wdhs
Western District
Health Service

2017
ANNUAL REPORT

Working together

Creating healthier communities

wdhs
Western District Health Service

Our Vision
Creating healthier communities.

Our Mission
To support our community's physical, mental and social wellbeing by:
- Providing safe, high quality and innovative services
- Building enduring partnerships; and
- Delivering customer service excellence.

Our Values

Integrity
We will be open and honest and will do the right thing for the right reason.

Innovation
We will be an industry leader by breaking new ground and improving the way things are done.

Collaboration
We will actively work together in teams and partnerships.

Accountability
We will take personal responsibility for our decisions and actions.

Respect
We will value all people's opinions and contributions.

Empathy
We will endeavour to understand other peoples' feelings and perspectives.

About This Report
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 annual report outlines the operational and financial performance of Western District Health Service (WDHS) from 1 July 2016 to 30 June 2017. The relevant ministers for the period were The Hon. Jill Hennessy MP, Minister for Health; Minister for Ambulance Services, The Hon. Jenny Mikakos MP, Minister for Families and Children; Minister for Youth Affairs, The Hon. Martin Foley MP, Minister for Housing, Disability and Ageing; Minister for Mental Health. This report is also available on the WDHS website at: *www.wdhs.net/publications*

Front cover: Staff working together 'creating healthier communities'

Back cover: Theatre Staff celebrating International Nurses Day

Contents

About WDHS

Western District Health Service (WDHS) is one of Victoria's leading rural and regional healthcare providers, delivering a range of high quality health services.

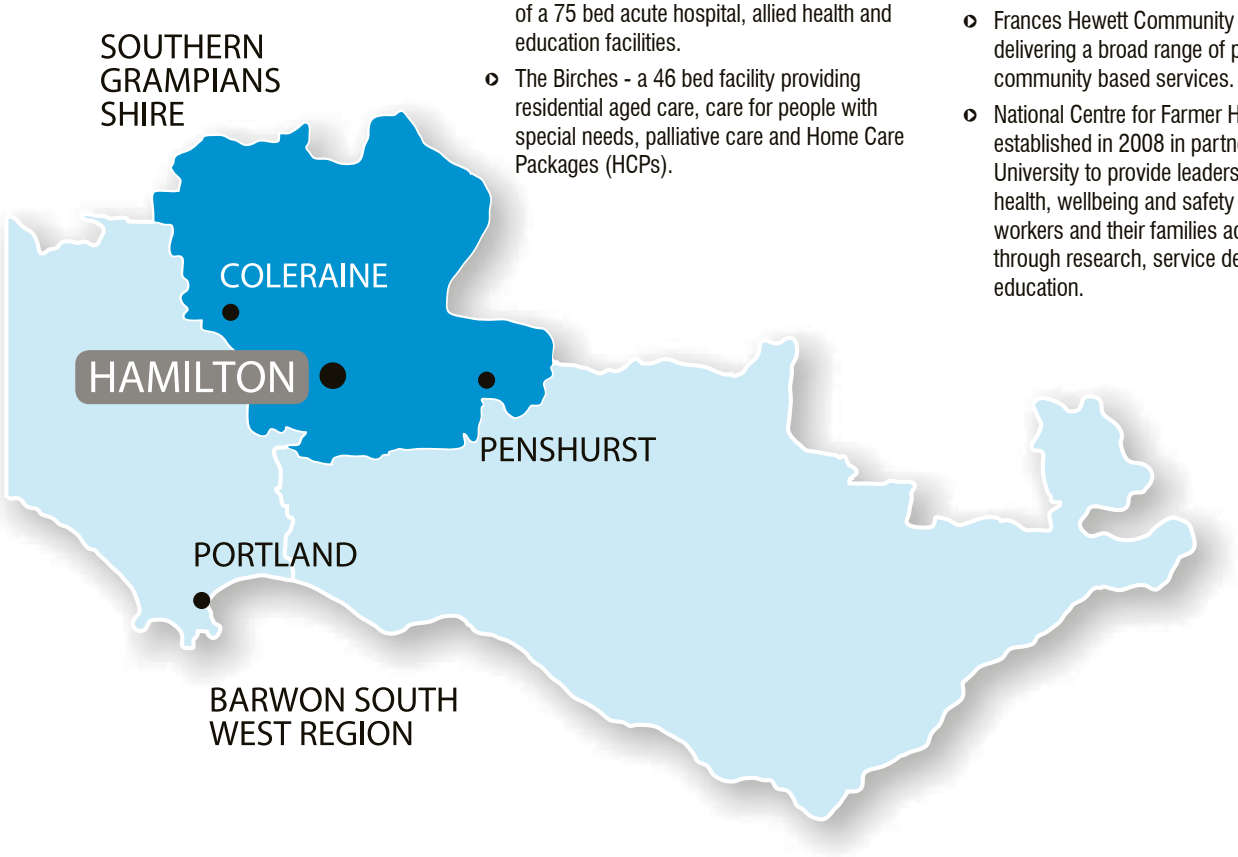
Located in Victoria's Western District, WDHS is the largest employer in the Southern Grampians Shire, delivering quality healthcare to a resident population of 16,200 people, approximately 9,800 who live in Hamilton, the geographic and business hub of the region.

