the Medical Staff Association.

Four meetings were held during the year.

Quality Improvement (QI) Committee
Provides support and direction for Continuous Quality Improvement and performance monitoring. Ensures systems are in place for internal/external review. Ms Dorothy Mc Laren is the community representative.

Six meetings were held during the year.

Development Council
Oversees and guides WDHS fundraising strategy. The Council operates in compliance with the Fundraising Appeals Act 1984.

Megan Campbell, Caroline Coggins, Sharon Donohue, Leesa Iredell, Libby Macgugan, Renae Porter and Vicki Whyte were the community members on the Council in 2013-14.

Six meetings were held during the year.

Penshurst (PDHS) Advisory Committee
Reviews operation, performance and strategic planning for the Penhurst Campus.

Community representatives are:

Don Adamson, Lucy Cameron, Margaret Eales, Mary Johnson, Jennifer Kinnealy, Tom Nieuwveld, Wendy Williams and WDHS Board Member Jen Hutton.

Six meetings were held during the year.

Coleraine (CDHS) Management Committee
Reviews operation, performance and strategic planning for the Coleraine Campus.

Community representatives are Gabrielle Baudinette, Kim Chintock, Lesley Kruger, Ashley Lambert, Grant Little, John Mc Meekin, Alan Millard and Anne Pekin.

Six meetings were held during the year.

Community Advisory Committee
Provides consumer views and advice to the Board on planning, implementation and evaluation of health services.

Rev. Peter Cook, Sherryn Jennings, Dorothy McLaren, Chris Phillips and Kay Scholfield were the community representatives.

Four meetings were held during the year.

Project Control Committee
Makes recommendations on the design, management and construction of major building projects.

Eight meetings were held during the year.

Remuneration Committee
Oversees and sets remuneration policy and practice for Executive staff, under the principles of the Government Sector Executive Remuneration Panel.

One meeting was held during the year.

Executive Team

Chief Executive Officer

Jim Fletcher

BHA, AFCHSE, CHE, MIPAA

Jim has held a number of senior executive positions within the human services field across the Loddon Mallee, Grampians, Northern Metropolitan and Barwon South Western Regions. His background includes the role of Chief Executive Officer at three of the State's largest regional psychiatric hospitals and community services, leading these agencies through significant reform and change. Jim commenced as CEO of WDHS on 17 July, 2000. Jim is Chair of a number of regional committees.

Deputy Chief Executive Officer, Director of Corporate Services

Patrick Turnbull

BBus, BHA, FCPA

Patrick has been with Hamilton Base Hospital since 1982. He has been the Hospital's principal accounting officer since 1987 and was appointed to his current role in 1993. Financial and business support of patient services is managed through the Corporate Services Division. Among Patrick's commitments with WDHS are his roles as Chair of the SWARH Finance Sub-Committee and participation as a member of the National ABF Implementation Reference Group established by the Victorian Department of Health.

Director of Nursing

Janet Kelsh

RN, ICUCert, BAppSci (NAdmin), CertMgt (Deakin), GradDipAgedServicesMgt, MRCNA

Janet commenced her role as Director of Nursing at Hamilton Base Hospital in 1987. With experience overseas, Janet worked predominantly in intensive care and neurosurgery in a number of major city hospitals across Australia and overseas before moving to Hamilton. Janet represents WDHS on a number of regional committees including regional wound care, regional infection control and nurse education through collaborative relationships with a number of Universities.

Director of Primary and Preventative Health

Rosie Rowe

BNatRes, MBA, GAICD

Rosie was appointed as Director in May 2009. Prior to this appointment, Rosie was the Deputy Director of Community Services from October 2008 and for five years, the Executive Officer of Southern Grampians and Glenelg Primary Care Partnership. She has held senior positions in both the public and private sectors, including in natural resources and telecommunications. She was a participant in the Department of Health's 2011 LINK Executive Program. Rosie is a Graduate of the Australian Institute of Company Directors and is a Board Director of the Great South Coast Medicare Local.

Director of Medical Services (DMS)

Dr Nic van Zyl

MB ChB, MMed (CH), MBL, PMP.

Nic commenced at WDHS in May 2014 after a long career as a Public Health Physician and Medical Administrator in South Africa. Nic's background includes working in rural hospitals as a specialist in community medicine and developing and providing health management training courses in partnership with Universities. He was a founding member of the School of Management in the Faculty of Economics and Management Science of Free State University and served as the Health Management Program Director. From 2004 until joining WDHS Nic was the Medical Administrator of the 654 bed Universitas Academic Central Teaching Hospital and a member of the Free State Department of Health top management team.

Director, National Centre for Farmer Health

Associate Professor Susan Brumby

RN, DipFMgt, GDipWomen's Studies, MHM, Cert IV Assessment and Training, AFCHSE, MACN, GAICD, PhD in progress

Sue commenced as founding Director of the National Centre for Farmer Health in November 2008 – a partnership between WDHS and Deakin University. She leads the implementation of five key strategies to improve the health, wellbeing and safety of farm men and women blending both a theoretical and practical understanding of agriculture, health, management and rural communities. Sue is the course director for the Graduate Certificate in Agricultural Health and Medicine, and has been Principal Investigator of the award winning Sustainable Farm Families™ (SFF) project and Collaborative Investigator on Australian Research Council, NHMRC, RIRDC and Beyond Blue grants. She has been recognised for her contribution to rural health, undertaken overseas studies to the USA and the EU looking at farmer health and decision-making and presented locally and internationally on farmer health. Sue is a graduate of the Australian Rural Leadership Program.

Human Resources Manager

Hilary King

MBA, Grad Dip HRM, Dip Physio, BA in progress, CAHRI

Hilary commenced work at WDHS in October 2007. Hilary has extensive experience in conflict resolution, diversity management, mentoring, coaching and management development. Hilary worked as a physiotherapist in Australia and overseas before moving into management roles within both state and federal Government and then into senior management roles within heavy manufacturing before returning to the health industry. Hilary has a keen interest in workplace culture and health. She is a keen cyclist and represents the Executive on the Hamilton Base Bikers Murray to Moyne team. She currently participates in the state-wide VHIA Payroll Consultative Committee and is a mentor for both the AHRI and ACHSE mentoring programs.

Coleraine Manager/Director of Nursing

Tim Pitt-Lancaster

RN BN Cert Perioperative Nursing, GradDip Nursing Science

Tim commenced his role in Coleraine in July 2005. Prior to this appointment Tim was the Nurse Unit Manager of the Operating Theatre Suite of the Mount Gambier and District Health Service, a role he filled from 1998 to 2005. During 2005, Tim was also the Acting Director of Nursing and Patient Services of the Mount Gambier Hospital.

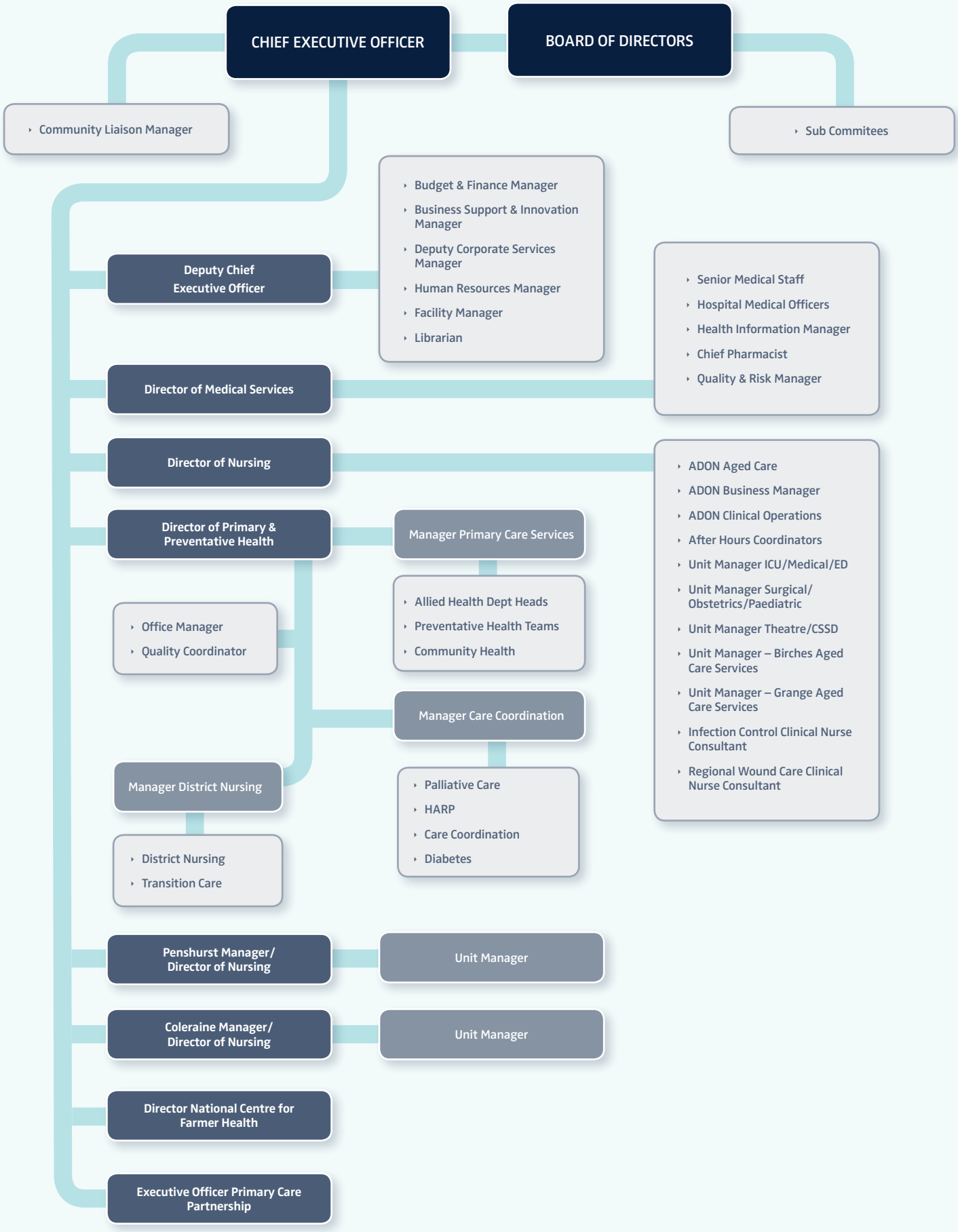
Penshurst Manager/Director of Nursing

Bronwyn Roberts

RN ICU Cert, Grad Cert Bus Admin, MRCNA

Bronwyn commenced her role at Penshurst in December 2013. Bronwyn has worked at WDHS Hamilton Campus and Ballarat Base Hospital over the last 28 years and has held management positions in Aged Care/ ICU/ Emergency and Projects over the last 20 years. Bronwyn's most recent role since 2004 was the Deputy Director of Nursing (Hamilton Base Hospital).

Organisational Structure



Our People in the Workplace

→ 2014 WDHS Registered Nurse Graduate Program participants, L – R: Back Row: Jemma Gale, Helen Edmondson, Kaitlin Sinclair, Jessica Kelly, Hannah Mugavin, Jessica Payne, Jeanette Rantall. Front Row: Katherine Uebergang, Erin Cooper, Sarah Schmidt, Krystal Morris.

Strategy

- Attract and retain high-performing staff committed to the Vision, Mission and Values of the Health Service
- Provide an environment for motivating and encouraging staff to develop and use their skills to enhance the health, wellbeing and safety of our community

Achievements

- Progression of the 2012-2017 Human Resources Strategic Plan
- Recruitment of Specialist Medical staff and middle Nursing and Allied Health Managers
- Participation in the Barwon South Western Regional Health and Wellbeing Workforce plan
- Implementation of Healthy Workforce initiatives
- Completion of the 2014 Organisational Effectiveness Survey
- Staff recognition awards
- Roll out of National Standards Education and Culture Program
- Continued Professional Development Program including e-learning
- Support Graduate Nursing placements and clinical placements for undergraduate Medical, Nursing and Allied Health students
- Completion of the Trifocal Model of Care education
- Implementation of simulated learning projects
- Participation in the Best Practice & Learning Environment Project
- Implementation of Occupational Health and Safety Strategy

Future

- Continuing implementation of 2012-2017 Human Resources Strategic Plan
- Recruitment of specialist staff, medical, nursing and allied health
- Launch of E recruitment
- Implementation of action plan developed as a result of the 2014 Organisational Effectiveness Survey
- Continue to implement Healthy Workforce initiatives
- Ongoing sustainability strategy to imbed National Standards into daily work routines
- Implementation plan developed as a result of the Best Practice Clinical Learning Environment (BPCLE) self-assessment

HR Strategic Plan 2012-2017

A five-year Human Resources Strategic Plan was adopted by the Board early in 2012.

The strategic imperatives for the next five year Human Resources plan include:

- Redesigning and resourcing WDHS for the future
- Developing organisational culture and commitment to excellence
- Growing research and innovation capability and readiness
- Using technology to support client care, staff management and corporate services functions
- Developing strategic partnerships to maximise impact

Recruitment

WDHS has been pleased to finalise recruitment for a number of senior positions. We welcomed the arrival of Dr Nic van Zyl in May 2014, an experienced Director of Medical Services from South Africa. In the absence of a full-time Director of Medical Services, we were well supported by Dr John Christie and Dr Bruce Warton on a temporary basis. Our major focus for our medical recruitment going forward will be the recruitment of GP proceduralists for obstetrics and a general surgeon as part of succession planning.

A number of senior managers were recruited throughout the year. Bronwyn Roberts was appointed Director of Nursing/ Manager at Penshurst and Steve Laidlaw commenced as the Community Liaison Manager. We also welcomed June Morris into the Penshurst Nurse Unit Manager role and Aisling Cunningham returned from maternity leave commencing as Nurse Unit Manager in the Medical Unit. Lee Donald has replaced Carolyn Roe as the Nurse Unit Manager at The Grange.

Succession Planning

Our structured leadership development

→ WDHS Dietitians L-R: Jessica Nobes, Tamara Barker (Allied Health Assistant), Jodie Nelson, Danielle Creek and Natalie Lim.

Workforce Profile

LABOUR CATEGORY	JUNE CURRENT MONTH FTE		JUNE YTD FTE	
	2013	2014	2013	2014
Nursing	244.63	241.30	242.44	240.56
Administration and Clerical	90.65	87.49	86.47	87.28
Medical Support	24.25	22.14	26.68	23.74
Hotel and Allied Services	137.03	130.98	142.71	137.17
Medical Officers	4.34	4.27	2.33	2.69
Hospital Medical Officers	14.02	14.92	14.22	14.15
Ancillary Staff (Allied Health)	37.15	43.36	34.44	40.09
Total	**552.07**	**544.46**	**549.29**	**545.68**

program for associate nurse unit managers, nurse unit managers and registered nurses in aged care continues to improve our leadership competency and succession planning.

A number of WDHS staff continue to work beyond the traditional retirement age by utilising flexible work options such as casual work, reduced hours or consultancy work. The ageing workforce (60% of our workforce are over 45) reinforces WDHS's commitment to business innovation and the use of technology throughout our health service. We have seen an increasing number of staff transitioning to retirement over the past 12 months. This generational change will bring its own challenges in planning for our future workforce.

Workforce Planning

Workforce planning continues to be a major focus for WDHS and the wider health sector.

This year we participated in the development of the Barwon South Western Regional Health and Wellbeing Workforce Plan.

The implementation of our strategic objectives of redesigning and resourcing WDHS for the future will draw upon some of the actions developed in the Barwon South Western Region Workforce Plan.

Healthy Workforce Initiatives

The health and wellbeing of our workforce is a key element of the Human Resources Strategic Plan. In 2013-2014 WDHS received Worksafe funding for a number of small healthy workforce initiatives. The focus of the initiatives was mental health with funds spent on staff training in the areas of conflict resolution, resilience and management. Some funds were allocated to provide additional bike racks and to continue our corporate membership with the Hamilton Indoor Leisure and Aquatic Centre.

Our two Murray to Moyne Cycle Relay teams continue to be well supported with over half the riders and support teams coming from staff across our three campuses. Fortunately the 2014 event saw both teams safely complete the 520km ride from Mildura to Port Fairy.

→ Craig Richardson from WDHS Environmental Services, recipient of the 2013 Above & Beyond Award.

Organizational Effectiveness Survey

The final actions of the last Organizational Effectiveness Survey were implemented during the year with outcomes including the redesign of the weekly Bulletin and communication strategies.

The triennial Organizational Effectiveness Survey was undertaken in May 2014. Overall the results were very pleasing with improvement in 27 of the 30 key performance areas, with 20 improving by 3% or more.

In terms of comparison within the health sector, the very high performing indicators were cost consciousness, recognition and appreciation, physical conditions, communication and leadership effectiveness which were 14 to 23% above industry benchmarks. An organizational action plan will be developed to follow up on

individual departmental and organizational improvements.

Work Experience Program

Twenty two students completed work experience at WDHS during 2013-14. Most students completed placements in nursing and allied health. WDHS also offers work experience placements in administration (finance, public relations and human resources), maintenance and community health. The Careers Forum was again held for senior regional students in July with an excellent attendance. This is always a great opportunity for students to interact with some of our new graduates to gain a better understanding of the career options in health. In 2014, steps are underway to reformat the careers day based on feedback from students and staff.

Staff Recognition and Awards

Employee of the Month Program

This program has continued to grow and most months now see about three or four strong nominations for the coveted employee of the month award sponsored by local business, Darriwill Farm. It is pleasing to see the broad range of staff nominated for this award. During the past 12 months almost every department has had a staff member nominated. The employees who received the award over the past twelve months were:

July	Mark Stevenson	Infection Control
August	Ruth Ikobe	Surgical Unit
September	Jen Membrey	Transfusion Trainer
October	Brenda Uebergang	Planned Activity Groups
November	Lyn Christie	Pharmacy
December	Linda Miller	The Birches
December	Nancy Jones	Midwifery
January	Robyn Beaton	HARP
February	Tim Hicks	The Birches
March	Kay Diana	Human Resources
April	Chantelle Lottering	Emergency Department
May	Heather McKenry	Penshurst
June	Susie Stevenson	Home Referral
	Lise Lowe	P&PH Reception

Industrial Relations

In 2013-14 the Maintenance Enterprise Bargaining Agreement was finalised. No work hours were lost at WDHS as a result of industrial action during 2013-2014.

Statutory Compliance

During 2013-14, WDHS made no mandatory reports to AHPRA regarding health professionals.

Human resource staff continue to monitor and manage legal compliance with occupational health and safety, equal opportunity, industrial law, protected disclosure compliance and similar legislation. Policies are regularly reviewed and updated as legislation or case law requires, ensuring best practice.

In the current year there were no complaints under the Protected Disclosure Act, Fairwork or the Equal Opportunity Act.

Code of Conduct

All staff receive training in the code of conduct and expected standards of behavior on a regular basis. This training is completed in conjunction with regular prevention of bullying and harassment training.

Education and Learning

Professional Development

The Education Centre aims to work in partnership with education and training providers to facilitate relevant, superior quality programs that meet the needs of our staff and those within our partner agencies. True to this mission, the Centre delivered a series of face-to-face as well as e-learning programs in 2013-14.

Face-to-face programs covered areas such as professional resilience, performance management, conflict resolution, dealing with aggressive behaviour, handling complaints, advocacy for clients' rights in the legal framework, Aboriginal culture safety training, and first aid.

The introduction of new e-learning programs in response to staff training needs and the implementation of the National Standards continued in 2013-14. For example, new online modules on Aseptic Technique and Wound Management were introduced. In addition, two new e-learning modules were introduced in response to increasing numbers of people suffering mental illness presenting to the Emergency Department or having to be transported to the Health Service. The first module outlines strategies to assist both mental health clinicians and emergency department staff when interacting with people with mental health concerns. The other module deals with balancing the right to safe transport which minimises interference with the rights, dignity and self-respect of patients with mental health issues against the safety of the transport provider.

Staff Service Milestones

10 YEARS	20 YEARS
Lesley Barling	Jennifer Fitzgerald
Mary Boney	Rhonda Hamilton
Trudy Boyes	Marlene Lee
Devon Maslen	Mardi Mailes
Anne McArlien	Julie Morice
Debra Robinson	Pam Pollock
Moria Robinson	Rosemary Rowlands
Joanne Ross	Geoffrey Winnell
Rosie Rowe	
Sonia Shaw	**25 YEARS**
Susan Watt	Kathleen Baugh
	Cheryle Casey
15 YEARS	Cheryl Martin
Marilyn Callaby	Debbie White
Robert Cook	
Debra Clugston	**30 YEARS**
Peter Davies	Sandra Anton
Tim Hall	Leonie Eales
Brian Hearn	Rowena Ford
Paula Heine	Annette Mason
Phuong Huynh	Louise Milne
Susan Patterson	Kaye Roberts-Rendell
Gwenda Rentsch	Lesley Stewart
Julianne Schultz	Debbie Vaughan
Jan Street	
Janene Taylor	**35 YEARS**
Helen Thomas	George Donaldson
Ann Warburton	Timothy Hicks
Alison Woolridge	Jean Killen
	Graeme Marnell
	Christopher Storer

Orientation

All staff are required to complete face-to-face as well as online core competency orientation upon commencing service at WDHS. During the full-day general hospital orientation, knowledge essential to working at WDHS is shared. Clinical staff complete a second day of orientation focused on additional clinical requirements.

Practice Development

In-service programs continued to be facilitated by Practice Development Nurses (PDNs) for each of the clinical areas, namely aged care, medical and surgical.

Aged care had a full-time PDN appointed to cover all residential aged care facilities within WHDS. During 2013, their main focus was on the implementation of the Trifocal Model of Care, a model focused on person-centred

→ **Work experience students from Casterton Secondary College, Remy Hurst and Liza Mutch practise their nursing skills using a blood pressure machine.**

care. Since early 2014 the main strategic focus progressed to the Aged Care Funding Instrument (ACFI), Best Practice in Wound Management and Link Nurse Palliative Approach Toolkit.

In the latter half of 2013, Practice Development for the Medical Unit and Emergency focused on education around the introduction of the National Standards. In early 2014 the focus shifted to looking at staffing requirements and ensuring that staff were appropriately trained to meet the National Standards requirements. In addition, three staff were trained in Chemotherapy.

The aim of the PDN role for the Surgical Unit is predominately to provide on the spot guidance and support for all staff on the ward, including registered nurses, graduate registered nurses and enrolled nurses, in the practicalities of nursing. This includes areas of general and specialised surgery, step down recovery, paediatric patients, and a wide variety of medical conditions.

E-Learning

The delivery of quality e-learning programs has become an increasingly important component of education and training, especially in rural areas where access to face-to-face learning opportunities are limited. This year the Education Centre invested in upgraded e-learning software, resources and training of educators as a strategy to strengthen the organisation's capacity to develop and deliver e-learning which would meet consumer expectations in an increasingly sophisticated online media environment.

Switch – Occupational Violence Prevention Program

WDHS successfully applied for funding to support the implementation of the Switch program; an occupational violence prevention program designed for all staff, across all areas of clinical and non-clinical services. A train-the-trainer process was implemented in late 2013-14 and the roll-out of training to all relevant staff will continue in 2014-15.

Continuing Nursing and Midwifery Education

WDHS continued to be the fund holder for a Department of Health grant aimed at facilitating local sessions for continuing nursing and midwifery education. Sessions held during the year covered topics such as emergency presentations, advanced clinical skills, legal issues, pressure areas, maternity emergencies, clinical handover, falls and post-operative care. Nurses attended from consortia member agencies WDHS, Portland Health Service, Casterton Memorial Hospital, Heywood Rural Health, Balmoral and Dartmoor Bush Nursing Centres as well as nurses from outside our region.