In 1998 the Health Service was established 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). In 2005 Coleraine and District Health Service (CDHS) also amalgamated with WDHS.

The Health Service has 89 acute and subacute beds, 175 residential aged care beds, 35 independent living units and delivers primary care, youth, community and allied health services.

Based in Hamilton, with campuses in Coleraine and Penshurst in the Southern Grampians Shire and Merino in the Glenelg Shire, WDHS incorporates the following sites, services and facilities:

- Hamilton Base Hospital (HBH) - the location of a 75 bed acute hospital, allied health and education facilities.
- The Birches - a 46 bed facility providing residential aged care, care for people with special needs, palliative care and Home Care Packages (HCPs).
- The Grange Residential Care Service - providing 50 residential aged care beds.
- Coleraine District Health Service (CDHS) providing acute care, residential aged care and primary care services to the Coleraine community. Services include medical, dental and maternal and child health. CDHS also manages 25 independent living units.
- Penshurst and District Health Service (PDHS) providing acute care, residential aged care, community services and independent living units in Penshurst and Dunkeld.
- Merino Community Health Centre providing primary nursing, district nursing, visiting podiatry, dietetics and diabetes education services to the Merino community.
- Frances Hewett Community Centre (FHCC) - delivering a broad range of primary care and community based services.
- National Centre for Farmer Health (NCFH) – established in 2008 in partnership with Deakin University to provide leadership to improve the health, wellbeing and safety of farmers, farm workers and their families across Australia through research, service delivery and education.



1862 HBH
Hamilton Base Hospital & Benevolent Asylum established to provide care for people suffering from illness and accidents and for victims of personal tragedy and social distress

1998 WDHS
Amalgamation of HBH, Southern Grampians Community Health Services and Penshurst and District War Memorial Hospital to create WDHS

2000 BIRCHES
Aged Care redevelopment at Hamilton campus including construction of the Birches Residential Care facility

2005 CDHS
Coleraine District Health Service amalgamation with WDHS

2008 NCFH
National Centre for Farmer Health established in partnership with Deakin University

2012 GRANGE
Grange redevelopment works carried out, including construction of new wing

2013 $27M
Coleraine and District Health Service $27 million 'one stop shop' health precinct completed

From the President and Chief Executive

→ WDHS Board Chair, Hugh Macdonald and Chief Executive, Rohan Fitzgerald highlight the issue of family violence and its impact in our community.

In 2016-17 we introduced our new vision 'creating healthier communities' and lead a national campaign to support a reduction in obesity rates across Australia. We continued our investment in infrastructure projects and received enormous local financial support to achieve this aim. We supported an increase in the level of sub-regional clinical governance cooperation, successfully undertook accreditation in three areas across the Health Service, broadened the reach of our community engagement programs and expanded our staff wellbeing initiatives and the availability of local services.

Delivering quality care and services

WDHS took part in National Standards Accreditation across all acute campuses this year and passed with flying colours. Hamilton Base Hospital was reaccredited as a Baby Friendly Health Initiative (BFHI) hospital and our Commonwealth Home Support Program was also reaccredited.

Our Hotel Services teams once again demonstrated the level of pride they have in their work, achieving a cleanliness result of 99%.

The breadth of specialist services at WDHS continued to build this year. A Radiation Oncologist and a new Orthopaedic Surgeon commenced visiting Hamilton from Warrnambool. WDHS appointed a GP Obstetrician and two Respiratory Physicians also joined the team.

We continued our emphasis on improving clinical governance capability across the region. Three health services participated in the South West Service Design Plan, to investigate ways to work more collaboratively into the future and we extended the Director of Medical Services role to include Moyne Health Service in Port Fairy.

WDHS lead a sub-regional process to implement an electronic credentialing system and we also introduced a new learning management tool across the organisation to support the training and development of our staff.

Following a public tender process, WDHS entered into a new contract with Bendigo Radiology to deliver a broad range of medical and specialist imaging services.

Leading the way

We also strengthened our health promotion credentials this year, both at a local and national level. Our Sugar Tax Petition received national coverage, as we continued to show leadership on addressing rising levels of overweight and obesity in our region.

The Southern Grampians and Glenelg Primary Care Partnership (SGGPCP) and WDHS hosted a community forum to discuss overweight and obesity levels, which included a presentation from Dr Steven Allender from the Global Obesity Centre at Deakin University.