Medical Education

This year has seen the continuation of programs targeting medical staff offering opportunities for interns on rotation with WDHS to attend sessions specifically addressing their needs. There are regular meetings on radiology and pathology that are open to all local medical practitioners. On Fridays a general 'grand rounds' type of presentation is held by visiting and local practitioners and is available to others externally via WebEx or video conferencing. The session is coordinated in conjunction with staff from the Great South Coast Medicare Local.

Hindson Professional Development Fund

Two nurses will attend a Trauma Nursing Care Course in Bendigo in August 2014. The course is a two-day program delivered by the Royal College of Emergency Nursing. The program aims to increase knowledge, skills and confidence of nurses working in the Emergency Department when dealing with trauma. This training is partly funded by the Hindson Professional Development Fund. The staff who attend are grateful for the opportunity to do so.

Graduate Nurse Programs

WDHS provides a graduate nurse program for Registered Nurses (RNs) and Enrolled Nurses (ENs) designed to support the newly graduated nurses in the clinical area and to provide opportunities to consolidate both theoretical and clinical skills. These programs support the transition from student to nurse in a friendly and stimulating working environment as they undertake rotations under the guidance of experienced and competent nurses. In the 2013-14 period, ten nurses completed the 12-month program and a new intake of 10 nurses commenced.

→ Student Enrolled Nurses Rose Wani and Meghan Coleman from Careers Australia Melbourne and Danielle Leckning from SWTAFE participate in simulated learning at WDHS.

In addition, WDHS had one graduate completing and one commencing the Victorian Southwest Collaborative Program. The program provides participants with unique experience rotating throughout three health services; WDHS, Portland District Health and Moyne Health Service.

WHDS continued to partner with Leading Aged Care Services Australia (LASA) and Monash University to provide an Aged Care Graduate Nurse Program. There was one participant in 2013 and another commenced in 2014. This program encourages a greater understanding and awareness of the ageing process, allows for evidence-based implementation strategies for resident-centred care and allows the graduate to gain a greater understanding of aged care legislation.

Our Enrolled Nurse Program operated across all WDHS facilities with five participants completing the program in February 2014.

Clinical teachers have promoted the programs throughout the region by attending careers expo's at universities in Melbourne, Warrnambool, Ballarat and Bendigo, and an information open day was held at WDHS in June.

Undergraduate Placements

Clinical placements allow students to experience learning encounters with all relevant aspects of the health industry, to enable them to reinforce and consolidate the theoretical component of their training. A range of nursing undergraduates, comprising Bachelor, Diploma and Certificate students attended clinical placements in acute care, extended care, community health and units in primary and preventative health. We also hosted a number of medical, pharmacy, physiotherapy, occupational therapy, dietetic and speech pathology students throughout WDHS campuses in 2013-14.

Nursing Graduate Diplomas

WDHS supports nurses to further their qualifications and knowledge by undertaking a Graduate Diploma with Deakin University. Each year applicants apply to complete a Graduate Diploma in one of the areas such as critical care, peri-operative nursing or midwifery. A clinical teacher is available in each of these areas to assist the students with experience, and to complete assessments of the students' performance. Further experience may be gained by a placement at another health service. Four students undertook further studies in 2013-14.

Aged Care – Trifocal Model of Care

In November 2012 WDHS, in partnership with Deakin University and Southern Health introduced The Trifocal Model of Care Project. The project aimed to promote person-centered care, evidence based practices and positive and healthy work environments in residential aged care.

In January 2013 Deakin undertook a pre-evaluation survey of The Birches and The Grange. The education component of the project was rolled out at these facilities between March and December 2013.

Deakin completed a post-evaluation survey of the WDHS facilities in March 2014 with the aim of completing the overall project in October 2014.

Simulated Learning Project

Continuing on from the completion of the Simulated Learning Project in June 2013, WDHS partnered with the Greater Green Triangle University Department of Rural Health (GGT UDRH) to provide simulation training. A dedicated simulation trainer based at GGT UDRH now works with the WDHS Education Centre to plan and deliver training targeting undergraduate students in nursing, medicine, paramedicine and allied health.

Best Practice Clinical Learning Environment (BPCLE)

WDHS took part in the Best Practice Clinical Learning Environment (BPCLE) project, which is an initiative of the Victorian Department of

→ WDHS environmental staff member Anthony Jackson helps ensure that high cleaning standards are maintained.

Health aimed at improving the overall quality of clinical training in Victoria.

The BPCLE Framework defines six key elements as essential in underpinning a quality clinical learning environment. These include an organisational culture that values learning, best practice clinical practice, a positive learning environment (e.g. incorporating elements such as a welcoming environment for students, appropriate learning opportunities, high-quality clinical education staff, and appropriate ratios of learners to both educators and patients), a supportive health service–education provider relationship, effective communication processes and appropriate learning resources and facilities.

Funding received for the project allowed for the appointment of a part-time project officer who facilitated the BPCLE process through a series of workshops and activities which included an assessment of the WDHS clinical environment against the best practice framework. It also included developing an action plan and indicators for addressing priority performance issues. Implementation of the action plan will occur over the next 12-18 months following the continuous quality improvement process.

Occupational Health and Safety

Equipment Procurement Program
WDHS continued its commitment to improving Occupational Health and Safety management through an ongoing equipment procurement program. During 2013-2014 WDHS invested almost $80,000 to make the workplace safer for staff and patients. Occupational violence training is an area of concern within healthcare and WDHS recently purchased a training program (SWITCH) to be provided to frontline staff. A lifting sling replacement program has been instigated and food trolleys in the Grange have been motorised to assist staff manoeuvring the ramps at the facility.

Fire Safety and Emergency Procedures
Fire and emergency code training is compulsory for all staff at WDHS.

As a result of the introduction of the National Standards in 2013, the staff and volunteer orientation pack has now been updated with an increased focus on understanding the relevance of the Standards to every staff member's role.

Regular drills are held throughout the Health Service to ensure that emergency readiness remains constant.

Occupational Health and Safety policies are regularly reviewed to ensure compliance with best practice and legislative changes.

Over the past year there have been no chemical, biological or radiation incidents where the exhaust mode in the Emergency Department needed to be activated.

Occupational Health and Safety Training
OHS training continues to occur on a regular basis throughout the Health Service. All health and safety representatives have either attended or booked to attend their mandatory health and safety training.

Occupational Health and Safety Audits
An independent audit was conducted in March 2014 to ascertain compliance with hazardous materials management. WDHS was fully compliant, however a recommendation was made in relation to electronic management of material safety data sheets which is currently being considered.

Patient handling self-assessments were completed across all aged residential care facilities during 2013-2014. Some minor improvement opportunities were identified as a result. No major gaps were identified.

2013-2014 Work Cover Premiums
WDHS changed its Workcover insurer on 1 January 2014 from CGU to Allianz.

- Total indicative Work Cover premium for this period was $433,313
- Indicative performance rating was 0.9032 which is 9.6% lower than the industry average. WDHS' Work Cover premium rate has improved by 25.05% from last year. This result can be attributed to an overall improvement in the health sector's Work Cover performance and reflects the impact of a number of complex cases dealt with by WDHS over the past two years.
- There were no Work Safe notifiable incidents in 2013-2014. However, one incident relating to a non-injury near-miss contractor incident was advised to Work Safe during this timeframe.

Corporate Social Responsibility - Business and Systems Support

→ **Hamilton Medical Group GP Dr Dale Ford, with client Peter Teal and HARP Chronic Care Nurse, Janine Huf in a telehealth consult with Pain Specialist Dr Malcolm Hogg.**

The Corporate Services Division comprises departments staffed by people with a wide-range of skills and expertise in business analysis, budget and finance, food, environmental and linen, human resources, information communications and technology, library and supply and maintenance services. These departments form the power-house that supports direct patient care and ensures that WDHS functions effectively and efficiently. We employ 102 people (86.7 EFT) and have an annual budget of $11.8 million.

The Division participates in management decision-making for the entire organisation, in particular the interpretation of government policy, the implementation of changes required for compliance with statutory obligations and the management of resources necessary for the delivery of clinical and aged-care services.

Challenges

- Monitor, interpret and respond to changes in government policy and strategic directions
- Implement, monitor and review risk management strategies
- Manage organisational emergency response and ensure business continuity
- Ensure effective governance and management of resources
- Support clinical services development, review and restructure
- Develop, implement and monitor infrastructure and technology strategic initiatives
- Take a leadership role in alliances and peer groups to promote innovative practice within the Sub-Region
- Maintain timely, accurate, efficient and effective reporting on finance, service activity and compliance
- Ensure efficient and contemporary workforce management strategies to maximise organisational effectiveness

Achievements

- Participation and implementation of National Reform agendas
- Implementation of Regional and Sub Regional alliances and partnerships
- Regional Centralised Supply Model developed and adopted by participating agencies to commence operation from July 2014
- Final Stage of the Trak-Care integrated patient system Trak-Care Community project initiated in September 2013 – project progressing with WDHS Go-Live scheduled for November 2014
- CAMMS Executive Reporting Knowledge Management system implemented
- Theatre 2015 Redesigning Care Project – imprest system implementation complete June 2014 – recurrent savings $100,000 per annum
- Regional Intravenous Therapy Strategy adopted by health services in the South West Region. Contract entered in June 2014 to implement technology and provide service for the next 10 years
- Coleraine Health Precinct completed in October 2013 – services relocated in November 2013 and demolition of old site completed in April 2014
- Kolor Lodge redevelopment completed and opened in November 2013
- Stage 2 (including rendering) of Hamilton Medical Group Upgrade completed May 2014.
- $1.2m Fire Protection Upgrade commenced with completion of $860K Stage 1 works comprising ring main upgrade, pumps, tanks and sprinkler protection to the ground floor; with Stage 2 to commence August 2014 for completion March 2015
- HBH Main Chiller Plant refurbishment and upgrade completed in April 2014 at a total cost of $90,000
- Carpark upgrade strategy commenced in 2010 completed with the finalisation of Medical Group/Education Centre carpark in February and the Tyers Street car park in March 2014
- New Birches Nurse Call System commissioned in November 2013
- Boiler Upgrade to energy efficient burner and controls completed in March 2014 – expected annual gas savings of $12,000
- Stage 2 – Conversion of Trade Workshops to Education Offices completed January 2014
- Department of Health State Government endorsement obtained for 10 year capital master-plan for Hamilton Base Hospital and Penshurst sites
- $1.8m submission to the Rural Capital Support Fund for Stage 1 Penshurst Masterplan completed
- Environmental Management Plan completed in June 2014 – initial public report to be completed in December 2014
- Building Management System on-line real time energy consumption monitoring system completed and available on intranet site
- Energy Initiative – LED lights in passage ways assessment completed – very high usage areas converted cost $2,500 payback period 3 years
- Introduced the WDHS Emergency Preparedness (All Hazards) Clients and Services Policy in December 2013
- Hazard Identification and Risk Assessment of lifts at Hamilton Base Hospital completed in March 2014
- 100% Compliance with Department of Health - Statement of Priorities
- Penshurst Small Rural Health Service Business Model completed in January 2014
- 100% compliance for annual external food safety audit
- Annual state-wide external cleaning audit score of 98.7%
- Achieved above the mean average in all

areas in food satisfaction that measured Quantity, Temperature and Quality, in the VPSM state-wide food satisfaction survey for Category B Hospitals

- Independent Security Audit undertaken and 2012-2017 Security Action Plan developed – to date six of the ten recommendations have been actioned in line with five-year action plan

The Future

- Complete implementation of Trak- Care Community Clinical System and roll out to other health services
- Continue to monitor and implement changes associated with the National Health Reform agendas
- Implementation of strengthening Health Services Regional plan
- Continue to progress Theatre 2015 Redesigning Care Project
- Continue to expand the use of virtual services to support innovative service delivery models
- Complete implementation of Regional IV Therapy strategy across all WDHS sites
- Establish RFIS tracking system for Medical Equipment at Hamilton Base Hospital site
- Complete fire safety upgrade Stage 2 – installation of fire sprinkler protection for bed based services first floor Hamilton Base Hospital
- Implement environment, waste management, food and fire safety programs
- Continue development of 10 year capital master-plan for Hamilton Base Hospital and Penshurst sites following Department of Health State Government endorsement
- Establish remote connectivity throughout the District Nursing Service area
- Ongoing expansion of technology platforms and innovation to achieve service goals and direct care times
- Enhancing technology literacy throughout WDHS
- Implement new Regional Central Supply model
- Continue to identify budget and revenue initiatives as required to accommodate restructure, productivity cuts and reform initiatives at both the State and Commonwealth levels
- Negotiate new contracts with Private Health Funds

National Health Reform

The National Health Reform – "A National Health and Hospitals Network" is being progressively implemented in conjunction with the States. As a consequence of the potential redistribution between agencies and the lack of maturity of the new funding models, Victoria has elected to retain the current "WIES" system for inpatients and continue to fund other non-inpatient services on the same basis at least until July 2015.

WDHS participates as a member of the Department of Health ABF Implementation Reference Group providing input to government on the potential impacts of proposed changes on rural health services. The key areas of concern with potential to significantly impact on WDHS are:

- Excessive discounts applied to Private Inpatients treated in Public Hospitals
- No funding provided for smaller Intensive Care Units
- Penshurst Health Service not recognised as a Block Funded Small Rural Health Service
- Lack of robust systems and data to implement non-inpatient activity based funding

The election of a new Commonwealth Government and subsequent funding policy changes announced in the May 2014 Federal Budget have thrown into doubt the future of the proposed changes under the reforms.

The Living Longer Living Better Federal Aged Care Reform was passed into law on 28 June 2013. The reform consists of a 10 year plan designed to address these challenges by reshaping aged care and building a better, fairer and more nationally consistent aged care system.

Many of the key aspects of the reforms start on 1 July 2014 including:

- Removal of the distinction between High and Low care
- Aged Care Providers required to publish accommodation prices on the "My Aged Care" website
- Higher Accommodation Subsidies for facilities "significantly upgraded" since April 2012

The reforms are focused on market competition with pricing and descriptive information to be readily available to those people considering residential aged care. WDHS has provided relevant data to My Aged Care and is also in the process of enhancing www.wdhs.net to promote the services and facilities available in all WDHS Residential Aged Care facilities.

WDHS staff from all facilities are involved in managing the implementation of the reforms and ensuring the Health Service complies with new legislative requirements and maximises marketing opportunities. Sub-regional agencies are working as a collaborative group. The Victorian Healthcare Association (VHA) has developed an Operational Readiness Tool and targets information products designed to assist public sector residential aged care facilities assess their own operational readiness in order to respond effectively to the Federal Aged Care Reforms and the ongoing changes faced in the sector.

Sub Regional Progress, Alliances and Partnerships

The key direction set out in the WDHS Strategic Plan is the development of alliances and partnerships to leverage the delivery of Corporate Support Services of the highest quality and in the most efficient and sustainable way. This strategic direction has been reinforced with the initiation of a number of statewide projects and programs designed to improve sustainability and service quality across the sector. It will also provide the opportunity for WDHS to participate in broader initiatives and new alliances and partnerships.

In February 2013 the Department of Health Sustainable Hospital Plan was released as an initiative to support the delivery of the Government's health priorities through a health service system 'living within its means'. Under the plan each region was to work in a collaborative way to develop a Regional Sustainable Hospitals Plan by June 2013 for implementation from 2013-14. The Barwon South Western Region Working Group is jointly chaired by the CEO's from Barwon Health and WDHS.

The Sustainable Health Services (SHS) for Barwon South Western Region Plan was completed in June 2013 and identified key priorities for collaboration in 2013/14 as follows:

- Telehealth – medicine, training and infrastructure
- Enabling a regional supply hub
- Knowledge Management – access to management & clinical data
- Sub-regional support for accreditation
- Linen – sub-regional arrangements (Eastern Region)
- Sustainability of workforce in focused areas
- Optimising South West Alliance of Rural Health (SWARH)(ICT)

The SHS has had some traction throughout the projects, with a complete audit of tele-health equipment within the SWARH region for compatibility. Protocols and policies for Telehealth are currently being developed.

The Knowledge Management priority is progressing with shared library services across Barwon and SWARH as well as shared services with subscriptions. Barwon has been

sending their discharge summaries and other electronic documents to improve continuity of care into the Lorne area. Expressions of interest are being sought and a business case being finalised for a Regional Healthcare Analytics project to provide a data repository to be shared across the region.

The adoption by SWARH members South West Healthcare, WDHS, Colac Area Health and Portland District Health of the HealthSMART Oracle Financial Management System in 2009 created opportunities within the agencies to better utilise resources. This included the ability to consolidate purchasing, warehousing and logistic activities into a shared service.

In March 2013 all four agencies formed a Central Supply Steering Committee (CSSC) to explore and approve the development of this shared service. The development of this model has required an extensive period of groundwork to identify a business case and transition plan to move to a central shared service. This model has been adopted by the agencies for implementation from July 2014.

The central supply model "South West Supply & Logistics" will involve the consolidation of four regional warehouses into one central warehouse to be located at South West Healthcare. This consolidation will eliminate the duplication of supply activity by centralising product fulfilment and logistics into one central hub with expected annual savings of $400K across the four agencies. In addition the four health services will invest in supply chain reform, which will involve the appointment of a clinical product advisor and contract managers to ensure health services are maximising purchasing opportunities.

The transition process for all four agencies into the Central Supply Model will take two years. Project resources have been appointed to manage this process. The cost of the implementation is being partially funded by $150,000 allocation from the Sustainable Health Services Funding project and will commence in July 2014, with the transition of Colac Area Health followed by Portland District Health, WDHS and South West Healthcare.

Health Purchasing Victoria (HPV) have acknowledged the importance of this project and have reviewed the business plan. HPV believes it is consistent with its modelling being undertaken to assess the feasibility of a centrally led approach to procurement and logistics across the State. As such HPV deem the CSM as a "proof of concept" or pilot opportunity that will assist in driving supply chain reform cross Victoria. It also paves the way for the South West region being reform ready when a broader state-wide approach proceeds.

→ **Catering staff member at the Coleraine Campus, Shirley Menz cooking for the residents.**

SWARH Alliance

As a member of the SWARH ICT Alliance, WDHS staff takes an active role in the governance of the joint venture and the support of all the specialist sub-committees.

The major priority for WDHS since July 2013 has been the implementation of the Trak-Care integrated Patient and Client Management system. It will provide a single integrated system for management of clinical data and will provide the foundation for significant progress towards the achievement of a patient electronic record across the region.

Progress on the Patient and Client Management System to date includes:

- WDHS & South West Healthcare – Go Live PAS completed – 1st November 2012
- All other SWARH sites (9 in total) – Go Live completed - 1st June 2013
- Upgrade to latest software version T2012 – completed 12th June 2013
- Trak-Care Community implementation commenced – September 2013

WDHS (and other SWARH members) now have in place an integrated Patient Management and Clinical System including a specialist Theatre and Emergency Department module. During the next year with the completion of the Trak Community project, SWARH health service members will be well-placed to deliver the electronic medical record across the region.

Business Support and Innovation Projects

The Business Support and Innovation (BSI) Unit leads change management across the organisation by assisting with process improvements including planning, organising and managing resources to bring about successful completion of projects that impact across the organisation.

The BSI Unit continues to be actively involved in the Department of Health Redesigning Hospital Care Program. WDHS is represented on the Redesign Lead Sub-Committee and participates in an annual "Tollgate Review" undertaken by the Department of Health. Redesign projects in the current year included the Theatre 2015 Improvement Project and the Sub-Acute Redesign Project looking at pathways and care coordination.

In addition to the Theatre 2015 Redesigning Care project and TrakPas Patient Management System Replacement, other improvement highlights included:

- CAMMS – Corporate Executive Reporting

→ **Maintenance staff member Rodney Nolte helps maintain beautiful grounds at the new Coleraine Campus.**

→ **Members of the Hamilton Base Hospital maintenance team Doug Johnstone and Ben Taylor painting at The Birches.**

System project completed in August 2013 projected full year savings of $69,000 per annum

- Regional Supply and Logistics model adopted to commence implementation from July 2014
- Theatre Imprest system completed in June 2014 – annual savings $100,000
- Adoption of Regional Intravenous Therapy Strategy and finalisation of a 10 year contract

The year ahead will focus on workflows and processes to support the implementation of the final component of integrated Patient and Client Management System – Trak Community and the continued progress towards the electronic medical record. A significant challenge will continue to be the identification of mobile technology to access systems which do not compromise patient or clinical workflows.

Facilities Management

Facilities Management provides the ongoing maintenance of physical facilities to ensure they are reliable, safe and comply with relevant standards. The significant investment in infrastructure requires a long-term planning approach, which includes major redevelopment and refurbishment and the maintenance of essential plant at all campuses. The Facilities Department also has responsibility for the procurement of capital equipment for the Health Service in accordance with constantly changing product standards and government procurement policies.

The highlight for the year was the completion of the $27m Coleraine Health Precinct ahead of time and under budget. Commenced in August 2011 the project was completed in October 2013 with relocation from the old site undertaken in November 2013 and demolition works at the old site completed in April 2014.

A summary of other major works undertaken is detailed as follows:

- Penshurst Kolor Lodge upgrade – completed August 2013 (cost $520,000)
- Hamilton Medical Group Renovation Stages 1 & 2 – completed May 2014 (cost $1.1m)
- Fire Ring Main, Pumps and Storage Tanks and Fire Sprinkler Protection to the Ground Floor HBH nearing completion (cost $860,000)
- Chiller Upgrade (cost $90,000).
- Completion of 5 Year Carpark Upgrade Strategy – Tyers Street & Education Centre in March 2014 (Total Strategy cost $300,000)
- Birches nurse call system upgraded
- Upgrade to one boiler with energy efficient burner and controls
- Stage 2 conversion of trade workshops to education office accommodation

In February 2012 a 10 Year Capital Investment Strategy covering the period to 2020/21 was completed, identifying capital investments of $120m required in the next 10 years.

The strategy identified that in addition to major works currently underway, the building fabric and functional layout of key service areas at HBH will require substantial investment in the next 5 to 10 years. The most urgent areas which will require significant investment include the Catering Department, Theatre, Emergency Department and the Acute Ward Area.

Master-Plans for the Hamilton Base Hospital and Penshurst Health Service were completed. During the year the Department of Health State Government endorsed the

planning process and the key components of the Capital Investment Strategy.

Sustainable Energy – Carbon & Water Performance

WDHS adopted an Environmental Management Plan in June 2014 with the following objectives:

- Management of water, energy consumption and waste generation
- Preference for procurement of sustainable products and services
- Integration of environmental assessments into key decision making processes

The initial public report against the management plan is required by December 2014.

During the year a boiler upgrade to install an energy efficient burner and associated control system was completed. This upgrade was completed in March 2014 and will reduce gas consumption in operating the boiler by 25% with savings of $12,000 per annum.

In June 2012 WDHS received funding from the Rural Capital Support Fund for the upgrade of the Building Management System at the Hamilton Base Hospital Campus. This upgrade was completed in December 2012 and in August 2013 an extension of the system to enable real time monitoring was installed. On-line energy and water consumption is now available on the WDHS intranet site and supports internal awareness of energy efficiency initiatives.

An assessment of energy consumption required to illuminate passageways within Hamilton Base Hospital was undertaken during the year. As a consequence a project to replace existing lights with LED alternatives identified an investment of $10,500 which would deliver recurrent savings of $1,680 per annum. The very high usage areas identified in the assessment have now been converted for a cost of $2,500 with a payback period of 3 years. The remaining areas will be converted during 2014/15.

Risk Management

WDHS maintains an organisation wide risk register which is reviewed at least 6 monthly by the Board of Directors. Regular risk assessments are conducted and a comprehensive incident reporting system is integrated into the risk register with incidents reported regularly through the Quality Improvement Coordinating Comittee to the Board. The WDHS Business Continuity and External Emergency Preparedness Plans and other emergency protocols are regularly reviewed and updated. A regular risk assessment is undertaken by our insurer VMIA. The Audit and Compliance Committee has an active annual program undertaken in accordance with the Internal Audit Strategy based on an independent risk assessment undertaken every 3 years.

During October 2012 our insurers VMIA conducted a Site Risk Assessment and issued WDHS the highest rating available – ''very good''. The highest medium priority risk identified in the audit was the lack of a fire sprinkler system for bed based services at Hamilton Base Hospital. During the course of this year, WDHS has received funding and has upgraded its fire ring-main and is in the process of installing a sprinkler system throughout Hamilton Base Hospital.

Similarly, in order to provide increased emergency power during a blackout, a new, more powerful emergency generator is being sought for our Penshurst District Health Service Campus.

Infrastructure works and equipment identified as priorities include:

- Lightning protection for buildings at HBH site - $160,000
- Removal of asbestos – HBH site - $250,000
- Replacement of emergency generator Penshurst - $60,000

The Audit & Compliance Committee continues to monitor the adequacy of risk management, accounting procedures, financial reporting and compliance with statutory requirements. The internal audit program was undertaken by RSM Bird Cameron, independent internal auditors contracted by the WDHS Board. Activities undertaken by the internal auditors and the Auditor General agent for the period of July 2013 to June 2014 that required governance from the Audit & Compliance Committee included:

- Audit Committee Approval of WDHS 2012-2013 Annual Finance Statements
- Audit Committee Approval for Appropriation to Reserves for 2012-2013
- Audit Committee Approval for Risk Management Attestation
- Audit Committee Review of 2013/14 Operating Budget Assumptions & Parameters
- Internal Audit Project – Financial Management Compliance Framework.

Hotel Services

Hotel Services comprises departments responsible for Food, Environmental, Linen and Gardens/Grounds, as well as contracted services for Security, Pest Control, Chemicals and General/Prescribed Waste. Of these, Food provides externally-contracted Meals on Wheels Service to the Southern Grampians Shire that generates annual revenue in excess of $275K.

Hotel Services is an integral part of WDHS and continues to pursue excellence in the delivery of quality services to our clients and the broader community by participating in rigorous, on-going external audit examinations, as well as benchmarking exercises against other similar peer-group services.

Achievements during the year included:

- 100% compliance - external food safety audit – January 2014
- Annual external cleaning audit score of 98.7% - February 2014
- Achieved above the mean-average in all areas in food satisfaction that measured Quantity, Temperature and Quality, in the VPSM state-wide food satisfaction survey for Category B Hospitals, in 2013/2014
- Progressed the implementation of the 5 year Security Audit Action Plan with the completion of 6 of the 10 recommendations
- Completed tender for the Southern Grampians Shire's Meals on Wheels Program for two years from 1 July 2014
- Completed consultancy of non-clinical departments at Beechworth Health Service in January 2014

The long-term, sub-regional linen service alliance with Southwest Healthcare continues to provide a cost-effective alternative to our previous linen service. WDHS continues to act as a hub for the packing and distribution of linen to clients located in the Coleraine, Casterton, Heywood, Portland and Hamilton areas. This vital service has been structured to provide a contemporary and quality service to existing clients for the next ten years and beyond. The service also has the scope to provide linen to new clients.

During January 2014 in line with our ongoing commitment to the provision of services to other health care providers, the WDHS Hotel Services Manager undertook a consultancy of non-clinical departments at the Beechworth Health Service (BHS). The consultancy provided BHS with benchmark data and an Action Plan for the future.

Our Community Partnerships

→ **Volunteer tradesmen working on the Watermark Charity House L-R: Peter McDonald & Michael King from Finchett's, James Jensen & Gary Hearn from GN Hearn Builders and (balcony) Dylan Golding & Laurie Gordan from DJ & I Fitzpatrick with retiree Graeme Smith.**

WDHS values its partnerships with the communities of the Western District. The Health Service's Community Liaison Department has the lead in developing and fostering our community partnerships.

Community Liaison promotes new WDHS programs and services, coordinates fundraising events and initiatives, supports the many volunteers who give their valuable time, and represents WDHS at community events. The commendable image of WDHS is promoted through the media, Annual and Quality of Care Reports, brochures, biannual newsletters and the website.

The goal of the Community Liaison Department is to fully inform the community, increasing awareness of and promoting its involvement with the Health Service. Community Liaison has a commitment to community feedback, which identifies needs and facilitates community participation in the current and future activities of the Health Service.

We thank everyone in the community who has contributed to WDHS, whether financially or in-kind throughout this year.

Fundraising Strategy

WDHS' fundraising is conducted in accordance with the Fundraising Appeals Act 1994, and the Fundraising Institute of Australia Ethical Codes of Fundraising. The total fundraising strategy of the Health Service is guided by the WDHS Development Council, an eleven-member committee including three from the Board of Directors.

The Community Liaison Department manages the overall fundraising strategy on behalf of WDHS. In addition to fundraising events and functions, the department submits applications to philanthropic trusts and foundations to support the Health Service's fundraising efforts. This year, a total of $1.145m was raised.

Key fundraising events in 2013-2014 were the Hospital Door Knock Appeal which raised $60,000, the Christmas Appeal $11,825, and the Murray to Moyne Cycle Relay teams from Hamilton and Penshurst raising $27,200 collectively. The Hamilton Vitality Fun Run and the WDHS Opportunity Shop Golf Tournament raised $7,555 and $14,790 respectively for the Grange Residential Aged Care Facility towards the purchase a new bus and Hamilton Base Hospital medical equipment. WDHS received bequests totalling $549,000 and grants from trusts and foundations totalling $98,505.

Fundraising Activities

WDHS Op Shop Golf Tournament

During November the WDHS Opportunity Shop continued it's sponsorship of the annual WDHS Op Shop Golf Tournament held on the Hamilton Golf Course, by contributing $5,000 towards the event. Around 120 players enjoyed a relaxing fun day which raised $14,790. The funds will be directed to the purchase of new medical treatment recliner chairs for the Day Procedure Unit.

Hamilton Vitality Fun Run

Over 400 participants took part in the 6th Annual Hamilton Vitality Fun Run during November, which raised $7,555 towards the purchase of the Grange bus. Although not the largest fundraiser for WDHS, the Fun Run is a very successful community event which promotes a healthy lifestyle and is steadily growing in popularity.

Christmas Appeal

In December the Hospital Christmas Appeal conducted via letters of request and newsletters sent into the community raised $11,825. The funds were directed to the purchase of a Midas Rex drill. It will be used by our visiting neurosurgeon to perform the following procedures:

- Lumbar discectomy
- Laminectomy
- Anterior cervical discectomy
- Posterior cervical laminectomy

These are all critical procedures used in the treatment of degenerative spinal conditions. The drill can also be used for ear, nose and throat surgery.

Murray to Moyne Cycle Relay
The annual Murray to Moyne Cycle Relay was held in April with a great team of enthusiasts participating. The Hamilton team of 12 riders and a support crew of four took up the challenge and managed to raise a total $17,700, which was used to purchase multiple equipment items for allied health departments across WDHS.

The Penshurst team of nine riders and five support crew again enjoyed a successful event and managed to raise a total of $9,500 for the purchase of new chairs for the Penshurst Campus residents.

Friday Night Drive In
In April 2014, a new event, the ''Friday Night Drive In'' was held to much acclaim. Over 120 vehicles filled with young and old packed the Monivae College Oval to watch ''Free Birds''. The inaugural Drive In raised $4,000 for the purchase of a new 45 degree telescope for the operating theatre. The telescope will provide greater vision for laparoscopic procedures and in particular will facilitate surgical access and vision for bariatric surgery.

WDHS Door Knock Appeal
This year's WDHS Door Knock Appeal in June involved around 120 volunteers door knocking from 14-22 June in the communities of Hamilton, Penshurst, Dunkeld, Branxholme and surrounding rural districts as well as a mail-out. The appeal tally reached $60,000 with most of the funds going towards the purchase of CTG remote viewing technology for a mother/fetus monitoring system. Part of the funds totalling $8,142 was directed to the Penshurst Campus.

Watermark Charity House Project
Since May 2013 WDHS has been managing it's largest fundraising project ever undertaken. The exciting Watermark Charity House Project involves building a magnificent large family home on a prime position overlooking Lake Hamilton, using largely volunteer labour and donated services and materials. It is anticipated that the house will be completed in August and sold during September/ October 2014. The net proceeds of sale will be utilised by the Hamilton Base Hospital to upgrade equipment in the operating theatres, emergency and intensive care units. Apart from providing direct community benefits well into the future, the project has been extremely successful in fostering outstanding community spirit and generosity with over 200 businesses based locally and further afield providing extraordinary support.

Support for Appeals
Many community groups and individuals have provided WDHS with considerable financial and in-kind support throughout the year, including:

RES Australia	$3,000
Birches Auxiliary	$4,245
Mr Michael Krowicky	$4,740
North Hamilton Base Hospital Ladies Auxiliary	$5,000
Rotary Club of North Hamilton	$5,000
Freemasons Public Charitable Fund	$5,000
Hamilton Base Hospital Ladies Auxiliary	$6,000
Estate of Alma Brinkmann	$10,000
Marion Flack Foundation	$12,800
Arthur Thomas Trust	$12,800
Collier Charitable Fund	$22,000
Estate of Gordon Stanley McGregor	$25,000
Coleraine District Health Service Ladies Auxiliary	$30,000
Perpetual Trustees	$40,000
Hamilton & District Aged Care Trust	$42,500
Hospital Opportunity Shop	$64,825
Dr Geoff Handbury AO	$110,000
Estate Of Alec Scott McBride	$513,998

Jacinta and John Hedley of Darriwill Farm provided sponsorship of our Employee of the Month Award, Alexander House sponsored our Volunteer of the Month Award, James Dean Pharmacy provided gift packs for Midwifery private patients and IGA Hamilton contributed via the Community Benefit Scheme.

Our generous donors and supporters are extremely important to WDHS, making it possible to purchase much needed equipment and refurbish our facilities to meet the needs of our community.

We sincerely thank all those who contributed, financially or in-kind throughout the 2013-2014 year. A list of donors contributing $100 or more is shown on page 52.

Auxiliaries and Community Groups
WDHS' five auxiliaries, the Hamilton Base Hospital Opportunity Shop, the Penshurst Opportunity Shop (which closed in early 2014) and the Hamilton & District Aged Care Trust again contributed a great deal to the Health Service. The North Hamilton Ladies' Auxiliary donated $5,000 used to purchase a Welch Allwyn monitor, two digital bed monitors and a Doppler monitor. The Hamilton Base Hospital Ladies' Auxiliary donated $6,000 which was used to purchase a new pelvic tilt chair and an insulation tester for Theatre.

The Hamilton & District Aged Care Trust assisted with grant applications to trusts and foundations for equipment, donated $40,000 as their final pledge towards the Grange redevelopment and a further $2,500 towards the erection of a Gopher Shed at the Grange.

The Coleraine District Health Service Ladies' Auxiliary is continually raising funds for equipment for the newly redeveloped Coleraine Hospital. This year they donated $30,000 which was used to fit out the new Palliative Care Unit at the Coleraine Hospital.

The Coleraine Opportunity Shop donated $1,250 to the Health Service.

Opportunity Shop
The Hamilton Base Hospital Opportunity Shop is open five days each week from 10:00am-4:00pm and is staffed by up to five volunteers each day. For the 2013-14 year, 4,582 hours were contributed by a team of 20 volunteers. The Opportunity Shop has raised a total of $546,032 since its inception in 1938.

During 2013- 2014 the Hospital Op Shop donated $64,823 used to purchase a Hovermatt Package for Theatre, a Day Procedure Chair, Orthopaedic and Urology Theatre equipment.

WDHS is extremely grateful for the excellent contribution made by the hard working auxiliaries and community groups which continue to support the Health Service .

Our Volunteers

WDHS has 298 registered, unpaid volunteers, excluding auxiliary members, who give their valuable time and skills to support our patients, residents and clients across the Health Service. Volunteers are recruited through an interview process managed by the Volunteer Coordinator to determine where their skills, experience and interests may be best used. All volunteers undergo a police check and a comprehensive orientation program before commencing service.

Volunteers visit residents at our aged care facilities to provide companionship, escort them to appointments, help with shopping and recreational activities such as cooking, gardening, playing cards, music, having manicures, hair sets, wheelchair walks and outings. They also assist activity coordinators and occupational therapy staff in regular activities, including the Men's Out and About Program which provides interaction for male residents between campuses.

→ **Competitors at the start of the 2013 Hamilton Vitality Fun Run.**

The Health Service relies heavily on the support of all its volunteers and we acknowledge and appreciate their dedication and tireless contribution to improving the lives of people we provide services to.

Volunteers Hours of Service in 2013-2014
Seventeen volunteers provided 928 hours of support to the Grange Residential Care Service.

Seventeen volunteers provided 320.25 hours of support to The Birches.

Seventeen volunteers provided 1,015 hours of support to Penhurst Campus residents through individual and group visits, activities, excursions and gardening.

Twelve volunteers provided 453.5 hours of support at Wannon Court and Mackie House in Coleraine. Three volunteers support the Planned Activity Group (PAG) for 12 hours each week and two volunteers assist in the nursing home at Coleraine with one volunteer supporting the Mens Out and About program for 6 hours each month.

The Merino Community Health Centre is supported by 17 volunteers.

The Planned Activity Group 'Charm' in Hamilton and Penshurst received 642 hours of support from 13 volunteers assisting with transport, meals, activities and an annual three-day trip.

Eleven volunteers worked 450 hours to provide a comforts' trolley service to Hamilton Base Hospital inpatients.

Over 100 volunteers donated in excess of 300 hours to collect donations during the annual WDHS Door Knock Appeal. Students from Baimbridge College and The Hamilton and Alexandra College also volunteered as Door Knock Appeal collectors.

A new program for volunteers visiting Hamilton Base Hospital Medical and Surgical wards commenced providing supplementary services and support to professional staff, carers and families to enhance the patients' experience at WDHS. They also socialize with patients to help reduce their loneliness and isolation within the acute hospital. These volunteers are easily identified by their bright pink polo shirts and are very well received by the patients who look forward to their visits. They are particularly popular in the dialysis area where patients are sitting for long hours. During 2013-2014 seven volunteers provided 639.9 hours volunteering in the Medical and Surgical wards of the hospital.

Volunteer Support for Fundraising
WDHS receives help from registered volunteers in its fundraising program separate from auxiliary committees. Their hours of assistance included:

- WDHS Op Shop Golf Tournament – 90 hours
- Hamilton Vitality Fun Run - 30 hours

Community Transport Program
The Hamilton Community Transport Program had 50 volunteer drivers and seven escorts assisting the Health Service in 2013-2014. The volunteers contributed 3,643.5 hours of service and made 2,137 trips travelling a total of 173,160 kilometres.

The majority of clients are from Hamilton and district, however the program will provide transport for clients living further afield if they are unable to access transport in their region. The program takes clients to medical appointments locally and to

Life Governors

Baxter CJ
Beggs HN
Boyle J
Broers M
Brumby A
Bunge B
Bunge R
Burgin E
Clifforth S
Dean J
Duff S
Edmonds J
Fleming JD
Ford D
Fraser M
Fraser T
Gaussen D
Gardiner PD
Gubbins J
Gumley F PSM
Gurry AJ
Handbury G AO
Heazlewood P
Hickleton E
Holmes ES
Hope M OAM
Hutton T
Kanoniuk M
Kruger N
Langley C
Lawson V
Linke N
Lyon E
McLean M
Morrison HM
Murray EM
Northcott J
Rabone M
Rensch T
Robertson M
Ross J
Runciman P
Ryan D
Scaife C
Scaife S
Scullion E
Templeton H
Thornton A
Turner J
Walker O
Wallis V
Walter R AM
Wettenhall HM
Wettenhall M
Wraith L

NOTE: A full list of Life Governors, inluding those who are deceased, is available from the Community Liaison Department at the Hamilton Base Hospital Campus

→ **Members of the Hamilton Base Hospital Ladies Auxiliary with WDHS Theatre Manager, Rachal Porter take time out to discover how equipment purchased with their annual donation is used.**

services in Ballarat, Warrnambool, Geelong, Horsham, Portland and Mt Gambier. As many as four trips each week are provided to Melbourne hospitals for appointments and admission. Clients are regularly delivered to Melbourne hospitals including The Alfred, The Austin, St Vincent's, The Royal Melbourne, The Royal Women's, The Royal Children's, Peter McCallum, the Eye and Ear, and to orthopaedic surgeon, Mr Ric Cunningham in Heidelberg.

Drivers also transport clients to the Hamilton PAGs program four days each week and fortnightly to the Penshurst PAG program. Volunteer escorts accompany residents from the Grange Residential Care Service to medical, radiology and dental appointments.

The Coleraine Community Transport program was supported by 30 volunteers who made 915 trips totalling 28,182 kilometres and 1,284 hours, enabling clients to attend local activities and medical appointments.

The Palliative Care Program

The following is a summary of contact hours and activities for WDHS Palliative Care Volunteer Service registered volunteers for the 2013-2014 year:

- We received 3 referrals for palliative care volunteer support and provided support for 2 clients
- Volunteer support / visiting hours totalled 125 hours
- One client received a weekly visit from a volunteer for company, walks, drives and visiting a café. The client reported that he was very happy with his volunteer and enjoyed her company
- A second client requested volunteer assistance to walk his dog. Three volunteers assisted for 35 weeks until the client passed away and other arrangements were made for the dog

New Volunteer Services

Buddy 4 You

This is a joint initiative between WDHS and the Southern Grampians Shire, with WDHS eventually taking over the program. The aim of this new program is to provide opportunities to develop friendships and reduce loneliness for the Shire's isolated senior residents.

Six clients have been referred to Buddy 4 You of which 4 have been set up with a volunteer buddy. During 2013-2014 the volunteers contributed a total of 32 hours of service to the program.

Delta Dog Program

In August 2013 we were fortunate to recruit Stan Deane, the first local volunteer to take his Labrador Tessa and Collie Jill through the Delta Dog Therapy program, which supports volunteers and their special dogs to make regular visits to health care facilities. To be approved as a volunteer Delta Dog, all animals must be vet checked and temperament tested in Geelong by the Delta Society.

Stan visits the Hamilton based aged and acute areas of our Health Service on a weekly basis and during 2013 -2014 has provided 70.5 hours of his time to enrich the lives of our patients, residents and clients. The program gives clients an opportunity to interact with Stan's dogs, which are greatly appreciated by all who come into contact with them.

Dr Kristabel Lewis from Hamilton Animal Health is supporting the program by providing free vet checks and samples to Gribbles Pathology every three months, for participating dogs.

Administration Support

Four volunteers provided 64 hours of administrative support to the Community Liaison Department.

Volunteering Awards 2013 - 2014

- Dan Tehan National Volunteer Awards – Group Volunteer Award – Hospital Opportunity Shop
- 'The Charlie Watt Volunteer of the Month Award' was presented to the following volunteers in recognition of their support and loyalty to the Health Service and outstanding volunteering achievements:
  - **July:** Roma Tully – Hamilton Base Hospital & Aged Care
  - **August:** Tony Auden - Penshurst Campus gardener
  - **September**: Marie Kinnane – Coleraine Campus Aged Care
  - **October:** Eric & Jan Collins – Hamilton Community Transport, Consumer & Friends Network, Op Shop
  - **November:** Gail Darling – Grange Residential Aged Care Facility
  - **December:** Leonie Jacobson – Hamilton Base Hospital
  - **January:** Janet Shalders - Penshurst Campus & The Birches
  - **February:** Neil & Rosemary Sandford – Community Transport & Palliative Care
  - **March:** Barbara Botterill - Merino Campus & Community Transport
  - **April:** Ron Sommerville – Murray to Moyne Cycle Relay
  - **May:** Dot Donaldson – Grange Residential Aged Care Facility & Hospital Op Shop
  - **June:** Joy Darroch – Hospital Door Knock Appeal

Appreciation

The staff of the Community Liaison Department extend their sincere appreciation to the WDHS auxiliaries, the Op Shop, Hamilton Aged Care Trust, Murray to Moyne Cycling teams, community groups, local businesses, trusts and foundations, WDHS staff, volunteers and many local individual donors for their outstanding support during 2013-2014. Clearly, we are able to continue to provide high calibre service to our community because of your generosity and commitment and we thank you all for your ongoing contribution.

Our Donors

Donations over $100

Mr and Mrs Barrie Aarons
Mrs Sandra Adams
Mr and Mrs John Addinsall
Mrs Joyce Alexander
Mr and Mrs Terry Arkcoll
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Mr and Lady D Bailey
Ms Sarah Baker
Bank of Melbourne
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Mr and Mrs K Beaton
Mr and Mrs Robert & Margie Beggs
Bendigo Community Bank, Dunkeld
Bendigo Radiology
Beveridge Agriculture
Birches Auxiliary
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Mrs Isobel K Boyd
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Miss Elizabeth Britten
Miss Patricia Britten
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Mrs Mary-Ann Brown
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Mr and Mrs Henry R Cameron
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Ms Caroline Coggins
Dr Geoffrey Coggins
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Coleraine Opportunity Shop
Construction Industry Services
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The Reverend Peter Cook
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Mr Rowan Coote
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Ms Jess Delrayne
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Mr and Mrs Clive Whitehead
Mrs Maree Willey
Mr and Mrs Peter Young
Your Beauty Laser & Spa

Senior Staff

Chief Executive Officer
Jim Fletcher BHA, AFCHSE, CHE, MIPAA, MAICD

Community Liaison Manager
Lachy Patterson BComms (Public Relations) to 14 September 2013
Steve Laidlaw BLaws, Cert IV Training & Assessment from 23 September 2013

Penshurst Manager/Director of Nursing
Alastair Doull DipN, MBA to 6 December 2013
Bronwyn Roberts RN,ICU Cert, Grad Cert Bus Admin, MRCNA from 23 December 2013

Penshurst Unit Manager
Acting - Carolyn Templeton to 12 January 2014
June Morris RN BSci (Nursing) from 13 January 2014

Coleraine Manager/Director of Nursing
Tim Pitt-Lancaster RN BN Cert Peri-Operative Nursing, GradDipNursingSci

Coleraine Unit Manager
Denise Beaton RN RM

Deputy Chief Executive Officer/Director of Corporate Services
Patrick Turnbull BBus, BHA, FCPA

Manager Finance & Budget
Nicholas Starkie BBus DipTS(Bus),GradCertBusAdmin, ASA

Business Support and Innovation Manager
Colin Barrie BE

Hotel Services Manager
Peter Davies BA

Human Resources Manager
Hilary King MBA, Grad Dip HR, Dip Physio, CAHRI

Facility Manager
Trevor Wathen Dip Frontline Mgt, MFAM

Learning and Education Manager
Deborah Smith PGradCert Ed, PGradDipEval, BAAdmin (Hons), Cert IV A&WT to 13 December 2013
Therese Gerber Post GradDipPsych, Cert IV T&A, BAHons(Communications),Cert.ProjectMgt from 3 February 2014

Librarian
Louise Milne ALIA

NURSING SERVICES

Director of Nursing
Janet Kelsh RN, ICUCert, BAppSci(Nadmin), CertMgt(Deakin), GradDipAgedServMgt, MRCNA

Deputy Director of Nursing
Bronwyn Roberts RN, CriticalCareCert, GradCertBusAdmin, MRCNA to 13 December 2013

ADON Aged Care
Katherine Armstrong BA AppSci (Nursing) & Grad Cert BusAdmin. (Acting from February 2014)

ADON Business Manager
Lorraine Hedley RN, BN, MRCNA

ADON Clinical Operations
Judy Esson RN,RM,BN,CertCritCare, GradDipHealth Admin

After Hours Coordinators
Leanne Deutscher RN
Linda Donaldson RN, MRCNA
Dianne Nagorcka RN, RM, Peri-opCert,BN
Jennifer O'Donnell RN, RPN, AdvCertMgt, AdvCertWorkplace Practice Skills to 22 December 2013
Dianne Raymond RN
Kathy Ross RN GradDipCriticalCare
Lesley Stewart RN, Sterilisation&InfectionControlCert, Post Grad Cert Wound Management

Nurse Managers

Unit Manager The Birches
Linda Miller RN, Ba of Applied Science (Nursing), Cert Management, Dip Business Management for Executives, Cert IV Workplace Training Assessment

Unit Manager The Grange
Pam Vince RN, B Health Science (Nursing), Nurse Immuniser, MRCNA, AdvDip Business to 17 November 2013
Carolyn Roe Dip Nursing, Adv Dip OHS, Cert IV Frontline Management, Grad Dip Social Sci to 3 March 2014
Acting - Leanne Donald, B Health Science (Nursing), from 31 March 2014

Unit Manager Medical/ICU/ED
Acting - Leanne Deutscher RN to 16 December 2013
Acting - Julie Stevens RN to 28 April 2014
Aisling Cunningham RN from 28 April 2014

Unit Manager Surgical/Obstetrics/ Paediatrics
Ruth Ikobe RN, Bachelor of Science (Nursing), Master of Science in Nursing

Unit Manager Theatre/CSSD
Rachal Porter RN. Graduate Diploma Perioperative Services to 17 February 2014. (Maternity leave)
Acting - Michelle Walkley, Graduate Diploma of Nursing (Perioperative) from 18 February 2014

REGIONAL PROGRAMS

Infection Control
Mark Stevenson RN, PeriopCert, GradCertBusAdmin, Sterilisation&InfectionControl Cert, Accredited Nurse Immuniser
Carolyn Templeton RN, Sterilisation&InfectionControlCert, CertHIV/HEPCounselling, Accredited Nurse Immuniser

Palliative Care Service
Erika Fischer RN to 7 May 2014
Acting - Sheralyn Ross RN from 12 May 2014

Regional Wound Management
Lesley Stewart RN, Sterilisation &InfectionControlCert, Post Grad Cert Wound Management

MEDICAL SERVICES

Director Medical Services
Dr John Christie Dip. Med. Surg, DTM&H, FAFPHM, FRACMA, MACTM to 29 November 2013
Acting - Dr Bruce Warton RFD, MB,BS,BHA,FRCOG ,FRANZCOG,FRACMA,AFACHSM, DTM&H, Grad Dip Health and Medical Law from 2 December 2013 to 22 April 2014
Dr Nic van Zyl MB ChB, MMed (CH), MBL, PMP from 22 May 2014

Quality Manager
Gillian Jenkins RN Master of Education (Rsch), GradCertBusAdmin, MRCNA

Chief Pharmacist
Lynette Christie M Pharm, MPS, GradCertBusAdmin

Chief Health Information Manager
Carolyn Gellert Grad Dip HSci, BAppSci to 28 March 2014

SENIOR MEDICAL STAFF

Anaesthetics (Director)
James Muir MBChB, FRCA

Specialist Anaesthetics
Doug Paxton MBBS, FCARSI, FANZCA
Michael Shaw MBBS, FANZCA, FRCA
Roger Skilton MBBS, MRCP,MRCGP, FRCA to 22 April 2014

Anaesthetists in General Practice
Craig deKievit MBBS, DRANZCOG, FACRRM
Kim Fielke MBBS, DRANZCOG, DA (UK), FRACGP
Stuart Perry MBBS

General Practitioners
Mohamed Abdullah MBBS
Syed Ansari MBBS, FSC
Victoria Blackwell MB, ChB, MRCGP, DRCOG, DFFP
Brian Coulson MBBS, FACRRM, Dip O&G
Craig deKievit MBBS, DRANZCOG, FACRRM
Dale Ford MBBS, FRACGP, FACRRM
Allan Mark Johnson MBBS(HON)
Robey Joyce MB, ChB (Pretoria)

Anita Lindell BMBS to 23 December 2013

Andrew McAllan MBBS, MMed (Ophth) FRACGP

Nazar Osman BMBS

Stuart Perry MBBS BMBS, FRACGP, DCH, BSc(Biomedical),JCC Anaesthesia

Greta Prozesky MB, ChB, FRACGP

Shaun Renfrey MBBS, FRACGP, Grad Dip Rural Health

Susan Robertson MBBS, DipRACOG, FRACGP, DipPallCare, Dip Obs,

Robert Scaife MBBS, FACRRM

Jan Slabbert MB, ChB (Free State), FRACGP, RACGP

Ramin Tatteri MBBS

Linda Thompson BMS, FRACGP

Sharma Kaipa Tripura MD, FHM to December 2012

Leesa Walker MBBS, FRACGP

Anthony Wark MBBS, FACRRM

General Practitioner Registrar

Parbati Gurung MBBS

Dentists

David Baring BDSc

Timothy Halloran LDS,BDSc

(Steven) Jiwen Sun BDSc

Dermatologist

Julie Wesley RFD, MBBS, FACD to December 2013

Visiting Emergency Physicians

Bruce Bartley MBBS, FACEM, FRCSE

Anna Davis MBBS, FACEM

David Eddey MBBS, Dip RACOG, DTM+H, FACEM

Georgina Hayden MBBS, ACEM

Ameera Khan MBBS, FACEM

Chris Mobbs MBBS, FACEM

Jean Moller MBBS, FCEM, B.Med Sc

Michael Ragg MBBS, Dip RACOG, FACEM

Tom Reade MBBS, B.Med Sc, FACEM

Nicole Reid MBBS, DRANZCOG, FACEM

Michael Sheridan MB ChB, MRCP, FCEM

Julian Stella MBBS, FACEM

Endocrinologist

Fergus Cameron B Med Sci, MD, BS, Dip RACOG, FRACP

General Surgeons

Stephen Clifforth MBBS, FRACS

Uvarasen Kumarswami Naidoo MBcHB, FCS, FRACS

Peter Tung MBBS, FRACS, FHKAM

Neurosurgery

Caroline Tan FRACS. MBBS from November 2013

Nephrologist

Professor Steven Holt BSc, BBS, PHD, FRCP, FRACP from November 2013

Obstetrician/Gynaecologist

Christopher Beaton MB.ChB, FRANZCOG

Dr Bharat Sandeep Gavankar MBBS, MD, DGO, DA, FRANZCOG

Obstetricians in General Practice

Craig deKievit MBGBS, DRANZCOG, FACRRM

Anita Lindell BMBS to December 2013

Jan Slabbert MB, ChB, (Free State), FRACGP, RACGP

Oncologist

David Ashley MBBS; FRACP; PHS

David Campbell MBBS, FRACP

Ophthalmologist

Robert Harvey MBBS, BSc, FRCOphth from February 2014

Vincent Lee MBBS, MMed, FRACS, FRANZCO

Oral and Maxillofacial Surgeons

Graeme Fowler LDS, BDSc, MDSc, FDSRCPS

Orthopaedic Surgeon

Ric Cunningham MBBS, FRACS (ORTH)

Alasdair Sutherland MB, ChB,FRCS Ed,MD(Hons) FRCSEd(Tr & Orth),GMC Registration,CCST,FRACS (Orth) from November 2013

Otolaryngologists

Anne Cass MBBS, FRACS

Paediatrician

Christian Fiedler MD, (KIEL), FRACP

Pathologist

David Clift MBBS, FRCPA

Physicians

Camelia Borta MBBS, FRACP

Andrew Bowman MBChB (Zimb),LRCP(Edin),LRCS(Edin),LRCP&S(Glas),FRCP(UK),CCST(UK),FRACP

Andrew Bradbeer MBBS, FRACP

Trevor Branken MB. ChB (Birm) FCP (Sth Africa)

Geoffrey Coggins MBBS, FRACP

Weerasinghe Wimal Weerasinghe MBBS, DCH,MD, MRCP, FCCP

Radiologists

Margaret Bennett MBBS, FRANZCR

Damien Cleeve MBBS, FRACR

John Eng MBBS, FRANZCR

Robert Jarvis MBBS, FRACR

Sarah Skinner BMBS, Flinders University SA

Dr Julius Tamangani MBChB(Hons), MSc, FRCR

Dr Jill Wilkie BSc(Hons), MBBS, MRCP, FRCR

Urologists

Richard Grills MBBS, FRACS

Hospital Medical Officers (visiting on rotation)

Austin Hospital – one surgical registrar

Barwon Health – one general medicine intern, one surgical registrar, two medical registrars

St Vincent's Hospital-two general surgical interns, two general medicine interns

Hospital Medical Officers (employed by WDHS)

Thant Htut MBBS

Farha Hussain MBBS

Fouzia Kashem MBBS

Ratna Koyyalumudi MBBS

Prakruthi Lakshman MBBS

Farideh Lashkary MBBS

Zannatun NUR MBBS

Hafiz Ziaullah MBBS

PRIMARY & PREVENTATIVE HEALTH

Director Primary & Preventative Health

Rosie Rowe BNatRes, MBA, GAICD

Manager, Primary Care Services

Belinda Payne, GradDipBus

Manager, Care Coordination

Usha Naidoo, MSc, BSocSc, RN, DipOncol, DipMgt

Manager, District Nursing

Pat O'Beirne RN, RM

Chief Dietitian

Jodie Nelson BHSc(Nutrition&Dietetics) to 16 May 2014 (Maternity leave)

Acting - Jessica Nobes from 19 May 2014

Chief Occupational Therapist

Fran Patterson BAppSci (O.T), Dip VET

Chief Physiotherapist

Tatum Pretorius BSc (Physio) to 20 December 2013 (Maternity leave)

Acting - Lauren Richardson BSc (Physio) to 30 June 2014

Speech Pathologist

Sue Cameron BAppSc(SpeechPath), MSPAA

Senior Social Worker

Rinu Thomas B.Com, MSocialWrk to 17 February 2014 (Maternity leave)

Acting – Beth Bryan BSocWrk from March 2014

Senior Podiatrist

Phuong Huynh MSc, BAppSci(Pod), MAPodA, AAPSM

PRIMARY CARE PARTNERSHIP

Executive Officer

Janette Lowe MBA, BEng

NATIONAL CENTRE FOR FARMER HEALTH

Director, National Centre for Farmer Health

Clinical Associate Professor Susan Brumby RN, DipFMgt, GDipWomen's Studies, MHM, Cert IV (Assessment and Training), GAICD, AFCHSE, MACN,

Sustainable Farm Families Program Manager

Cate Mercer-Grant GCAHM, B.Bus (Marketing) B. Bus (Property Valuations), Certificate IV (Training and assessment), FAIM, AMAMI, MAICD

Statement of Priorities Agreement

Strategic Priorities for 2013-14

The Victorian Government's priorities and policy directions are outlined in the Victorian Health Priorities Framework (VHPF) 2012-2022.

In 2013/14 WDHS contributed to the achievement of the priorities by:

VHPF PRIORITY	HEALTH SERVICE STRATEGY	DELIVERABLES	OUTCOMES
Developing a system that is responsive to people's needs	Implement formal advanced care planning structures and processes that provide patients with opportunities to develop, review and have their express preferences for future treatment and care enacted	Review of policies and procedures	Completed
		Implementation of on line education packages for clinical staff	Completed
		Development of end of life care plan template	Terms of reference developed and implementation in progress
	In partnership with other local service providers apply existing service capability, frameworks to maximise the use of available resources across the catchment	Implementation of the South West Dental Service model in collaboration with South West Healthcare and Portland District Health under the management of South West Healthcare	WDHS Dental Clinic established under a Sub Regional model from 6/1/2014
Improving every Victorian's health status and experiences	Improve the thirty–day unplanned re-admission rate	Complete detailed analysis of unplanned admissions and audit of referrals and care pathways to HARP, Home Referral and HITH Programs	Analysis completed with no instances identified that should or could have been referred to other care pathways. Only 2 patients with a chronic condition (MS) admitted to hospital. Both were unpreventable admissions.
	Use consumer feedback to improve person and family centred care and patient experience	Hold four Consumer and Friends Network forums and develop a Consumer Participation plan	Four forums held on Aged Care, Disability, Mental Health and Advanced Care Planning. Consumer Participation Plan released.
Expanding service, workforce and system capacity	Build workforce capability and sustainability by supporting formal and informal clinical education and training for staff and health students, in particular inter-professional learning.	Delivery of National Centre for Farmers Health/Deakin Agriculture Health and Medicine unit	Completed with 15 students bringing the total over 5 years to 102
	Optimise workforce productivity through identification and enhancement of workforce models that enhance individual and team capacity and support flexibility	Pilot and evaluate the implementation of team nursing model for Hamilton Base Hospital accute services	Completed
	Develop and implement a workforce immunisation policy that builds capacity and aligns with national guidelines, including reference to employment screening and staff immunisation assessment	5% improvement to staff immunisation rate	72% achieved – 14 % improvement
Increasing the system's financial sustainability and productivity	Reduce variations in Health Service administration costs	Completion of Operating Theatre supply chain project including evaluation of post implementation cost savings	Completed with evaluation of cost savings to be completed during 2014/15
Implementing continuous improvements and innovation	Develop and implement improvement strategies that optimise access, patient flow, system coordination and the quality and safety of hospital services	Completion of emergency care improvement and innovative clinical network project on improving the care and management of deteriorating patients	Completed with four improvements implemented
	Develop and implement strategies that support service innovation and co-design	Completion of the sub acute redesigning care project	Completed
Increasing accountability & transparency	Prepare for the National Safety and Quality Health Service Standards as applicable	Implementation of WDHS National Standards action plan in preparation for organisational wide accreditation survey in October 2013	Completed with all 207 core standards met with 12 met with merit. All Community Care Standards met Full accreditation achieved for 3 years
Improving utilisation of e-health and communications technology.	Maximise the use of ICT infrastructure	Participate in the development and progression of the implementation plan for a new community health client record system for the South West	Implementation of new community client record system well advanced with implementation planned for 1/11/14
	Work with partners to better connect services to rural and regional Victoria	Expand the use of Telehealth	Telehealth Urology Clinic expanded to Warrnambool Telehealth Pain Management Clinic extended to Coleraine Stroke Telehealth Project with Barwon Health completed Participation in Strengthening Health Services Telehealth Project

Service Performance

Financial Performance

KEY PERFORMANCE INDICATOR	TARGET	2013/14 ACTUAL
OPERATING RESULT		
Annual operating result ($m)	$32k	$89k
WIES (1) ACTIVITY PERFORMANCE		
Percentage of WIES (public & private) performance to target	100	102
CASH MANAGEMENT		
Creditors	< 60 days	38 days
Debtors	< 60 days	68 days

(1) WIES is Weighted Inlier Equivalent Separation

Access Performance

KEY PERFORMANCE INDICATOR	TARGET	2013/14 ACTUAL
EMERGENCY CARE		
Percentage of operating time on hospital bypass	3	0
Percentage of ambulance transfers within 40 minutes	90	100
NEAT - Percentage of emergency presentations to physically leave the emergency department for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours (July – December 2013)	75	89
NEAT - Percentage of emergency presentations to physically leave the emergency department for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours (January – June 2014)	81	91
Number of patients with a length of stay in the emergency department greater than 24 hours	0	0
Percentage of Triage Category 1 emergency patients seen immediately	100	100
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80	96

Service Performance

KEY PERFORMANCE INDICATOR	2013/14 ACTUALS
Quality and safety	Full compliance
Health service accreditation	Full compliance
Residential aged care accreditation	Full compliance
Cleaning standards	98.7%
Submission of data to VICNISS (1)	Full compliance
Health care worker immunisation - influenza	72
Hand Hygiene (rate)	80
Victorian Patient Satisfaction Monitor: (OCI) (2) (July to December 2013)	82
Consumer Participation Indicator (3) (July to December 2013)	82
Victorian Hospital Experience Measurement Instrument (4) (January to June 2014)	N/A
People Matter Survey	N/A
MATERNITY	
Percentage of women with prearranged postnatal home care	100

Activity Performance

FUNDING TYPE	TARGET	2013/14 ACTIVITY ACHIEVED
ACUTE ADMITTED		
WIES Public	3,485	3,553
WIES Private	1,043	1,051
WIES (PUBLIC AND PRIVATE)	4,528	4,604
WIES DVA	215	206
WIES TAC	29	18
WIES TOTAL	4,772	4,828
ACUTE NON-ADMITTED		
Rehab Public	1,803	1,489
Rehab Private	25	225
Rehab DVA	146	164
GEM Public	1,346	551
GEM Private	25	92
GEM DVA	92	162
Palliative Care Public	451	423
Palliative Care Private	36	92
Palliative Care DVA	25	51
SUB ACUTE NON-ADMITTED		
Hospital Admission Risk Program (HARP)	1,031	1,997
Transition Care – Beddays	1,095	836
Transition Care – Homeday	1,460	1,175
SACS	5,660	5279
SACS DVA		170
Palliative Care Community		841
AGED CARE		
Residential Aged Care	42,669	37,348
HACC	45,380	46,424
PRIMARY HEALTH		
Community Health / Primary Care Programs	3,908	3,963
SMALL RURAL		
Small Rural Primary Health	817	544
Small Rural Residential Care	19,165	16,171
Small Rural HACC	5,340	6,803

(1) VICNISS is the Victorian Hospital Acquired Infection Surveillance System

(2) The target for the Victorian Patient Satisfaction Monitor is the Overall Care Index (OCI) which comprises six categories

(3) The Consumer Participation Indicator is a category of the Victorian Patient Satisfaction Monitor

(4) The Victorian Health Experience Measurement Instrument (VHEMI) will succeed the VPSM as the instrument for measuring patient experience.

Legislative Compliance

CONSULTANCIES > $10,000				
CONSULTANT	PURPOSE OF CONSULTANCY	TOTAL APPROVED PROJECT FEE (ex. GST)	EXPENDITURE 2013-14 (ex. GST)	FUTURE EXPENDITURE (ex. GST)
Aurecon Australia	Coleraine Redevelopment	76,705	76,705	-
Aquenta Consulting	Coleraine Redevelopment	40,154	40,154	-
Balcombe Griffiths	Coleraine Redevelopment	141,225	141,225	
Michael Rhook (Health Economics Consultant)	Costing Compliance	33,119	33,119	-
Department of Treasury	Revaluation	45,300	45,300	-
Mirus Australia	ACFI Review	54,000	54,000	54,000
Total		**390,503**	**390,503**	**54,000**

Financial Management Act 1994

In accordance with the Direction of the Minister for Finance part 9.1.3 (IV), information requirements have been prepared and are available to the relevant Minister, Members of Parliament and the public on request.

Fees

WDHS charges fees in accordance with the Commonwealth Department of Health and Aged Care, the Commonwealth Department of Family Services and the Department of Health (Vic) directives, issued under Regulation 8 of the Hospital and Charities (Fees) Regulations 1986, as amended.

Competitive Neutrality

All competitive neutrality requirements were met in accordance with Government costing policies for public hospitals.

Consultancies

In 2013-14 WDHS engaged two consultancies where the total fees payable to the consultants were less than $10,000, with a total expenditure of $17,258 (excl GST).

Consultancies greater than $10,000 – refer to the table above.

Freedom of Information (FOI)

Access to documents and records held by WDHS may be requested under the Freedom of Information Act 1982. Consumers wishing to access documents should apply in writing to the FOI Officer at WDHS. This year 81 FOI requests were received. No request was denied. There were no documents for five requests and for all others access was granted in full.

Declarations of Pecuniary Interest

All necessary declarations have been completed. Refer to Note 24 of the Financial Statements.

Building and Maintenance

All building works have been designed in accordance with DOH Capital Development Guidelines and comply with the Building Act 1993, Building Regulations 2006 and Building Code of Australia relevant at the time of the works.

Buildings Certified for Approval

- A certificate of final inspection was issued on 29th January 2014 for Stage 2 of the Education Offices refurbishment (formerly ex- trade workshops).
- A certificate of final inspection was issued on 29th January 2014 for the main electrical switchboard room.
- A certificate of final inspection was issued 25th July 2013 for the completion of Stage 2 of works to the Hamilton Medical Clinic.
- A certificate of final inspection was issued on 16th September 2013 for fire safety improvements at The Grange.
- A certificate of final inspection was issued on 29th January 2014 for the refurbishment of Kolor Lodge, Penshurst.
- An occupancy certificate was issued on 10th October 2013 for the new Coleraine Hospital.

Building works 2013-14

The Coleraine Hospital redevelopment was completed in October 2013 with occupation and relocation from the old site completed in November 2013. Demolition of the old Coleraine Hospital was completed in April 2014.

The new fire ring main and installation of sprinklers into the bed based services at the Hamilton Base Hospital commenced during July 2013. The works are continuing.

Construction of the Watermark Charity House commenced in April 2013 and had tremendous support from local trades, businesses and the community. The project was completed in August 2014.

Infrastructure projects

- Patient Assist upgrade to the Hamilton Base Hospital Nurse Call System completed in August 2013.
- Birches Nurse Call System upgraded in November 2013.
- Rebuild to main Chiller Plant at the Hamilton Base Hospital completed in April 2014.
- Hamilton Medical Group / Education Centre car park resealed in February 2014.
- Tyers Street car park resealed in March 2014.
- Upgrade to one boiler with energy efficient burner and controls completed at the Hamilton Base Hospital in March 2014.
- Final top coat seal to rear car park at the Penshurst Campus completed in April 2014.
- Vinyl replacement to the Penshurst Campus kitchen completed in April 2014.
- Rendering of external walls of the Hamilton Medical Clinic completed in May 2014.

Carers Recognition Act 2012

The Carers Recognition Act 2012 recognises, promotes and values the role of people in care relationships. WDHS understands the different needs of people in care relationships and that care relationships bring benefits to the patients, their carers and to the community. WDHS takes all practicable measures to ensure that its employees, agents and carers have an awareness and understanding of the care relationship principles and this is reflected in our commitment to a model of patient and family centred care and to involving carers in the development and delivery of our services.

Protected Disclosure Act 2012

WDHS has in place appropriate procedures for disclosure in accordance with the Protected Disclosure Act 2012. No protected disclosures were made under the Act in 2013/2014.

Attestation on Data Integrity

I, Jim Fletcher, certify that WDHS has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. The Health Service has critically reviewed these controls and processes during the year.

Jim Fletcher

CHIEF EXECUTIVE OFFICER

6 August 2014

Attestation for compliance with the Ministerial Standing Direction 4.5.5.1 - Insurance

I, Jim Fletcher certify that the Western District Health Service has complied with Ministerial Direction 4.5.5.1 - Insurance.

Jim Fletcher

CHIEF EXECUTIVE OFFICER

6 August 2014

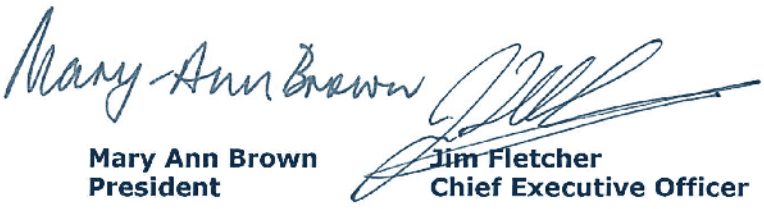
Board member's, accountable officer's and chief finance & accounting officer's declaration

We certify that the attached financial statements for Western District Health Service has been prepared in accordance with Standing Direction 4.2 of 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 notes, presents fairly the financial transactions during the year ended 30 June 2014 and the financial position at that date of Western District Health Service as at 30 June 2014.

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

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



Mary Ann Brown
President

Hamilton
6 August 2014

Jim Fletcher
Chief Executive Officer

Hamilton
6 August 2014

Pat Turnbull
Chief Finance and Accounting Officer

Hamilton
6 August 2014

Disclosure Index

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

Note: This Disclosure Index consists of 1 page, and is not required to be completed by denominational hospitals.

LEGISLATION	REQUIREMENT	PAGE REFERENCE
MINISTERIAL DIRECTIONS		
Report of Operations		
CHARTER AND PURPOSE		
FRD 22E	Manner of establishment and the relevant Ministers	3, 17, 84
FRD 22E	Objectives, functions, powers and duties	2, 12
FRD 22E	Nature and range of services provided	19
MANAGEMENT AND STRUCTURE		
FRD 22E	Organisational structure	36
FINANCIAL AND OTHER INFORMATION		
FRD 10	Disclosure index	59
FRD 11A	Disclosure of ex gratia expenses	NA
FRD 12A	Disclosure of major contracts	57
FRD 21B	Responsible person and executive officer disclosures	84
FRD 22E	Application and operation of Protected Disclosure 2012	57
FRD 22E	Application and operation of Carers Recognition Act 2012	57
FRD 22E	Application and operation of Freedom of Information Act 1982	57
FRD 22E	Compliance with building and maintenance provisions of Building Act 1993	57
FRD 22E	Details of consultancies over $10,000	57
FRD 22E	Details of consultancies under $10,000	57
FRD 22E	Employment and conduct principles	37-42
FRD 22E	Major changes or factors affecting performance	5-12
FRD 22E	Occupational health and safety	42
FRD 22E	Operational and budgetary objectives and performance against objectives	5-12
FRD 24C	Reporting of office-based environmental impacts	22
FRD 22E	Significant changes in financial position during the year	13-16
FRD 22E	Statement of availability of other information	57
FRD 22E	Statement on National Competition Policy	57
FRD 22E	Subsequent events	84
FRD 22E	Summary of the financial results for the year	6-16
FRD 22E	Workforce Data Disclosures including a statement on the application of employment and conduct principles	6, 38
FRD 25B	Victorian Industry Participation Policy disclosures	NA
FRD 29	Workforce Data disclosures	6, 38
SD 4.2(g)	Specific information requirements	3
SD 4.2(j)	Sign-off requirements	12
SD 3.4.13	Attestation on data integrity	57
SD 4.5.5.1	Ministerial Standing Direction 4.5.5.1 compliance attestation	57
SD 4.5.5	Risk management compliance attestation	33

Financial Statements

FINANCIAL STATEMENTS REQUIRED UNDER PART 7 OF THE FMA		
SD 4.2(a)	Statement of changes in equity	63
SD 4.2(b)	Comprehensive operating statement	62
SD 4.2(b)	Balance sheet	62
SD 4.2(b)	Cash flow statement	63
OTHER REQUIREMENTS UNDER STANDING DIRECTIONS 4.2		
SD 4.2(a)	Compliance with Australian accounting standards and other authoritative pronouncements	64
SD 4.2(c)	Accountable officer's declaration	58
SD 4.2(c)	Compliance with Ministerial Directions	64
SD 4.2(d)	Rounding of amounts	64
LEGISLATION		
Freedom of Information Act 1982		57
Protected Disclosure Act 2001		57
Carers Recognition Act 2012		57
Victorian Industry Participation Policy Act 2003		NA
Building Act 1993		57
Financial Management Act 1994		57

VAGO
Victorian Auditor-General's Office

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INDEPENDENT AUDITOR'S REPORT

To the Board Members, Western District Health Service

The Financial Report

The accompanying financial report for the year ended 30 June 2014 of the Western District Health Service which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board member's, accountable officer's and chief finance and accounting officer's declaration has been audited.

The Board Members' Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independent Auditor's Report (continued)

Independence

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

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of the Western District Health Service as at 30 June 2014 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

Matters Relating to the Electronic Publication of the Audited Financial Report

This auditor's report relates to the financial report of the Western District Health Service for the year ended 30 June 2014 included both in the Western District Health Service's annual report and on the website. The Board Members of the Western District Health Service are responsible for the integrity of the Western District Health Service's website. I have not been engaged to report on the integrity of the Western District Health Service's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in the website version of the financial report.

MELBOURNE
8 August 2014

John Doyle
Auditor-General

Comprehensive Operating Statement For the Year Ended 30 June 2014

	Note	Total 2014 $'000	Total 2013 $'000
Revenue from Operating Activities	2	64,300	64,063
Revenue from Non-Operating Activities	2	1,588	1,535
Employee Expenses	3	(43,555)	(43,255)
Non Salary Labour Costs	3	(3,785)	(3,501)
Supplies & Consumables	3	(6,213)	(5,894)
Property Maintenance & Contract	3	(1,142)	(1,068)
Administrative & ITC Costs	3	(6,396)	(7,173)
Other Expenses	3	(4,708)	(4,591)
Net Result Before Capital & Specific Items		**89**	**116**
Capital Purpose Income	2	5,106	15,254
Impairment of Financial Assets	3	-	-
Depreciation and Amortisation	4	(3,900)	(3,512)
Expenditure using capital purpose income	3a	(149)	(173)
NET RESULT FOR THE YEAR		**1,146**	**11,556**
Other comprehensive income			
Net fair value gains/(losses) on Available for Sale Financial Investments		156	150
Items that will not be reclassified ro net result			
Change in Physical Asset Revaluation Surplus		64,929	-
COMPREHENSIVE RESULT FOR THE YEAR		**66,231**	**11,835**

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

Balance Sheet As at 30 June 2014

	Note	Total 2014 $'000	Total 2013 $'000
Current Assets			
Cash and Cash Equivalents	5	18,305	20,357
Receivables	6	3,521	3,831
Inventories	8	273	262
Non Financial Assets Classified as held for sale	9	360	-
Other Current Assets	10	959	121
Total Current Assets		**23,418**	**24,573**
Non-Current Assets			
Receivables	6	1,100	1,127
Investments and other Financial Assets	7	2,180	1,907
Property, Plant & Equipment	11	140,914	74,226
Intangible Assets	12	1	3
Total Non-Current Assets		**144,195**	**77,263**
TOTAL ASSETS		**167,613**	**101,834**
Current Liabilities			
Payables	13	2,461	3,285
Provisions	14	9,266	9,186
Other Liabilities	15	2,035	2,176
Total Current Liabilities		**13,762**	**14,647**
Non-Current Liabilities			
Provisions	14	1,594	1,515
Other Liabilities	15	3,494	3,140
Total Non-Current Liabilities		**5,088**	**4,655**
TOTAL LIABILITIES		**18,850**	**19,302**
NET ASSETS		**148,763**	**82,532**
EQUITY			
Property, Plant & Equipment Revaluation Surplus	16a	67,366	2,437
Financial Asset Available for Sale Revaluation Surplus	16a	254	98
Restricted Specific Purpose Reserve	16a	4,391	4,007
Contributed Capital	16b	49,535	49,535
Accumulated Surpluses/(Deficits)	16c	27,217	26,455
TOTAL EQUITY		**148,763**	**82,532**
Contingent Assets and Contingent Liabilities	20		
Commitments for Expenditure	19		

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

Statement of Changes in Equity For the Year Ended 30 June 2014

	Note	Property, Plant & Equipment Revaluation Surplus	Financial Asset Available for Sale Revaluation Surplus	Restricted Specific Purpose Surplus	Contributions by Owners	Accumulated Surpluses/ (Deficits)	Total
		$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2012		**2,437**	**(52)**	**8,716**	**49,535**	**10,061**	**70,697**
Net result for the year		-	-	-	-	11,685	11,685
Other comprehensive income for the year	16a	-	150	-	-		150
Transfer to accumulated surplus	16c	-	-	(4,709)	-	4,709	-
						.	
Balance at 30 June 2013		**2,437**	**98**	**4,007**	**49,535**	**26,455**	**82,532**
Net result for the year		-	-	-	-	1,146	1,146
Other comprehensive income for the year	16a	64,929	156	-	-	-	65,085
Transfer to/ from accumulated surplus	16c	-	-	384	-	(384)	-
Balance at 30 June 2014		**67,366**	**254**	**4,391**	**49,535**	**27,217**	**148,763**

This Statement should be read in conjunction with the accompanying notes

Cash Flow Statement For the Year Ended 30 June 2014

	Note	Total 2014 $'000	Total 2013 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		42,991	42,253
Patient and Resident Fees Received		12,076	13,081
Private Practice Fees Received		86	29
GST Received from/(paid to) ATO		1,793	2,830
Interest Received		571	524
Dividend Received		26	24
Other Receipts		7,573	6,227
Employee Expenses Paid		(44,039)	(44,097)
Non Salary Labour Costs		(3,785)	(3,501)
Payments for Supplies & Consumables		(10,744)	(9,931)
Other Payments		(8,754)	(9,486)
Cash Generated from Operations		**(2,206)**	**(2,047)**
Capital Grants from Government		3,439	13,108
Capital Grants from Non-Government		35	18
Capital Donations and Bequests Received		1,145	1,073
Other Capital Receipts		1,393	1,448
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	17	**3,806**	**13,600**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Investments		(273)	(273)
Payments for Non-Financial Assets		(5,921)	(17,472)
Proceeds from sale of Non-Financial Assets		145	594
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		**(6,049)**	**(17,151)**
NET INCREASE/(DECREASE) IN CASH HELD		**(2,243)**	**(3,551)**
Cash and cash equivalents at beginning of financial year		**15,691**	**19,242**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	5	**13,448**	**15,691**

This Statement should be read in conjunction with the accompanying notes

Contents

Note 1: Statement of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for Western District Health Service for the period ending 30 June 2014. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the Financial Management Act 1994 and applicable Australian Accounting Standards (AASs), 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.

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

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

The annual financial statements were authorised for issue by the Audit & Compliance Committee of Western District Health Service on 30/07/2014.

(b) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2014, and the comparative information presented in these financial statements for the year ended 30 June 2013.

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

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

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 these items, that is they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

The Financial Statements are prepared in accordance with the historical cost convention, except for:

• non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed with sufficient regularity to ensure that the carrying amounts do not materially differ from their fair values;

• available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income – items that may be reclassified subsequent to net result).

• the fair value of assets other than land is generally based on their depreciated replacement value.

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 associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

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

» the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 1(k));

» superannuation expense (refer to note 1(h)); and

» actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 1(l).

Consistent with AASB 13 Fair Value Measurement, Western District Health Service determines the policies and procedures for both recurring fair value measurements such as property, plant and equipment, investment properties and financial instruments, and for non-recurring fair value measurements such as non-financial physical assets held for sale, in accordance with the requirements of AASB 13 and the relevant FRDs.

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

» Level 1 – Quoted (unadjusted) market prices in active markets for identical assets or liabilities

» Level 2 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable

» Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

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

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

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

Western District Health Service, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required.

(c) Reporting entity

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

Its principle address is:
20 Foster Street,
Hamilton 3300

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

Objectives and funding
Western District Health Service mission is to meet the health and wellbeing needs of our community by delivering a comprehensive

range of high quality, innovative and valued health services, as well as improve the quality of life to Victorians.

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

(d) Principles of consolidation

In accordance with AASB 127 Consolidated and Separate Financial Statements, the consolidated financial statements of Western District Health Service incorporates the assets and liabilities of all entities controlled by Western District Health Service as at 30 June 2014, and their income and expenses for that part of the reporting period in which control existed. Control exists when Western District Health Service has the power to govern the financial and operating policies of a Health Service so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable are taken into account.

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 dissimilar accounting policies are adopted by entities and their effect is considered material, adjustments are made to ensure consistent policies are adopted in these financial statements.

Bodies consolidated into Western District Health Service reporting entity include:

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

Jointly Controlled Assets
Interests in jointly controlled assets or operations are not consolidated by Western District Health Service, but are accounted for in accordance with the policy outlined in Note 1 (k) Financial Assets.

(e) Scope & presentation of financial statements

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

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

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

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

Residential Aged Care Service
The following Residential Aged Care Services operations are an integral part of the Health Service and share its resources.

- The Birches and Grange Residential Care Service (located in Hamilton)
- Kolor Lodge and W J Lewis Nursing Home (located in Penshurst)
- Valley View Nursing Home and Wannon Hostel (located in Coleraine)

An apportionment of land and buildings has been made based on floor space. The results of the two operations have been segregated based on the actual revenue earned and expenditure incurred by each operation in Note 2b to the financial statements.

The WDHS Residential Aged Care has a separate Committee of Management and is substantially funded from Commonwealth bed-day subsidies.

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

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

- capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer Note 1 (g)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.
- specific income/expense, comprises the following items, where material:
  - Non-current asset revaluation increments/decrements
  - Diminution in investments
- impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), which have been recognised in accordance with Note 1 (k)
- depreciation and amortisation, as described in Note 1 (h)
- assets provided or received free of charge, (refer to Notes 1 (g) and (i)); and
- expenditure using capital purpose income, which comprises expenditure which either falls below the asset capitalization threshold or doesn't meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

Balance Sheet
Assets and liabilities are categorised either as current or non-current (non-current being those assets or liabilities expected to be recovered/settled more than 12 months after reporting period), are disclosed in the notes where relevant.

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

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

For the cash flow statement presentation purposes, cash and cash equivalents includes bank overdrafts, which are included as current borrowings in the balance sheet.

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

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

Comparative Information
Where necessary the previous year's figures have been reclassified to facilitate comparisons.

(f) Change in accounting policies

AASB Fair Value Measurement
AASB 13 establishes a single source of guidance for all fair value measurements. AASB 13 does not change when a health service is required to use fair value, but rather provides guidance on how to measure fair value under Australian Accounting Standards when fair value is required or permitted. The health service has considered the specific requirements relating to highest and best use, valuation premise, and principal (or most advantageous) market. The methods, assumptions, processes and procedures for determining fair value were revised and adjusted where applicable. In light of AASB 13, the health service has reviewed the fair value principles as well as its current valuation methodologies in assessing the fair value, and the assessment has not materially changed the fair value recognised.

AASB 13 has predominantly impacted the disclosures of the health service, It requires specific disclosures about fair value measurements and disclosures of fair values, some of which replace existing disclosure requirements in other standards, including AASB 7 Financial Instruments: Disclosures.

The disclosure requirements of AASB 13 apply prospectively and need not to be provided for comparative periods, before initial application. Consequently, comparatives of these disclosures have not been provided for 2012-2013, except for financial instruments, of which the fair value disclosures are required under AASB 7 Financial Instruments: Disclosures.

AASB 119 Employee Benefits
In 2013-2014, the health service has applied AASB 119 Employee Benefits (Sep 2011, as amended), and related consequential amendments for the first time.

The revised AASB 119 changes the accounting for defined benefit plans and termination benefits. The most significant change relates to the accounting for changes in defined benefit obligation and plan assets. As the current accounting policy is for the Department of Treasury and Finance to recognise and disclose the State's defined benefit liabilities in its financial statements, changes in defined benefit obligations and plan assets will have limited impact on the health service.

The revised standard also changes the definition of short-term employee benefits. These were previously benefits that were expected to be settled within 12 months after the end of the reporting period in which the employees render the related service, however, short-term employee benefits are now defined as benefits expected to be settled wholly within 12 months after the end of the reporting period in which the employees render the related service. As a result, accrued annual leave balances which were previously classified as short-term employee benefits no longer meet this definition and are now classified as long-term employee benefits. This has resulted in a change of measurement for the annual leave provision from an undiscounted to discounted basis.

Western District Health Service considers that this change in classification has not materially altered its measurement of the annual leave provision.

Comparative amounts for 2012-13 and the related amounts as at 1 July 2012 have been restated in accordance with the relevant transitional provisions set out in AASB 119

(g) Income from transactions

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

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

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

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

Indirect Contributions from the Department of Health
- Insurance is recognised as revenue following advice from the Department of Health.
- Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 05/2013 (update for 2012-2013).

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

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

Revenue from commercial activities
Revenue from commercial activities such as commercial laboratory medicine is recognised at the time invoices are raised.

Donations and Other Bequests
Donations and bequests are recognised as revenue when received. If donations are for a special purpose, they may be appropriated to a surplus, such as specific restricted purpose surplus.

Dividend Revenue
Dividend revenue is recognised when the right to receive payment is established.

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

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

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

Other income
Other income includes non-property rental, dividends, forgiveness of liabilities, and bad debt reversals.

(h) Expense recognition

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

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

Employee expenses
Employee expenses include;

- wages and salaries;
- annual leave;
- sick leave;
- long service leave; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

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

Defined benefit superannuation plans
The amount charged to the comprehensive operating statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation plans in respect of the services of current Health Service staff during the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan and are based upon actuarial advice.

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

The name and details of the major employee superannuation funds and contributions made by the Health Service are disclosed in note 26: Superannuation.

Depreciation
All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. excludes land assets held for sale, and investment properties). Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

Intangible produced assets with finite lives are depreciated as an expense from transactions on a systematic basis over the asset's useful life. Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health. Assets with a cost in excess of $1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2014	2013
Buildings	2 to 40 Years	2 to 40 Years
Plant & Equipment	8 to 10 Years	8 to 10 Years
Medical Equipment	8 to 10 Years	8 to 10 Years
Computers and Communication	1 to 5 Years	1 to 5 Years
Furniture and Fittings	8 to 10 Years	8 to 10 Years
Motor Vehicles	1 to 5 Years	1 to 5 Years
Intangible Assets	1 to 5 Years	1 to 5 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.

Intangible produced assets with finite lives are depreciated as an expense from transactions on a systematic basis over the asset's useful life.

Amortisation
Amortisation is allocated to intangible assets with finite useful lives on a systematic (typically straight-line) basis over the asset's useful life. Amortisation begins when the asset is available for use, that is, when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. The consumption of intangible non-produced assets with finite useful lives is classified as amortisation.

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the assets concerned are tested as to whether their carrying value exceeds their recoverable amount.

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the asset concerned is tested as to whether its carrying value exceeds its recoverable amount.

Intangible assets with indefinite useful lives are not amortised, but are tested for impairment annually or whenever there is an indication that the asset may be impaired. The useful lives of intangible assets that are not being amortised are reviewed each period to determine whether events and circumstances continue to support an indefinite useful life assessment for that asset. In addition, the Health Service tests all intangible assets with indefinite useful lives for impairment by comparing the recoverable amount for each asset with its carrying amount:

- annually; and
- whenever there is an indication that the intangible asset may be impaired

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

Intangible assets with finite useful lives are amortised over a 10-15 year period. (2013 10-15 years)

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

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

Bad and doubtful debts
Refer to Note 1 (k) Impairment of financial assets.

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

Borrowing costs of qualifying assets
In accordance with the paragraphs of AASB 132 Borrowing Costs applicable to not-for-profit public sector entities, the Health Services continues to recognise borrowing costs immediately as an expense, to the extent that they are directly attributable to the acquisition, construction or production of a qualifying asset.

(i) Other comprehensive income

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

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

Revaluation gains/(losses) of non-financial physical assets
Refer to Note 1 (k) Revaluations of non-financial physical assets.

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

Net gain/(loss) on financial instruments
Net gain/(loss) on financial instruments includes:

- realised and unrealised gains and losses from the revaluations of financial instruments at fait value;
- impairment and reversal of impairment for financial instruments at amortised cost (refer to Note 1 (k); and
- disposals of financial assets and derecognition of financial liabilities

Impairment of non-financial assets
Goodwill and intangible assets with indefinite useful lives (and intangible assets not available for use) are tested annually for impairment and whenever there is an indication that the asset may impaired. Refer to Note (k) Assets.

Revaluations of financial instrument at fair value
Refer to Note 1 (k) Financial instruments.

Share of net profits/(losses) of associates and joint entities, excluding dividends.
Refer to Note 1 (d) Basis of consolidation.

Other gains/(losses) from other comprehensive income
Other gains/(losses) include:

- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

(j) Financial instruments

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

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

The following refers to financial instruments unless otherwise stated.

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

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

Held-to-maturity investments
If the Health Service has the positive intent and ability to hold nominated investments to maturity, then such financial assets may be classified as held-to-maturity. Held to maturity financial assets are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition held-to-maturity financial assets are measured at amortised cost using the effective interest method, less any impairment losses.

The Health Service makes limited use of this classification because any sale or reclassification of more than an insignificant amount of held-to-maturity investments not close to their maturity, would result in the whole category being reclassified as available for sale. The Health Service would also be prevented from classifying investment securities as held-to-maturity for the current and the following two financial years.

The held-to-maturity category includes certain term deposits and debt securities for which the entity concerned intends to hold to maturity.

Available-for-sale financial assets
Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised in 'other comprehensive income' until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in net result for the period. Fair value is determined in the manner described in Note 18.

Financial liabilities at amortised cost
Financial instrument liabilities are initially recognised on the date they originated. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition,

these financial instruments are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in profit and loss over the period of the interest-bearing liability, using the effective interest rate method.

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

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 concerned 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.

(k) Assets

Cash and Cash Equivalents
Cash and cash equivalents recognised on the balance sheet comprise cash on hand and cash at bank, deposits at call and highly liquid investments with an original maturity of 3 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 cash flow statement presentation purposes, cash and cash equivalents include bank overdrafts, which are included as current interest bearing liabilities in the balance sheet.

Receivables
Receivables consist of;

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

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

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

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

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

Investments are classified in the following categories;

- financial assets at fair value through profit & loss;
- held-to-maturity;
- loans and receivables; and
- available-for-sale financial assets.

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

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

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

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

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

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

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

Cost is assigned to land for sale (undeveloped, under development and developed) and to other high value, low volume inventory items on a specific identification of cost basis .

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

Non-financial physical assets classified as held for sale
Non-financial physical assets and disposal groups and related liabilities are treated as current and are classified as held for sale if their carrying amount will be recovered through a sale transaction rather than through continuing use. This condition is regarded as met only when the sale is highly probable, the asset's sale (or disposal group) is expected to be completed within 12 months from the date of classification, and the asset is available for immediate use in the current condition.

Non-financial physical assets (including disposal groups) classified as held for sale are treated as current and are measured at the lower of carrying amount and fair value less costs of disposal, and are not subject to depreciation or amortisation.

Property, Plant and Equipment
All non current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government are transferred at their carrying amount.

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 11 Property, plant and equipment.

The initial cost for non-financial physical assets under finance lease is measured at amounts equal to the 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.

Crown Land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or constructive restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply.

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

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

Cultural, collections, heritage assets and other non-current physical assets that the State intends to preserve because of their unique historical, cultural or environmental attributes are measured at the cost of replacing the asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

Restrictive nature of cultural and heritage assets, Crown land and infrastructure assets
During the reporting period, the Health Service may hold cultural assets, heritage assets, Crown land and infrastructure assets.

Such assets are deemed worthy of preservation because of the social rather than financial benefits they provide to the community. The nature of these assets means that there are certain limitations and restrictions imposed on their use and/or disposal.

Leasehold improvements
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.

Revaluations of non-current physical assets
Non-current physical assets measured at fair value are revalued in accordance with FRD 103E Non-current physical assets. This revaluation process normally occurs at least every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRD's. 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 revenue in the net result.

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

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

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

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

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

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

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

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

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.

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

Disposal of non-financial assets
Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to note 1(i) – 'comprehensive income'.

Impairment of non-financial assets
Goodwill and intangible assets with indefinite lives (and intangible assets not yet available for use) are tested annually for impairment (as described below) and whenever there is an indication that the asset may be impaired.

All other non-financial assets are assessed annually for indications of impairment, except for:

- inventories;
- investment properties that are measured at fair value;
- non-current physical assets held for sale; and
- assets arising from construction contracts.

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

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

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

the present value of the future cash flows expected to be obtained from the asset and fair value less costs to sell.

Investments in jointly controlled assets and operations
In respect of any interest in jointly controlled assets, Western District Health Service recognises in the financial statements:

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

For jointly controlled operations Western District Health Service recognises:

- the assets that it controls;
- the liabilities that it incurs;
- the expenses that it incurs; and
- the share of income that it earns from selling outputs of the joint venture.

Derecognition of financial assets
A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is derecognised when:

- the rights to receive cash flows from the asset have expired; or
- the Health Service retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or
- the Health Service has transferred its rights to receive cash flows from the asset and either:
  (a) has transferred substantially all the risks and rewards of the asset; or
  (b) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

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

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

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowances for doubtful receivables are expensed. Bad debt written off by mutual consent and the allowance for doubtful debts are classified as 'other comprehensive income' in the net result.

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

Where the fair value of an investment in an equity instrument at balance date has reduced by 20 percent or more than its cost price or where its fair value has been less than its cost price for a period of 12 or more months, the financial asset is treated as impaired.

In order to determine an appropriate fair value as at 30 June 2014 for its portfolio of financial assets, Western District Health Service obtained a valuation based on the best available advice using an estimated valuation method provided by a reputable financial institution. This value was compared against valuation methodologies provided by the issuer as at 30 June 2014. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

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.

Net gain/(loss) on financial instruments
Net gain/(loss) on financial instruments includes:

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

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

(l) Liabilities

Payables
Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the health service prior to the end of the financial year that are unpaid, and arise when the health service becomes obliged to make future payments in respect of the purchase of those goods and services. The normal credit terms for accounts payable are usually Nett 30 days.
- statutory payables, such as goods and services tax and fringe benefits tax payables.

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

Borrowings
All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs (refer also to note 1(m) Leases). The measurement basis subsequent to initial recognition depends on whether the Health Service has categorised its borrowings as either, financial liabilities designated at fair value through profit or loss, or financial liabilities at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowings using the effective interest method.

The classification depends on the nature and purpose of the borrowing. The Health Service determines the classification of its borrowing at initial recognition.

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

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

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

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

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

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

- Undiscounted value – if the health service expects to wholly settle within 12 months; or
- Present value – if the health service does not expect to settle within 12 months.

Long Service Leave (LSL)
Liability for LSL is recognised in the provision for employee benefits.

Unconditional LSL is disclosed in the notes to the financial statements as a current liability even where the Health Service does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months.

The components of this current LSL liability are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; and
- Present value – if the health service does not expect to settle within 12 months.

Conditional LSL is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. This non-current LSL liability is measured at present value.

Any gain or loss 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 bond interest rates for which it is then recognised as an other economic flow.

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

The health service recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

On-costs
Provisions for on-costs such as payroll tax, workers compensation and superannuation are recognised together with provisions for employee benefits.

Superannuation liabilities
The Health Service does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the Health Service has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due.

Onerous contracts
An onerous contract is considered to exist when the Health Service has a contract under which the unavoidable cost of meeting the contractual obligation exceeds the estimated economic benefits to be received. Present obligations arising under onerous contracts are recognised as a provision to the extent that the present obligation exceeds the estimated economic benefits to be received.

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

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

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

(m) Leases

A lease is a right to use an asset for an agreed period of time in exchange for payment. Leases are classified at their inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

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

For service concession arrangements, the commencement of the lease term is deemed to be the date the asset is commissioned.

All other leases are classified as operating leases.

Operating leases
Entity as lessor
Rental income from operating lease is recognised on a straight-line basis over the term of the relevant lease.

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

In the event that lease incentives are given to the lessee, the aggregate cost of incentives are recognised as a reduction of rental income over the lease term, on a straight-line basis unless another systematic basis is more appropriate of the time pattern over which the economic benefit of the leased asset is diminished.

Entity as lessee
Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. The leased asset is not recognised in the balance sheet.

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

In the event that lease incentives are received by the lessee to enter into operating leases, such incentives are recognised as a liability. The aggregate benefits of incentives are recognised as a reduction of rental expense on a straight-line basis, except where another

systematic basis is more representative of the time pattern in which economic benefits from the leased asset is diminished.

Leasehold Improvements
The cost of leasehold improvements are capitalised as an asset and depreciated over the remaining term of the lease or the estimated useful life of the improvements, whichever is the shorter.

(n) Equity

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

Transfers of net assets arising from administrative restructurings are treated as contributions by owners. Transfers of net liabilities arising from administrative restructures are to go through the comprehensive operating statement.

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

Financial 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 reserve which relates to that financial asset is effectively realised, and is recognised in the comprehensive operating statement. Where a revalued financial asset is impaired that portion of the surplus which relates to that financial asset is recognised in the comprehensive operating statement.

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

(o) Commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer to note 18) at their nominal value and are inclusive of the goods and services tax ("GST") payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

(p) Contingent assets and contingent liabilities

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

(q) Service concession arrangements

Western District Health Service sometimes enters into certain arrangement with private sector participants to design and construct or upgrade assets used to provide public services. These arrangements are typically complex and usually include the provision of operational and maintenance services for a specified period of time. These arrangements are often referred to as either public private partnerships or service concession arrangements (SCAs).

These SCAs usually take one of two main forms. In the more common form, the Health Service pays the operator over the period of the arrangement, subject to specified performance criteria being met. At the date of commitment to the principal provisions of the arrangement, these estimated periodic payments are allocated between a component related to the design and construction or upgrading of the asset and components related to the ongoing operation and maintenance of the asset. The former component is accounted for as a lease payment in accordance with the lease policy (see Note 1(m)). The remaining components are accounted for as commitments (see Note 1(o)) for operating costs which are expensed in the comprehensive operating statement as they are incurred.

The other less common form of SCA, is one in which the Health Service grants to an operator for a specified period of time, the right to collect fees from users of the SCA asset, in return for which the operator constructs the asset and has the obligation to supply agreed upon services, including maintenance of the asset for the period of the concession. These private sector entities typically lease land, and sometimes state works, from the Health Service and construct infrastructure. At the end of the concession period, the land and state works, together with the constructed facilities, will be returned to the grantor Health Agency.

(r) Goods and Services Tax ("GST")

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case it is recognized

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 9 Financial Instruments	This standard simplifies requirements for the classification and measurement of financial assets resulting from Phase 1 of the IASB's project to replace IAS 39 Financial Instruments: Recognition and Measurement (AASB 139 Financial Instruments: Recognition and Measurement).	1 Jan 2017	The preliminary assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 10 Consolidated Financial Statements	This Standard forms the basis for determining which entities should be consolidated into an entity's financial statements. AASB 10 defines 'control' as requiring exposure or rights to variable returns and the ability to affect those returns through power over an investee, which may broaden the concept of control for public sector entities. The AASB has issued an Australian Implementation Guidance for Not-for-Profit Entities – Control and Structured Entities that explains and illustrates how the principles in the Standard apply from the perspective of not-for-profit entities in the private and public sectors.	1 Jan 2014 (not-for-profit entities)	For the public sector, AASB 10 builds on the control guidance that existed in AASB 127 and Interpretation 112 and is not expected to change which entities need to be consolidated. Ongoing work is being done to monitor and assess the impact of this standard.
AASB 11 Joint Arrangements	This Standard deals with the concept of joint control, and sets out a new principles-based approach for determining the type of joint arrangement that exists and the corresponding accounting treatment. The new categories of joint arrangements under AASB 11 are more aligned to the actual rights and obligations of the parties to the arrangement.	1 Jan 2014 (not-for-profit entities)	Based on current assessment, entities already apply the equity method when accounting for joint ventures. It is anticipated that there would be no material impact. Ongoing work is being done to monitor and assess the impact of this standard.
AASB 12 Disclosure of Interests in Other Entities	This Standard requires disclosure of information that enables users of financial statements to evaluate the nature of, and risks associated with, interests in other entities and the effects of those interests on the financial statements. This Standard replaces the disclosure requirements in AASB 127 Separate Financial Statements and AASB 131 Interests in Joint Ventures.	1 Jan 2014 (not-for-profit entities)	The new standard is likely to require additional disclosures and ongoing work is being done to determine the extent of additional disclosure required.
AASB 127 Separate Financial Statements	This revised Standard prescribes the accounting and disclosure requirements for investments in subsidiaries, joint ventures and associates when an entity prepares separate financial statements.	1 Jan 2014 (not-for-profit entities)	Current assessment indicates that there is limited impact on Victorian Public Sector entities. Ongoing work is being done to monitor and assess the impact of this standard.
AASB 128 Investments in Associates and Joint Ventures	This revised Standard sets out the requirements for the application of the equity method when accounting for investments in associates and joint ventures.	1 Jan 2014 (not-for-profit entities)	Current assessment indicates that there is limited impact on Victorian Public Sector entities. Ongoing work is being done to monitor and assess the impact of this standard.
AASB 1055 Budgetary Reporting	AASB 1055 extends the scope of budgetary reporting that is currently applicable for the whole of government and general government sector (GGS) to NFP entities within the GGS, provided that these entities present separate budget to the parliament.	1 July 2014	[If separate budget is presented to the parliament]: The entity will be required to restate in the financial statements the budgetary information in accordance with the presentation format prescribed in Australian Accounting Standards and explain the significant variances from the original budget. [If separate budget is not presented to the parliament]: This Standard is not applicable as no budget disclosure is required.
AASB 1056 Superannuation Entities	AASB 1056 replaces AAS 25 Financial Reporting by Superannuation Plans. The standard was developed in light of changes in recent years, developments in the superannuation industry and Australia's adoption of IFRS.	1 July 2016	The standard was issued in June 2014. While preliminary assessment has not identified any material impact arising from AASB 1056, further work to assess the impact of this standard will be undertaken.

as part of the cost of acquisition of the asset or part of the expense.

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

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

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

(s) AASs issued that are not yet effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2014 reporting period. DTF 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 2014, 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.

In addition to the new standards above, the AASB has issued a list of amending standards that are not effective for the 2013-14 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. The AASB Interpretation in the list below is also not effective for the 2013-14 reporting period and is considered to have insignificant impacts on public sector reporting.

AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010).

AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards.

2013-1 Amendments to AASB 1049 – Relocation of Budgetary Reporting Requirements.

2013-3 Amendments to AASB 136 – Recoverable Amount Disclosures for Non-Financial Assets.

2013-4 Amendments to Australian Accounting Standards – Novation of Derivatives and Continuation of Hedge Accounting.

2013-5 Amendments to Australian Accounting Standards – Investment Entities

2013-6 Amendments to AASB 136 arising from Reduced Disclosure Requirements

2013-7 Amendments to AASB 1038 arising from AASB 10 in relation to consolidation and interests of policy holders

2013-9 Amendments to Australian Accounting Standards – Conceptual Framework, Materiality and Financial Instruments

AASB Interpretation 21 Levies.

(t) Category Groups

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

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

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

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

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

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

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

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

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

Note 2: Revenue

	HSA 2014 $'000	HSA 2013 $'000	H&CI 2014 $'000	H&CI 2013 $'000	Total 2014 $'000	Total 2013 $'000
Revenue from Operating Activities						
GOVERNMENT GRANTS						
- Department of Health	28,765	22,698	-	-	28,765	22,698
- Victorian Health Funding Pool	14,275	18,145	-	-	14,275	18,145
- Commonwealth Government						
- Residential Aged Care Subsidy	6,465	7,255	-	-	6,465	7,255
- Other	1,632	1,498	-	-	1,632	1,498
Total Government Grants	**51,137**	**49,596**	-	-	**51,137**	**49,596**
INDIRECT CONTRIBUTIONS BY DEPARTMENT OF HEALTH						
- Insurance	67	662	-	-	67	662
Total Indirect Contributions by Department of Health	**67**	**662**	-	-	**67**	**662**
PATIENT AND RESIDENT FEES						
- Patient and Resident Fees (refer note 2b)	2,188	2,235	-	-	2,188	2,235
- Residential Aged Care (refer note 2b)	3,759	3,465	-	-	3,759	3,465
Total Patient & Resident Fees	**5,947**	**5,700**	-	-	**5,947**	**5,700**
COMMERCIAL ACTIVITIES & SPECIFIC PURPOSE FUNDS						
- Private Practice and Other Patient Activities Fees	-	-	86	29	86	29
- Catering	-	-	284	309	284	309
- Laundry	-	-	19	120	19	120
- Cafeteria	-	-	266	276	266	276
- Other (include any unit or fund not stated above)	-	-	6,494	7,371	6,494	7,371
Total Commercial Activities & Specific Purpose Funds	-	-	**7,149**	**8,105**	**7,149**	**8,105**
Total Revenue from Operating Activities	**57,151**	**55,958**	**7,149**	**8,105**	**64,300**	**64,063**
REVENUE FROM NON-OPERATING ACTIVITIES						
Donations & Bequests	-	-	40	-	40	-
Interest & Dividends	-	-	690	732	690	732
Other Revenue from Non-Operating Activities	-	-	858	803	858	803
Total Revenue from Non-Operating Activities	-	-	**1,588**	**1,535**	**1,588**	**1,535**
CAPITAL PURPOSE INCOME						
State Government Capital Grants						
- Targeted Capital Works and Equipment	3,474	13,127	-	-	3,474	13,127
Residential Accommodation Payments (refer note 2b)	443	848	-	-	443	848
Net Gain/(Loss) on Disposal of Non-Financial Assets (refer note 2c)	-	-	68	46	68	46
Net Gain/(Loss) on Disposal of Financial Assets	-	-	16	29	16	29
Capital Interest	-	-	-	131	-	131
Donations & Bequests	-	-	1,105	1,073	1,105	1,073
Total Capital Purpose Income	**3,917**	**13,975**	**1,189**	**1,279**	**5,106**	**15,254**
Total Revenue (refer to note 2a)	**61,068**	**69,933**	**9,926**	**10,919**	**70,994**	**80,852**

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

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

Note 2a: Analysis of Revenue by Source

	Admitted Patients 2014 $'000	RAC incl. Mental Health 2014 $'000	Aged Care 2014 $'000	Primary Health 2014 $'000	Other 2014 $'000	Total 2014 $'000
Revenue from Services Supported by Health Services Agreement						
Government Grants	34,204	9,475	6,201	1,257	-	51,137
Indirect contributions by Department of Health	41	19	5	2	-	67
Patient & Resident Fees (refer note 2b)	1,950	3,759	238	-	-	5,947
Capital Purpose Income (refer note 2)	-	400	-	-	43	443
Total Revenue from Services Supported by Health Services Agreement	**36,195**	**13,653**	**6,444**	**1,259**	**43**	**57,594**
Revenue from Services Supported by Hospital and Community Initiatives						
Commercial Activities and Specific Purpose Funds	-	-	-	-	7,149	7,149
Donations & Bequests	-	-	-	-	40	40
Interest & Dividends	-	-	-	-	690	690
Other	-	-	-	-	858	858
Capital Purpose Income (refer note 2)	-	-	-	-	4,663	4,663
Total Revenue from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**13,400**	**13,400**
Total Revenue	**36,195**	**13,653**	**6,444**	**1,259**	**13,443**	**70,994**

Indirect contributions by Department of Health:

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

Note 2a: Analysis of Revenue by Source (cont.)

	Admitted Patients 2013 $'000	RAC incl. Mental Health 2013 $'000	Aged Care 2013 $'000	Primary Health 2013 $'000	Other 2013 $'000	Total 2013 $'000
Revenue from Services Supported by Health Services Agreement						
Government Grants	32,149	10,122	6,116	1,209	-	49,596
Indirect contributions by Department of Health	368	247	33	14	-	662
Patient & Resident Fees (refer note 2b)	1,853	3,465	382	-	-	5,700
Capital Purpose Income (refer note 2)	-	799	-	-	49	848
Total Revenue from Services Supported by Health Services Agreement	**34,370**	**14,633**	**6,531**	**1,223**	**49**	**56,806**
Revenue from Services Supported by Hospital and Community Initiatives						
Commercial Activities and Specific Purpose Funds	-	-	-	-	8,105	8,105
Interest & Dividends	-	-	-	-	732	732
Other	-	-	-	-	803	803
Capital Purpose Income (refer note 2)	-	-	-	-	14,406	14,406
Total Revenue from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**24,046**	**24,046**
Total Revenue	**34,370**	**14,633**	**6,531**	**1,223**	**24,095**	**80,852**

Indirect contributions by Department of Health:

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

Note 2b: Patient and Resident Fees

	Total 2014 $'000	Total 2013 $'000
Patient and Resident Fees		
Recurrent:		
Acute		
– Inpatients	1,875	1,853
– Outpatients	313	382
Residential Aged Care		
– Generic	3,759	3,465
Total Recurrent	**5,947**	**5,700**
Capital Purpose:		
Residential Accommodation Payments	443	848
Total Capital	**443**	**848**

Note 2c: Net Gain/(Loss) on Disposal of Non-Financial Assets

	Total 2014 $'000	Total 2013 $'000
Proceeds from Disposals of Non-Current Assets		
Plant and Equipment	-	185
Medical Equipment	-	12
Motor Vehicles	127	328
Circulating Linen	-	40
Total Proceeds from Disposal of Non-Financial Assets	**127**	**565**
Less: Written Down Value of Non-Current Assets Sold		
Plant and Equipment	10	137
Medical Equipment	2	21
Motor Vehicles	43	244
Computers & Communications	1	1
Furniture & Fittings	3	
Circulating Linen	-	116
Total Written Down Value of Non-Financial Assets Sold	**59**	**519**
Net gains/(losses) on Disposal of Non-Financial Assets	**68**	**46**

Note 3: Expenses

	HSA 2014 $'000	HSA 2013 $'000	H&CI 2014 $'000	H&CI 2013 $'000	Total 2014 $'000	Total 2013 $'000
Employee Expenses						
Salaries & Wages	37,905	37,452	799	604	38,704	38,056
WorkCover Premium	411	581	-	-	411	581
Departure Packages	19	32	-	-	19	32
Long Service Leave	807	1,095	-	-	807	1,095
Superannuation	3,614	3,491	-	-	3,614	3,491
Total Employee Expenses	**42,756**	**42,651**	**799**	**604**	**43,555**	**43,255**
Non Salary Labour Costs						
Fees for Visiting Medical Officers	3,785	3,501	-	-	3,785	3,501
Total Non Salary Labour Costs	**3,785**	**3,501**	-	-	**3,785**	**3,501**
Supplies & Consumables						
Drug Supplies	1,675	1,318	-	-	1,675	1,318
S100 Drugs	-	-	-	-	-	-
Medical, Surgical Supplies and Prosthesis	3,059	3,010	4	2	3,063	3,012
Pathology Supplies	258	389	-	-	258	389
Food Supplies	1,091	1,046	126	129	1,217	1,175
Total Supplies & Consumables	**6,083**	**5,763**	**130**	**131**	**6,213**	**5,894**
Other Expenses						
Domestic Services & Supplies	807	836	23	61	830	897
Fuel, Light, Power and Water	1,306	1,200	66	72	1,372	1,272
Insurance costs funded by the Department of Health	774	662	-	-	774	662
Motor Vehicle Expenses	-	-	-	-	-	-
Repairs & Maintenance	792	719	20	75	812	794
Maintenance Contracts	328	274	2	-	330	274
Patient Transport	728	699	-	-	728	699
Bad & Doubtful Debts	194	93	-	-	194	93
Lease Expenses	735	862	-	-	735	862
Other Administrative Expenses	6,343	7,036	53	137	6,396	7,173
Audit Fees						
- VAGO - Audit of Financial Statements	35	34	-	-	35	34
- Other	40	72	-	-	40	72
Total Other Expenses	**12,082**	**12,487**	**164**	**345**	**12,246**	**12,832**
Expenditure using Capital Purpose Income	149	173			149	173
Avaliable-for-Sale Financial Assets	-	-	-	-	-	-
Depreciation & Amortisation (refer note 4)	3,900	3,512			3,900	3,512
Total	**4,049**	**3,685**	-	-	**4,049**	**3,685**
Total Expenses	**68,755**	**68,087**	**1,093**	**1,080**	**69,848**	**69,167**

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

Note 3a: Analysis of Expenses by Source

	Admitted Patients 2014 $'000	RAC incl. Mental Health 2014 $'000	Aged Care 2014 $'000	Primary Health 2014 $'000	Other 2014 $'000	Total 2014 $'000
Services Supported by Health Services Agreement						
Employee Expenses	23,877	11,942	3,420	2,286	1,231	42,756
Non Salary Labour Costs	3,785		-	-	-	3,785
Supplies & Consumables	4,276	1,101	352	277	77	6,083
Other Expenses from Continuing Operations	9,099	1,559	804	322	298	12,082
Sub-Total Expenses from Services Supported by Health Services Agreement	**41,037**	**14,602**	**4,576**	**2,885**	**1,606**	**64,706**
Services Supported by Hospital and Community Initiatives						
Employee Expenses	-	-	-	-	799	799
Supplies & Consumables	-	-	-	-	130	130
Other Expenses from Continuing Operations	-	-	-	-	164	164
Sub-Total Expense from Services Supported by Hospital and Community Initiatives (refer note 3b)	**-**	**-**	**-**	**-**	**1,093**	**1,093**
Expenditure using capital purpose income	-	-	-	-	149	149
Depreciation & Amortisation (refer note 4)	2,771	599	140	241	149	3,900
Sub-total Expenditure from Services supported by Health Services Agreement and by Hospital and Community Initiatives	**2,771**	**599**	**140**	**241**	**298**	**4,049**
Total Expenses	**43,808**	**15,201**	**4,716**	**3,126**	**2,997**	**69,848**

Costs are allocated directly to programs for direct-care staff and patient related non salary expenses. Measures of activity based on staff numbers, building utilization, beddays and patient workloads are used to apportion shared direct costs and corporate and domestic overheads between programs.

Note 3a: Analysis of Expenses by Source (Continued)

	Admitted Patients 2013 $'000	RAC incl. Mental Health 2013 $'000	Aged Care 2013 $'000	Primary Health 2013 $'000	Other 2013 $'000	Total 2013 $'000
Services Supported by Health Services Agreement						
Employee Expenses	23,715	11,864	3,411	2,274	1,387	42,651
Non Salary Labour Costs	3,501		-	-	-	3,501
Supplies & Consumables	4,050	1,043	334	263	73	5,763
Other Expenses from Continuing Operations	8,941	1,752	961	384	449	12,487
Sub-Total Expenses from Services Supported by Health Services Agreement	**40,207**	**14,659**	**4,706**	**2,921**	**1,909**	**64,402**
Services Supported by Hospital and Community Initiatives						
Employee Expenses	-	-	-	-	604	604
Supplies & Consumables	-	-	-	-	131	131
Other Expenses from Continuing Operations	-	-	-	-	345	345
Sub-Total Expense from Services Supported by Hospital and Community Initiatives (refer note 3b)	**-**	**-**	**-**	**-**	**1,080**	**1,080**
Expenditure using capital purpose income	-	-	-	-	173	173
Depreciation & Amortisation (refer note 4)	2,495	540	126	217	134	3,512
Sub-total Expenditure from Services supported by Health Services Agreement and by Hospital and Community Initiatives	**2,495**	**540**	**126**	**217**	**307**	**3,685**
Total Expenses	**42,702**	**15,199**	**4,832**	**3,138**	**3,296**	**69,167**

Costs are allocated directly to programs for direct-care staff and patient related non salary expenses. Measures of activity based on staff numbers, building utilization, beddays and patient workloads are used to apportion shared direct costs and corporate and domestic overheads between programs.

Note 3b: Analysis of Expenses by Internal and Restricted Specific Purpose Funds for Services Supported by Hospital and Community Initiatives

	Total 2014 $'000	Total 2013 $'000
Private Practice and Other Patient Activities	380	316
Catering	358	359
Laundry	144	127
Cafeteria	91	121
Property Expenses	120	157
TOTAL	**1,093**	**1,080**

Note 4: Depreciation and Amortisation

	Total 2014 $'000	Total 2013 $'000
Depreciation		
Buildings	2,423	2,151
Plant & Equipment	208	188
Medical Equipment	697	661
Computers and Communication	131	81
Furniture and Fittings	131	108
Motor Vehicles	308	319
Total Depreciation	**3,898**	**3,508**
Amortisation		
Intangible Assets	2	4
Total Amortisation	**2**	**4**
Total Depreciation & Amortisation	**3,900**	**3,512**

Note 5: Cash and Cash Equivalents

For the purposes of the cash flow statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

	Total 2014 $'000	Total 2013 $'000
Cash on Hand	9	9
Cash at Bank	8,912	12,416
Deposits at Call	9,384	7,932
TOTAL	**18,305**	**20,357**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	13,448	15,691
Cash for Monies Held in Trust		
- Cash at Bank	4,857	4,666
TOTAL	**18,305**	**20,357**

Note 6: Receivables

	Total 2014 $'000	Total 2013 $'000
CURRENT		
Contractual		
Trade Debtors	1,059	1,379
Patient Fees	1,156	975
Accrued Investment Income	-	-
Accrued Revenue Other	642	612
Accommodation Bonds Owing	672	650
Less Allowance for Doubtful Debts		
Trade Debtors	(6)	(58)
Patient Fees	(212)	(82)
	3,311	**3,476**
Statutory		
GST Receivable	210	355
	210	**355**
TOTAL CURRENT RECEIVABLES	**3,521**	**3,831**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health	1,100	1,127
	1,100	**1,127**
TOTAL NON-CURRENT RECEIVABLES	**1,100**	**1,127**
TOTAL RECEIVABLES	**4,621**	**4,958**

(a) Movement in the Allowance for doubtful contractual receivables

	Total 2014 $'000	Total 2013 $'000
Balance at beginning of year	140	89
Amounts written off during the year	(116)	(41)
Amounts recovered during the year	-	(1)
Increase/(decrease) in allowance recognised in net result	194	93
Balance at end of year	**218**	**140**

(b) Ageing analysis of receivables

Please refer to note 18(b) for the ageing analysis of contractual receivables

(c) Nature and extent of risk arising from receivables

Please refer to note 18(b) for the nature and extent of credit risk arising from contractual receivables

Note 7: Investments and other Financial Assets

	Specific Purpose Fund		Capital Fund		Total	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000	2014 $'000	2013 $'000
NON CURRENT						
Term Deposit						
Aust. Dollar Term Deposits > 12 months	-	-	266	258	266	258
Shares	1,914	1,649	-	-	1,914	1,649
Total Non Current	**1,914**	**1,649**	**266**	**258**	**2,180**	**1,907**
TOTAL	**1,914**	**1,649**	**266**	**258**	**2,180**	**1,907**
Represented by:						
Health Service Investments	1,914	1,649	266	258	2,180	1,907
TOTAL	**1,914**	**1,649**	**266**	**258**	**2,180**	**1,907**

(a) Ageing analysis of investments and other financial assets

Please refer to note 18(b) for the ageing analysis of investments and other financial assets

(b) Nature and extent of risk arising from investments and other financial assets

Please refer to note 18(b) for the nature and extent of credit risk arising from investments and other financial assets

Note 8: Inventories

	Total 2014 $'000	Total 2013 $'000
Pharmaceuticals		
At cost	152	164
Catering Supplies		
At cost	11	10
Housekeeping Supplies		
At cost	20	19
Medical and Surgical Lines		
At cost	45	43
Engineering Stores		
At Cost	15	1
Administration Stores		
At Cost	30	25
TOTAL INVENTORIES	**273**	**262**

Note 9: Non financial physical assets classified as held for sale

(a) Non-Financial physical assets including disposal assets group assets classifies as held for sale

	Total 2014 $'000	Total 2013 $'000
Land	280	-
Buildings	80	-
TOTAL NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE	**360**	**-**

(b) Fair value measurement of non-financial physical assets held for sale

	Carrying Amount Total 2014	Fair value measurement at end of reporting period using;		
		Level 1 $'000	Level 2 $'000	Level 3 $'000
Land	280	-	280	-
Buildings	80	-	80	-
TOTAL NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE	**360**	**-**	**360**	

Note 10: Other Current Assets

	Total 2014 $'000	Total 2013 $'000
CURRENT		
Prepayments	959	121
TOTAL CURRENT OTHER ASSETS	**959**	**121**
TOTAL OTHER ASSETS	**959**	**121**

Note 11: Property, Plant & Equipment

	Total 2014 $'000	Total 2013 $'000
Land		
Land at Fair Value	4,742	3,573
Land at Cost	-	114
Total Land	**4,742**	**3,687**
Buildings		
Buildings Under Construction at cost	1,258	22,640
Buildings at Fair Value	126,465	38,734
Less Acc'd Depreciation	-	8,897
Buildings at cost	-	9,945
Less Acc'd Depreciation	-	347
Total Buildings	**127,723**	**62,075**
Plant and Equipment		
Plant and Equipment at Fair Value	4,693	4,460
Less Acc'd Depreciation	1,858	1,766
Total Plant and Equipment	**2,835**	**2,694**
Medical Equipment		
Medical Equipment at Fair Value	8,151	8,104
Less Acc'd Depreciation	4,564	4,263
Total Medical Equipment	**3,587**	**3,841**
Computers and Communication		
Computers and Communication at Fair Value	1,078	955
Less Acc'd Depreciation	583	536
Total Computers and Communication	**495**	**419**
Furniture and Fittings		
Furniture and Fittings at Fair Value	1,190	1,143
Less Acc'd Depreciation	647	556
Total Furniture and Fittings	**543**	**587**
Motor Vehicles		
Motor Vehicles at Fair Value	1,907	1,873
Less Acc'd Depreciation	918	950
Total Motor Vehicles	**989**	**923**
TOTAL	**140,914**	**74,226**

Note 11: Property, Plant & Equipment (Continued)

	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Computers & Communications $'000	Furniture & Fittings $'000	Motor Vehicles $'000	SWARH Joint Venture $'000	Total $'000
Balance at 1 July 2012	**3,687**	**50,244**	**1,548**	**3,514**	**214**	**443**	**965**	**17**	**60,632**
Additions	-	13,982	1,471	1,009	241	252	521	29	17,505
Disposals	-	-	(137)	(21)	(1)	-	(244)	-	(403)
Depreciation and Amortisation (note 4)	-	(2,151)	(188)	(661)	(78)	(108)	(319)	(3)	(3,508)
Balance at 1 July 2013	**3,687**	**62,075**	**2,694**	**3,841**	**376**	**587**	**923**	**43**	**74,226**
Additions	**-**	4,849	359	445	207	90	417	1	6,368
Disposals	-	-	(10)	(2)	(1)	(3)	(43)	-	(59)
Classified as Held for Sale	(280)	(80)							(360)
Revaluation Increments/(Decrements)	1,335	63,302							64,637
Depreciation and Amortisation (note 4)	-	(2,423)	(208)	(697)	(124)	(131)	(308)	(7)	(3,898)
Balance at 30 June 2014	**4,742**	**127,723**	**2,835**	**3,587**	**458**	**543**	**989**	**37**	**140,914**

(i) Classified in accordance with the fair value hierarchy, see Note 1

There have been no transfers between levels during this period.

Note 11: Property, Plant & Equipment (Continued)

(c) Fair value measurement hierarchy for assets as at 30 June 2014

	Carrying Amount as at 30 June 2014 $'000	Fair value measurement at end of reporting period using; Level 1* $'000	Level 2* $'000	Level 3 $'000
Land at Fair Value				
Non-specialised land	523	-	523	-
Specialised land	4,219	-	-	4,219
Total of Land at Fair Value	**4,742**	**-**	**523**	**4,219**
Buildings at Fair Value				
Non-specialised Buildings	539	-	539	-
Specialised Buildings	125,542	-	-	125,542
Heritage assets	384	-	-	384
Assets Under Construction	1,258	-	-	1,258
Total of Building at Fair Value	**127,723**	**-**	**539**	**127,184**
Plant and Equipment at Fair Value				
Plant, Equipment and Vehicles at fair value	2,835		-	2,835
Total Plant and Equipment at Fair Value	**2,835**	**-**	-	**2,835**
Medical Equipment at Fair Value				
Medical Equipment at Fair Value	3,587	-	-	3,587
Total Medical Equipment at Fair Value	**3,587**	**-**	-	**3,587**
Computers and Communication at Fair Value				
Computers and Communication at Fair Value	495	-	-	495
Total Computers and Communication at Fair Value	**495**	**-**		**495**
Furniture and Fittings at Fair Value				
Furniture and Fittings at Fair Value	543	-	-	543
Total Furniture and Fittings at Fair Value	**543**	**-**	-	**543**
Motor Vehicles at Fair Value				
Motor Vehicles at Fair Value	989	-	-	989
Total Motor Vehicles at Fair Value	**989**	**-**	-	**989**
TOTAL	**140,914**	**-**	**1,062**	**139,852**

Non-specialised land, non-specialised buildings and artwork

Non-specialised land, non-specialised buildings and artworks are valued using the market approach.

Under this valuation method, the assets are compared to recent comparable sales or sale 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 independent valuers (VRC Property) 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 relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

For artwork, valuation of the assets is determined by a comparison to similar examples of the artists work in existence throughout Australia and research on price paid for similar examples offered at auction or through art galleries in recent years.

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

Specialised land and specialised buildings

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

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

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

An independent valuation of the Health Service's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014.

Heritage assets, infrastructure and road infrastructure and earthworks

Heritage assets, infrastructure and road infrastructure and earthworks are valued using the depreciated reproduction cost method. This cost represents the reproduction cost of the building/component after applying depreciation rates on a useful life basis. Reproduction costs relate to costs to replace the current service capacity of the asset. Economic obsolescence has also been factored into the depreciated reproduction cost calculation.

Where it has not been possible to examine hidden works such as structural frames and floors, the use of reasonable materials and methods of construction have been assumed bearing in mind the age and nature of the building. The estimated cost of reconstruction including structure services and finishes, also factors in any heritage classifications as applicable.

An independent valuation of the Health Service's heritage assets, infrastructure and road infrastructure and earthworks was performed by the Valuer-General Victoria. The valuation was performed based on the depreciated reproduction cost of the assets. The effective date of the valuation is 30 June 2014.

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 value (depreciated cost).

Plant and equipment

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

There were no changes in valuation techniques throughout the period to 30 June 2014.

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

Note 11: Property, Plant & Equipment (Continued)

(d) Reconciliation of Level 3 fair value

	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Computers & Communications $'000	Furniture & Fittings $'000	Motor Vehicles $'000	Total $'000
Opening Balance	**3,252**	**61,268**	**2,694**	**3,841**	**419**	**587**	**923**	**72,984**
Purchases / (Sales)	(280)	4,769	349	443	207	87	374	5,949
Transfers in (out) of Level 3	-	-	-	-	-	-	-	-
Gain or losses recognised in net result	-							
- Depreciation		(2,361)	(208)	(697)	(131)	(131)	(308)	(3,836)
- Impairment loss								
	2,972	63,676	2,835	3,587	495	543	989	**75,097**
Items recognised in other comprehensive income								
Revaluation Increments/(Decrements)	1,247	63,508				-	-	64,755
Closing Balance	**4,219**	**127,184**	**2,835**	**3,587**	**495**	**543**	**989**	**139,852**

(i) Classified in accordance with the fair value hierarchy, see Note 1

There have been no transfers between levels during this period.

Note 11: Property, Plant & Equipment (Continued)

(e) Description of significant unobservable inputs to Level 3 valuations

	Valuation technique (i)	Significant unobservable inputs (i)	Range (weighted average) (i)	Sensitivity of fair value measurement to changes in significant unobservable inputs
Specialised land	Market approach	Community Service Obligation (CSO) adjustment	10 - 30% (20%) (ii)	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value
Specialised buildings	Depreciated replacement cost	Direct cost per square metre	$500 - $5,100/m2 ($1,635)	A significant increase or decrease in direct cost per square meter adjustment would result in a significantly higher or lower fair value
		Useful life of specialised buildings	10 - 50 years (23 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Plant and equipment at fair value	Depreciated replacement cost	Cost per unit	$1,000 - $980,000 ($12,000)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value
		Useful life of PPE	10-40 years (16 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Vehicles	Depreciated replacement cost	Cost per unit	$4,000- $119,000 per unit ($27,200 per unit)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value A significant increase or
		Useful life of vehicles	5 -10 years (5.5 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Medical equipment at fair value	Depreciated replacement cost	Cost per unit	$1,000 - $105,000 ($7,000)	Increase (decrease) in gross replacement cost would result in a significantly higher (lower) fair value
		Useful life of medical equipment	5-20 years (10 years)	Increase (decrease) in useful life would result in a significantly higher (lower) fair value
Assets under construction at fair value	Depreciated replacement cost	Cost per unit	$1,000 - $800,000 ($650,000)	A significant increase or decrease in direct cost per unit adjustment would result in a significantly higher or lower fair value

(i) [Illustrations on the valuation techniques, significant unobservable inputs and the related quantitative range of those inputs are indicative and should not be directly used without consultation with entities' independent valuer.]

(ii) CSO adjustments ranging from 50% to 70% were applied to reduce the market approach value for the Department's specialised land, with the weighted average 60% reduction applied.

Note 12: Intangible Assets

	Total 2014 $'000	Total 2013 $'000
Computer Software	46	46
Less Acc'd Amortisation	45	43
	1	**3**
Total Written Down Value	**1**	**3**

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

	Computer Software $'000	Total $'000
Balance at 1 July 2012	**7**	**7**
Amortisation (note 4)	(4)	(4)
Balance at 1 July 2013	**3**	**3**
Amortisation (note 4)	(2)	(2)
Balance at 30 June 2014	**1**	**1**

Note 13: Payables

	Total 2014 $'000	Total 2013 $'000
CURRENT		
Contractual		
Trade Creditors (i)	1,796	1,549
Accrued Expenses	451	462
Other	179	207
	2,426	**2,218**
Statutory		
GST Payable (iii)	35	-
Department of Health (ii)	-	1,067
	35	**1,067**
TOTAL CURRENT	**2,461**	**3,285**

(i) The average credit period is 30 days. No interest is charged on the other payables for the first 30 days from the date of the invoice. Thereafter, interest is charged at 0% per year on the outstanding balance.

(ii) Terms and conditions of amounts payable to the Department of Health vary according to the particular agreement with the Department.

(iii) Where amount of taxes payable is material, Health Services should present statutory 'taxes payable' in the note broken down by classes of taxes, i.e. GST payable, FBT payable, income tax payable, and other tax payable, as appropriate].

(a) Maturity analysis of payables

Please refer to Note 18(c) for the ageing analysis of contractual payables

(b) Nature and extent of risk arising from payables

Please refer to note 18(c) for the nature and extent of risks arising from contractual payables

Note 14: Provisions

	Total 2014 $'000	Total 2013 $'000
Current Provisions		
Employee Benefits (Note 13(a))		
Annual Leave (Note 14(a))		
- Unconditional and expected to be settled within 12 months (ii)	2,389	2,425
Long Service Leave (Note 14(a))		
- Unconditional and expected to be settled within 12 months (ii)	564	732
- Unconditional and expected to be settled after 12 months (iii)	3,614	3,360
Accrued Days Off (Note 14(a))		
- Unconditional and expected to be settled within 12 months (ii)	66	65
Accrued Wages and Salaries (Note 14(a))		
- Unconditional and expected to be settled within 12 months (ii)	1,520	1,508
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months (ii)	742	776
- Unconditional and expected to be settled after 12 months (iii)	371	320
Total Current Provisions	**9,266**	**9,186**
Non-Current Provisions		
Employee Benefits (i) (Note 14 (a))	1,445	1,380
Provisions related to Employee Benefit On-Costs (Note 14(a) and Note 14(b))	149	135
Total Non-Current Provisions	**1,594**	**1,515**
Total Provisions	**10,860**	**10,701**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional LSL Entitlement	4,604	4,478
Annual Leave Entitlements	3,077	3,135
Accrued Wages and Salaries	1,520	1,508
Accrued Days Off	66	65
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements	1,593	1,515
Total Employee Benefits and Related On-Costs	**10,860**	**10,701**

(b) Movements in provisions	Total 2014 $'000	Total 2013 $'000
Movements in Long Service Leave		
Balance at start of year*	**5,992**	**5,600**
Provision made during the year		
- Revaluations	(87)	16
- Expense recognising Employee Service	856	1,107
Settlement made during the year	(564)	(731)
Balance at end of year*	**6,197**	**5,992**

Notes:

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

(iii) The amounts disclosed are discounted to present values

Note 15: Other Liabilities

	Total 2014 $'000	Total 2013 $'000
CURRENT		
Monies Held in Trust		
- Patient Monies Held in Trust	250	230
- Accommodation Bonds (Refundable Entrance Fees)	1,785	1,946
Total Current	**2,035**	**2,176**
NON CURRENT		
Monies Held in Trust		
- Accommodation Bonds (Refundable Entrance Fees)	3,494	3,140
Total Non-Current	**3,494**	**3,140**
Total Other Liabilities	**5,529**	**5,316**
Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 5)	4,857	4,666
Receivables (refer to Note 6)	672	650
TOTAL	**5,529**	**5,316**

Note 16: Equity

	Total 2014 $'000	Total 2013 $'000
(a) Surpluses		
Property, Plant & Equipment Revaluation Surplus		
Balance at the beginning of the reporting period	2,437	2,437
Revaluation Increment/(Decrements)		
- Land	1,627	
- Building	63,302	-
Balance at the end of the reporting period	**67,366**	**2,437**
* Represented by:		
- Land	3,688	2,061
- Building	63,302	
- Plant and Equipment	376	376
	67,366	**2,437**
Financial Assets Available-for-Sale Revaluation Surplus		
Balance at the beginning of the reporting period	98	(52)
Valuation gain/(loss) recognised	160	154
Cumulative (gain)/loss transferred to Operating Statement on Sale of Financial Assets	(4)	(4)
Cumulative (gain)/loss transferred to Operating Statement on Impairment of Financial Assets	-	-
Balance at end of the reporting period	**254**	**98**

Note 16: Equity (Continued)

	Total 2014 $'000	Total 2013 $'000
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	4,007	8,716
Transfer to Asset Replacement Reserve for Aged Care Capital Income	1,393	1,448
Transfer from Asset Replacement Reserve	(1,533)	(1,511)
Transfer Specific Donations/Bequests from Accumulated Surpluses	524	(4,646)
Balance at the end of the reporting period	**4,391**	**4,007**
Total Surpluses	**72,011**	**6,542**
(b) Contributed Capital		
Balance at the beginning of the reporting period	49,535	49,535
Balance at the end of the reporting period	**49,535**	**49,535**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	26,455	10,061
Net Result for the Year	1,146	11,685
Comprehensive Income from Associates and Joint Ventures		
Transfers to and from Reserve		
- Asset replacement reserve for Aged Care Capital Income	(1,393)	(1,448)
- Specific Donations/Bequests from Accumulated Services	(524)	4,646
- Asset Replacement Reserve	1,533	1,511
Balance at the end of the reporting period	**27,217**	**26,455**
Total Equity at end of financial year	**148,763**	**82,532**

Note 17: Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities

	Total 2014 $'000	Total 2013 $'000
Net Result for the Year	1,146	11,685
Depreciation & Amortisation	3,900	3,512
Net (Gain)/Loss from Non-Financial Assets	(68)	(46)
Net (Gain)/Loss from Financial Assets	(16)	(29)
Provision for doubtful debts	194	93
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	164	(652)
(Increase)/Decrease in Inventories	(11)	107
(Increase)/Decrease in Other Assets	(838)	(34)
Increase/(Decrease) in Payables	(824)	(810)
Increase/(Decrease) in Provisions	159	(226)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**3,806**	**13,600**

Note 18: Financial Instruments

(a) Financial Risk Management Objectives and Policies

Western District Health Service's principal financial instruments comprise of:

- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Investment in Equities
- Payables (excluding statutory payables)
- Accommodation Bonds

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

"The Health Service's main financial risks include credit risk, liquidity risk, interest rate risk, foreign currency risk and equity price risk. The Health Service manages these financial risks in accordance with its financial risk management policy.

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

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

2014	Contractual financial assets / liabilities designated at fair value through profit / loss $'000	Contractual financial assets / liabilities held for trading at fair value through profit / loss $'000	Contractual financial assets - loans and receivables $'000	Contractual financial assets - available for sale $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Financial Assets						
Cash and cash equivalents	-	-	18,305	-	-	18,305
Receivables						
- Trade Debtors	-	-	1,059	-	-	1,059
- Other Receivables	-	-	2,470	-	-	2,470
Other Financial Assets						
- Term Deposit	-	-	266	-	-	266
- Shares	-	-	-	1,914	-	1,914
Total Financial Assets (i)	**-**	**-**	**22,100**	**1,914**	**-**	**24,014**
Financial Liabilities						
Payables	-	-	-	-	2,426	2,426
Other Financial Assets						
- Accommodation Bonds	-	-	-	-	5,529	5,529
Total Financial Liabilities (ii)	-	-	-	-	**7,955**	**7,955**

2013						
Financial Assets						
Cash and cash equivalents	-	-	20,357	-	-	20,357
Receivables						
- Trade Debtors	-	-	1,381	-	-	1,381
- Other Receivables	-	-	2,237	-	-	2,237
Other Financial Assets						
- Term Deposit	-	-	258	-	-	258
- Shares	-	-	-	1,649	-	1,649
Total Financial Assets (i)	**-**	**-**	**24,233**	**1,649**	**-**	**25,882**
Financial Liabilities						
Payables	-	-	-	-	2,218	2,218
Other Financial Assets						
- Accommodation Bonds	-	-	-	-	5,316	5,316
Total Financial Liabilities (ii)	-	-	-	-	**7,534**	**7,534**

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

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

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

	Net holding gain/ (loss) $'000	Total interest income / (expense) $'000	Fee income / (expense) $'000	Impairment $'000	Total $'000
2014					
Financial Assets					
Available for Sale (i)	1,254				1,254
Total Financial Assets	**1,254**				**1,254**

	Net holding gain/ (loss) $'000	Total interest income / (expense) $'000	Fee income / (expense) $'000	Impairment $'000	Total $'000
2013					
Financial Assets					
Available for Sale (i)	1,048				1,048
Total Financial Assets	**1,048**				**1,048**

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

(ii) For financial liabilities measured at amortised cost, the net gain or loss is calculated by taking the interest expense, plus or minus foreign exchange gains or losses arising from the revaluation of financial liabilities measured at amortised cost; and

(iii) For financial assets and liabilities that are held for trading or designated at fair value through profit or loss, the net gain or loss is clacualted by taking the movement in the fair value of the financial asset or liability.

Note 18: Financial Instruments (continued)

(b) Credit Risk

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

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

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

Provision of impairment for contractual financial assets is recognised when there is objective evidence that the Health Service will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, debts which are more than 60 days overdue, and changes in debtor credit ratings.

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

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

2014	Financial institutions (AAA credit rating) $'000	Government agencies (AAA credit rating) $'000	Government agencies (BBB credit rating) $'000	Other (min BBB credit rating) $'000	Total $'000
Financial Assets					
Cash and Cash Equivalents	18,305	-	-	-	18,305
Receivables					
- Trade Debtors	-	-	-	1,059	1,059
- Other Receivables	-	-	-	2,470	2,470
Other Financial Assets					
- Term Deposit	266	-	-	-	266
- Shares in Other Entities	1,914	-	-	-	1,914
Total Financial Assets	**20,485**	**-**	**-**	**3,529**	**24,014**
2013					
Financial Assets					
Cash and Cash Equivalents	20,357	-	-	-	20,357
Receivables					
- Trade Debtors	-	-	-	1,381	1,381
- Other Receivables	-	-	-	2,237	2,237
Other Financial Assets					
- Term Deposit	258	-	-	-	258
- Shares in Other Entities	1,649	-	-	-	1,649
	22,264	**-**	**-**	**3,618**	**25,882**

Note 18: Financial Instruments (continued)

Ageing analysis of Financial Asset as at 30 June

2014	Total Carrying Amount $'000	Not Past Due and Not Impaired $'000	Past Due But Not Impaired				Impaired Financial Assets $'000
			Less than 1 Month $'000	1-3 Months $'000	3 months - 1 Year $'000	1-5 Years $'000	
Financial Assets							
Cash and Cash Equivalents	18,305	18,305	-	-	-	-	-
Receivables							
- Trade Debtors	1,059	673	166	163	51	-	6
- Other Receivables	2,470	-	1,742	58	670	-	212
Other Financial Assets							
- Term Deposit	266	266	-	-	-	-	-
- Shares in Other Entities	1,914	1,914	-	-	-	-	-
Total Financial Assets	**24,014**	**21,158**	**1,908**	**221**	**721**	**-**	**218**
2013							
Financial Assets							
Cash and Cash Equivalents	20,357	20,357	-	-	-	-	-
Receivables							
- Trade Debtors	1,381	869	295	160	-	-	57
- Other Receivables	2,237	-	1,735	88	414	-	83
Other Financial Assets							
- Term Deposit	258	258	-	-	-	-	-
- Shares in Other Entities	1,649	1,649	-	-	-	-	-
Total Financial Assets	**25,882**	**23,190**	**2,030**	**248**	**414**	**-**	**140**

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

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

Note 18: Financial Instruments (continued)
(c) Liquidity Risk

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due. The Health Services operates under the Government's fair payments policy of settling financial obligations within 30 days and in the event of a dispute, making payments within 30 days from the date of resolution.

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

Term deposits, investments and cash held at financial institutions are managed with variable maturity dates and take into consideration cashflow requirements of the health service from month to month.

Trade creditors are paid in accordance with their trading terms; and accommodation bonds are refunded when the resident departs the aged care facility.

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

Maturity analysis of Financial Liabilities as at 30 June

2014	Carrying Amount $'000	Contractual Cash Flows $'000	Maturity Dates: Less than 1 Month $'000	1-3 Months $'000	3 months - 1 Year $'000	1-5 Years $'000
Financial Liabilities						
Payables	2,426	2,426	2,426	-	-	-
Other Financial Liabilities (i)						
- Accommodation Bonds	5,279	-	-	-	1,785	3,494
- Other	250	-	-	195	55	-
Total Financial Liabilities	**7,955**	**2,426**	**2,426**	**195**	**1,840**	**3,494**
2013						
Financial Liabilities						
Payables	2,218	2,218	2,011	207	-	-
Other Financial Liabilities (i)						
- Accommodation Bonds	5,086	-	-	-	1,946	3,140
- Other	230	-	-	181	49	-
Total Financial Liabilities	**7,534**	**2,218**	**2,011**	**388**	**1,995**	**3,140**

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

Note 18: Financial Instruments (continued)
(d) Market Risk

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

Currency Risk

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

Interest Rate Risk

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

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

The Health Service has minimal exposure to cash flow interest rate risks through its cash and deposits, term deposits and bank overdrafts that are at floating rate.

The Health Service manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded for cash at bank and bank overdraft, as financial assets that can be left at floating rate without necessarily exposing the Health Service to significant bad risk, management monitors movement in interest rates on a daily basis."

Other Price Risk

Western District Health Service is exposed to normal price fluctulations from time to time through market forces. Where adequate notice is provided by suppliers, additional purchases are made for long term goods.

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

2014	Weighted Average Effective Interest Rate (%)	Carrying Amount $'000	Interest Rate Exposure: Fixed Interest Rate $'000	Variable Interest Rate $'000	Non-Interest Bearing $'000
Financial Assets					
Cash and Cash Equivalents	2.45	18,305	-	18,305	-
Receivables(i)					
- Trade Debtors		1,059	-	-	1,059
- Other Receivables		2,470	-	-	2,470
Other Financial Assets					
- Term Deposit	3.8	266	-	266	-
- Shares in Other Entities		1,914	-	-	1,914
		24,014	**-**	**18,571**	**5,443**
Financial Liabilities					
Payables(i)		2,426	-	-	2,426
Other Financial Liabilities					
- Accommodation Bonds	3.8	5,279	-	5,279	-
- Other		250	-	-	250
		7,955	**-**	**5,279**	**2,676**
2013					
Financial Assets					
Cash and Cash Equivalents	2.75	20,357	-	20,357	-
Receivables(i)					
- Trade Debtors		1,381	-	-	1,381
- Other Receivables		2,237	-	-	2,237
Other Financial Assets					
- Term Deposit	4.1	258	-	258	-
- Shares in Other Entities		1,649	-	-	1,649
		25,882	**-**	**20,615**	**5,327**
Financial Liabilities					
Payables(i)		2,218	-	-	2,218
Other Financial Liabilities					
- Accommodation Bonds	4.1	5,086	-	5,086	-
- Other		230	-	-	230
		7,534	**-**	**5,086**	**2,448**

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

Note 18: Financial Instruments (continued)
(d) Market Risk (continued)

Sensitivity Disclosure Analysis

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

- A shift of +1% and -1% in market interest rates (AUD) from year-end rates of 6%;
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%
- A movement of 15% up and down (2012: 15 %) for the top ASX 200 index.

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

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-1%		+1%	
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
2014		$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial Assets									
Cash and Cash Equivalents(i)	18,305	(183)	(183)	183	183	-	-	-	-
Receivables(ii)									
- Trade Debtors	1,059	-	-	-	-	-	-	-	-
- Other Receivables	2,470	-	-	-	-	-	-	-	-
Other Financial Assets									
- Term Deposit	266	(3)	(3)	3	3	-	-	-	-
- Shares in Other Entities	1,914	-	-	-	-	-	-	-	-
Financial Liabilities									
Payables	2,426	-	-	-	-	-	-	-	-
Other Financial Liabilities(ii)	-	-	-	-	-	-	-	-	-
- Accommodation Bonds	5,279	-	-	-	-	-	-	-	-
- Other	250	-	-	-	-	-	-	-	-
		(186)	**(186)**	**186**	**186**	**-**	**-**	**-**	**-**
2013									
Financial Assets									
Cash and Cash Equivalents(i)	20,357	(204)	(204)	204	204	-	-	-	-
Receivables(ii)									
- Trade Debtors	1,381	-	-	-	-	-	-	-	-
- Other Receivables	2,237	-	-	-	-	-	-	-	-
Other Financial Assets									
- Term Deposit	258	(3)	(3)	3	3	-	-	-	-
- Shares in Other Entities	1,649	-	-	-	-	-	-	-	-
Financial Liabilities									
Payables	2,218	-	-	-	-	-	-	-	-
Other Financial Liabilities(ii)	-	-	-	-	-				
- Accommodation Bonds	5,086	-	-	-	-	-	-	-	-
- Other	230	-	-	-	-	-	-	-	-
		(206)	**(206)**	**206**	**206**	**-**	**-**	**-**	**-**

(i) eg. Sensitivity of cash and cash equivalents to a +1% movement in interest rates: [$22,403k*0.07]-[$22,403k*0.06] = $224k. Similar for a -1% movement in interest rate, impact = $(224k).

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

Note 18: Financial Instruments (continued)
(e) Fair Value

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

• Level 1 - the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices;

• Level 2 - the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly; and

• Level 3 - the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

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

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

Comparison between carrying amount and fair value

	Carrying Amount 2014 $'000	Fair value 2014 $'000	Carrying Amount 2013 $'000	Fair value 2013 $'000
Financial Assets				
Cash and Cash Equivalents	18,305	18,305	20,357	20,357
Receivables(i)				
- Trade Debtors	1,059	1,059	1,381	1,381
- Other Receivables	2,470	2,470	2,237	2,237
Other Financial Assets				
- Term Deposit	266	266	258	258
- Shares in Other Entities	1,914	1,914	1,649	1,649
Total Financial Assets	**24,014**	**24,014**	**25,882**	**25,882**
Financial Liabilities				
Payables	2,426	2,426	2,218	2,218
Other Financial Liabilities(i)				
- Accommodation Bonds	5,279	5,279	5,086	5,086
- Other	250	250	230	230
Total Financial Liabilities	**7,955**	**7,955**	**7,534**	**7,534**

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

Note 18: Financial Instruments (continued)

Financial assets measured at fair value

	Carrying Amount as at 30 June $'000	Fair value measurement at end of reporting period using:		
2014		Level 1* $'000	Level 2* $'000	Level 3 $'000
Financial assets at fair value through profit & loss				
Available for sale financial assets				
- Equities and managed funds	1,914		1,914	-
Total Financial Assets	**1,914**	**-**	**1,914**	**-**
2013				
Financial assets at fair value through profit & loss				
Available for sale financial assets				
- Equities and managed funds	1,649		1,649	-
Total Financial Assets	**1,649**	**1,649**	**1,649**	**-**

*There is no significant transfer between level 1 and level 2

There have been no transfers between levels during the period.

The fair value of the finanical assets and liabilities is included at the amount at which the instrument could be exchanged in a current transaction between willing parties, other than in a forced or liquidation sale. The following methods and assumptions were used to estimate fair value;

Managed investment schemes

The Health Service invests in managed funds which are not quoted in an active market and which may be subject to restrictions on redemptions. The Health Service considers the valuation techniques and inputs used in valuing these funds as part of its due dilligence prior to the investment, to ensure they are reasonable and appropriate and therefore the net asset value of these funds may be used as an input into measuring their fair value. In measuring this fair value, the net asset value of the funds is adjusted, as necessary, to reflect restrictions and redemptions, futurecommitments and other specific factors of teh funds. In measuring the fair value, consideration is also paid to any transaction in teh shares of the fund. Depending on the nature and level of adjustments needed to the net asset value and the level of trading of the Health Service, the Health Service classifies these funds as either Level 2 or Level 3.

Note 19: Commitments for Expenditure

	Total 2014 $'000	Total 2013 $'000
Capital expenditure commitments		
Payable:		
Land and Buildings	350	5,467
Total capital expenditure commitments	**350**	**5,467**
Land and Buildings		
Not later than one year	350	5,467
Later than 1 year and not later than 5 years	-	-
Total	**350**	**5,467**
Other expenditure commitments		
Payable:		
IT Support Maintenance	640	1,322
Total Other Commitments	**640**	**1,322**
Not later than one year	317	459
Later than 1 year and not later than 5 years	323	589
Later than 5 years	-	274
TOTAL	**640**	**1,322**
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	2,716	2,034
Total lease commitments	**2,716**	**2,034**
Non-cancellable		
Not later than one year	1,754	487
Later than 1 year and not later than 5 years	962	1,547
Later than 5 years	-	-
TOTAL	**2,716**	**2,034**
Total Commitments (inclusive of GST) other than public private partnerships	**3,706**	**8,823**

All amounts shown in the commitments note are nominal amounts inclusive of GST.

Note 20: Contingent Assets and Contingent Liabilities

As at balance date, the Board of Directors is unaware of the existence of amy financial obligation that may have a material effect on the Balance Sheet as a result of any future event which may or may not happen.

2013 - Medical Workforce Enterprise Bargaining Agreement - $32,544..

Note 21: Operating Segments

	Hospital		RAC		Linen Service		Primary Care		Eliminations		Total	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000	2014 $'000	2013 $'000	2014 $'000	2013 $'000	2014 $'000	2013 $'000	2014 $'000	2013 $'000
REVENUE												
External Segment Revenue	55,370	64,143	13,653	14,633	22	120	1,259	1,223	-	-	70,304	80,119
Intersegment Revenue	1,021	986	-	-	71	66			(1,092)	(1,052)	-	-
Total Revenue	**56,391**	**65,129**	**13,653**	**14,633**	**93**	**186**	**1,259**	**1,223**	**(1,092)**	**(1,052)**	**70,304**	**80,119**
EXPENSES												
External Segment Expenses	(51,448)	(50,746)	(15,201)	(15,199)	(73)	(83)	(3,126)	(3,138)	-	-	(69,848)	(69,166)
Intersegment Expenses	(1,021)	(986)	-	-	(71)	(66)	-	-	1,092	1,052	-	-
Unallocated Expense	-	-	-	-	-	-	-	-	-	-	-	-
Total Expenses	**(52,469)**	**(51,732)**	**(15,201)**	**(15,199)**	**(144)**	**(149)**	**(3,126)**	**(3,138)**	**1,092**	**1,052**	**(69,848)**	**(69,166)**
Net Result from ordinary activities	**3,922**	**13,397**	**(1,548)**	**(566)**	**(51)**	**37**	**(1,867)**	**(1,915)**	**-**	**-**	**456**	**10,953**
Interest Income	690	732	-	-			-	-	-	-	690	732
Net Result for Year	**4,612**	**14,129**	**(1,548)**	**(566)**	**(51)**	**37**	**(1,867)**	**(1,915)**	**-**	**-**	**1,146**	**11,685**
OTHER INFORMATION												
Unallocated Assets	116,698	75,855	38,694	22,422	675	179	11,546	3,380	-	-	167,613	101,836
Total Assets	**116,698**	**75,853**	**38,694**	**22,422**	**675**	**179**	**11,546**	**3,380**	**-**	**-**	**167,613**	**101,836**
Unallocated Liabilities	11,728	12,008	6,825	6,989	30	30	267	274			18,850	19,301
Total Liabilities	**11,728**	**12,008**	**6,825**	**6,989**	**30**	**30**	**267**	**274**	**-**	**-**	**18,850**	**19,301**
Acquisition of Property, Plant and Equipment and Intangible Assets	6,184	17,425	180	84	-	-	4	-	-	-	6,368	17,509
Depreciation & Amortisation Expense	3,036	2,733	599	540	24	22	241	217	-	-	3,900	3,512
Non Cash Expenses other than Depreciation	41	401	19	247	-	-	7	14	-	-	67	662

Note 21: Operating Segments (continued)

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

BUSINESS SEGMENTS	SERVICES
Hospitals	Acute bed based services, accident and emergency, diagnostic, outpatient services.
Residential Aged Care Services (RACS)	Aged Care Residential Services
Linen Service	Linen Services
Primary Care Service	Primary Care and Community-based services.
The basis of inter-segment pricing is at cost	

GEOGRAPHICAL SEGMENT

Western District Health Service operates predominantly in Western Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets related to operations in Western Victoria.

Note 22: Jointly Controlled Operations and Assets

Name of Entity	Principal Activity	Ownership Interest 2014 %	Ownership Interest 2013 %
South West Alliance of Rural Health	Information Technology	12.93	12.93
Southern Grampians/Glenelg Shire PCP	Primary Health	45.00	45.00

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

	2014 $'000	2013 $'000
South West Alliance of Rural Health		
Current Assets		
Cash and Cash Equivalents	238	136
Receivables	132	266
Inventories	4	3
Other Current Assets	36	35
Total Current Assets	**410**	**440**
Non Current Assets		
Property, Plant & Equipment	38	43
Total Non Current Assets	**38**	**43**
Total Assets	**448**	**483**

Western District Health Service interest in revenue and expenses resulting from jointly controlled operations and assets is detailed below:

	2014 $'000	2013 $'000
South West Alliance of Rural Health		
Revenue		
Other Revenue	4,037	4,194
Total Revenue	**4,037**	**4,194**
Expenses		
Employee Expenses	670	739
Maitenance Contracts	1,195	943
Leases Expense	429	524
Other	1,735	2,009
Total Expenses	**4,029**	**4,215**
Net Result Before Capital & Specific Items	**8**	**(21)**
Depreciation	7	3
Net Result	**1**	**(24)**

	2014 $'000	2013 $'000
Southern Grampians/Glenelg Shire PCP		
Current Assets		
Cash and Cash Equivalents	310	338
Current Liabilities		
Other Liabilities	147	163
Staff Provisions	44	45
Net Assets	**119**	**130**

Western District Health Service interest in revenue and expenses resulting from jointly controlled operations and assets is detailed below:

	2014 $'000	2013 $'000
Southern Grampians/Glenelg Shire PCP		
Revenue		
Grants	152	202
Other Revenue	214	193
Total Revenue	**366**	**395**
Expenses		
Employee Expenses	154	198
Other	222	177
Total Expenses	**376**	**375**
Net Result	**(10)**	**20**

Note 23a: Responsible Persons Disclosures

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

	Period
Responsible Ministers:	
The Honourable David Davis, MLC, Minister for Health and Ageing	1/07/2013- 30/06/2014
The Honourable Mary Wooldridge, MLA, Minister for Mental Health	1/07/2013- 30/06/2014
Governing Boards	
Ms M Brown	1/07/2013- 30/06/2014
Ms J Huton	1/07/2013- 30/06/2014
Mr H Macdonald	1/07/2013- 30/06/2014
Mr M McGinnity	1/07/2013- 30/06/2014
Mr M Stratmann	1/07/2013- 19/11/2013
Mr I Whiting	1/07/2013- 30/06/2014
Mr. D Barber	1/07/2013- 30/06/2014
Accountable Officers	
Mr J Fletcher	1/07/2013- 30/06/2014

Remuneration of Responsible Persons

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

	Parent	
	2014	2013
Income Band	No.	No.
$0 - $9,999	7	7
$300,000 - $309,999	1	1
Total Numbers	8	8
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$309,457**	**$302,149**
Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet		
Other Transactions of Responsible Persons and their Related Parties.		

Note 23b: Executive Officer Disclosures

Executive Officers' Remuneration

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

	Total Remuneration		Base Remuneration	
	2014	2013	2014	2013
	No.	No.	No.	No.
$120,000 - $129,999	-	1	-	1
$130,000 - $139,999	1	1	1	1
$140,000 - $149,999	1	-	1	-
$160,000 – $169,999	2	1	2	1
$170,000 – $179,999	-	1	-	1
$180,000 – $189,999	1	-	1	-
$210,000 – $219,999	-	1	-	1
Total	**5**	**5**	**5**	**5**
Total annualised employee equivalents	**5**	**5**	**5**	**5**
Total Remuneration	**$792,085**	**$824,319**	**$792,085**	**$824,319**

((i) Annualised employee equivalent is based on paid working hours of 38 ordinary hours per week over the 52 weeks for

Note 24: Events Occurring after the Balance Sheet Date

There were no events occurring after reporting date which require additional information to be disclosed

Note 24: Remuneration of Auditors

	2014 $'000	2013 $'000
Audit fees paid or payable to the Victorian Auditor-	35	34
General's Office for audit of the current financial report		
Total Paid and Payable	**35**	**34**

Note 26: Superannuation

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

The Health Service does not recognise any defined benefit liability in respect of the plan(s) because the entity has no legal or constructive obligation to pay future benefits relating to its employees: its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance discloses the State's defined benefits liabilities in its disclosure for administered items.

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

	Paid contribution for the Year 2014 $'000	Paid contribution for the Year 2013 $'000	Contribution outstanding at Year End 2014 $'000	Contribution outstanding at Year End 2013 $'000
(i) Defined benefit plans:				
First State Super (Health Super)	222	247	-	-
Defined Contribution plans:				
First State Super (Health Super)	2,780	2,699	-	-
HESTA	516	437	-	-
Other	96	108	-	-
Total	**3,614**	**3,491**	**-**	**-**

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

Index

Glossary of Terms

ACHS
Australian Council on Healthcare Standards

ACHSE
Australian College of Health Service Executives

AFPHM
Australasian Faculty of Public Health Medicine

ARA
Australasian Reporting Awards

Best Practice
The way leading edge organisations deliver world class performance

BOD
Board of Directors

BSI
Business Support and Innovation

BSW
Barwon South West

BSWRICS
Barwon South West Regional Integrated Cancer Services

CACPs
Community Aged Care Packages

CDHS
Coleraine District Health Service

CEO
Chief Executive Officer

C&FN
Consumer and Friends Network

COAG
Council of Australian Governments

COPD
Chronic Obstructive Pulmonary Disease

CSSD
Central Sterile Supply Department

DoH
Department of Health

DON
Director of Nursing

DRG
Diagnostic Related Grouper; a means by which hospitals define and measure case mix

DVA
Department of Veterans Affairs

EBA
Enterprise Bargaining Agreement

ECG
Electrocardiograph

ECIICN
Emergency Care Improvement and Innovation Clinical Network

ED
Emergency Department

EN
Enrolled Nurse

ENT
Ear, Nose and Throat

FHCC
Frances Hewett Community Centre

FMIS
Financial Management Information System

FOI
Freedom of Information

FRD
Financial Reporting Directions

FReeZA
Alcohol and drug free activities for youth

GCAHM
Graduate Certificate of Agricultural Health and Medicine

GEM
Geriatric Evaluation Management

GP
General Practitioner

GSC Medicare Local
Great South Coast Medicare Local

GS
Glenelg Shire

HACC
Home and Community Care

HARP
Hospital Admission Risk Program

HBH
Hamilton Base Hospital

HITH
Hospital in the Home

HMG
Hamilton Medical Group

HMMC
Hamilton Midwifery Model of Care

HMO
Hospital Medical Officer

HR
Human Resources

ICT
Information, Communication and Technology

ICU
Intensive Care Unit

ILU
Independent Living Unit

IMG
International Medical Graduates

IT
Information Technology

KPI
Key Performance Indicator

NCFH
National Centre for Farmer Health

NHMRC
National Health Medical Research Council

NWAU
National Weighted Activity Unit

OH&S
Occupational Health and Safety

OT
Occupational Therapy

PAG
Planned Activity Group

PCMS
Patient and Client Management System

PCP
Primary Care Partnerships

PDHS
Penshurst & District Health Service

P&PH
Primary & Preventative Health

PMCV
Post Medical Council Victoria

QI
Quality Improvement

QOC
Quality of Care Report

QRME
Queensland Rural Medical Education

RFID
Radio Frequency Identification

RMIT
Royal Melbourne Institute of Technology (university with a site in Hamilton)

RN
Registered Nurse

Separation
Process by which a patient is discharged from care

SFF
Sustainable Farm Families

SGGPCP
Southern Grampians and Glenelg Primary Care Partnership

SGS
Southern Grampians Shire

SOHS
Securing Our Health System

Standard
A statement of a level of performance to be achieved

SWARH
South West Alliance of Rural Health

TIA
Transient Ischaemic Attack

TRAK
Hospital patient-based information system

VET
Vocational Education and Training

VHA
Victorian Healthcare Association Ltd

VICNISS
Healthcare Associated Infection Surveillance System

VMIA
Victorian Managed Insurance Authority

VMO
Visiting Medical Officer

VPSM
Victorian Patient Satisfaction Monitor

VTE
Venous Thromboembolism

WAN
Wide Area Network

WDHS
Western District Health Service

WIES
Weighted Inlier Equivalent Separations; allocated resource weight for a patient's episode of care. A formula is applied to the resource weight to determine the WIES for recovery of funding.

Images clockwise from top left:

- Students from Hamilton's Gray Street Primary School and teacher Kerry McFadden help with planting the Charity House garden.
- L-R WDHS Development Council Member Vicki Whyte, artist Jasmine Mansbridge, patient Fred Tait with Associate Nurse Unit Manager Aisling Cunningham and Medical Unit Manager Julie Stevens admiring "Ready to talk" painted and donated by Jasmine Mansbridge.
- Grange residents Lesley Holmes and Pearl Darling enjoying a visit from the mobile zoo.
- Representatives from the Hospital Op Shop look over the new theatre equipment purchased with their donation. L-R: Cecilia O'Donnell, Margaret Cameron, WDHS Theatre Manger Rachal Porter, Eloise Warren, Margaret Perkins and Helen Walker
- Participants at the WDHS Planned Activity Group's Old Time Dance. L-R: Ben Kennet, Aileen Cantwell, Gwen Tonissen, Mary Kearne, Annie Lovett, and Bev Lyons.
- L-R: WDHS Maternity Services Program Coordinator Sonia Shaw, Baimbridge College's Marley Meade and Sheba Gurm and Midwife Jenny Sutherland look on as new parents John & Jessica Skermer and baby Chloe, try out the sofa bed purchased with funds from the Cinema Fundraiser.
- Birches volunteer Janet Shalders and Lifestyle and Leisure co-ordinator Margaret Bilston with Janet's Volunteer of the Month Award.
- RN Ashleigh Kemp with North Hamilton Kindergarten students on a tour of the hospital.


wdhs


EXIT

wdhs
Western District
Health Service

www.wdhs.net

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