A Youth Board was established, which includes representatives from the WDHS Board, Shire Council and community. We continued to deliver our popular School Holiday Program, supported the 'Spring Break Festival' and introduced an innovative 'Health Pop-up Shop' to engage young people in open and honest conversations about their health.

A new nurse practitioner model of care is breaking new ground and will support the delivery of more urology services to our community.

The data-gathering stage of our world-leading 20 Minute Rounding Research Project came to an end and we are now looking forward to analysing the results.

International interest in the National Centre for Farmer Health continued to grow. We entered into a Memorandum of Understanding (MOU) with the University of Jember, Indonesia to develop and foster academic links between our institutions. Centurion University in India also signed a licensing agreement to use NCFH Health and Lifestyle Protocols.

Dr Susan Brumby's dedication to academic excellence and 'making a difference to farmers' lives' was also recognised, with her promotion to Conjoint Professor at Deakin University, School of Medicine.

Financial performance

The Health Service achieved an operating surplus of $12,000 this financial year. In real terms, revenue growth was approximately 2% compared to rising labour costs of between 3 and 5%. We will continue to identify efficiencies and support the introduction of innovative programs to ensure the ongoing viability of the Health Service.

Infrastructure and technology

Plans for the new cancer treatment and dialysis area were finalised, with preparations to go out to tender underway. This is the culmination of over two years of work, which would not have been possible without the immense generosity of our big hearted community, who have donated an amazing $1.5m to date.

We received funding to replace our nurse call system, chillers and boilers at the Hamilton Base Hospital and consideration is being given to making some changes to improve the overall amenity of the HBH Emergency Department.

New Operating Theatre anaesthetic machines and scopes were purchased with funds generously donated by the Collier Foundation and raised from the sale of the Watermark Charity House.

Community events and engagement

WDHS and the Southern Grampians Shire hosted a White Ribbon Day Luncheon and the Management Committee of the Coleraine District Health Service also held a number of forums to address this serious issue.

In March we held another successful International Women's Day Luncheon and in July an inaugural 'Walk with Midwives' celebrated and recognised the important contribution of our midwives.

Professor Robert Shepherd spoke at the 18th Annual Handbury Lecture about his work as the Director of The Bionics Institute and Head of the Medical Bionics Department at the University of Melbourne.

We held a Dementia Friendly Communities Forum, which was attended by over 60 people, commenced a #borninhamilton campaign and purchased three new automatic external defibrillators for the Hamilton CBD, with several community partners.

The WDHS Hospital Harmonies were also back at it again this year promoting the benefits of the flu vaccine. Their short Facebook clip was viewed over 16,000 times.

Supporting our team

Our Staff Wellbeing Program grew this year, with a wide variety of cultural experiences and fun physical challenges on offer. We won the 'Premier's Active April' award for a workplace with over 20 employees, we offered Latin dance classes, provided staff with an opportunity to view the John Wolseley Exhibition at the Hamilton Art Gallery and the WDHS Meet and Greet Women's Group was also a great success.

We continued to enrich our team by improving our process of applying for staff development grants and provided a variety of educational experiences including a leadership program.

Our organisation has a rich history of cultural diversity and awareness. WDHS staff members were invited to learn more about the local Aboriginal history and culture at the Budj Bim National Heritage Landscape. We also hosted students from Gunditjmara Country for Careers in Health Day and the Health Service purchased and displayed 26 pieces of Aboriginal artwork to support cultural inclusiveness.

Appreciation for continued support

We were once again overwhelmed by the generosity of our local community. Taylor Motors and the Hospital Opportunity Shop joined forces to fund a car for the highly successful WDHS Community Transport Program.

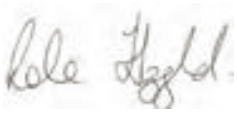
Guests at the Arctic Blast had a ball, on an appropriately chilly evening, raising over $23,000. The Op Shop Golf Tournament raised $16,500 and the Door Knock Appeal and Inaugural Garden Open Day contributed $83,000 toward the new Oncology and Dialysis Redevelopment. The Health Service was also the beneficiary of some very significant bequests for which we are extremely grateful.

The work of our ladies auxiliaries, volunteers and committees contributes significantly to our overall success and we are very thankful for the support and contribution they make to WDHS. We also value and recognise the work of the Coleraine Management Committee and Penshurst Advisory Committee over the last 12 months in supporting WDHS to deliver high quality services to these communities.

Mark McGinnity has retired from the Board after six years of service and we would like to thank Mark for his contribution and in particular, his role and stewardship of the Quality Committee over many years.

On behalf of the Board of Management, we would like to express our sincere appreciation to the community for its significant support throughout the year and for the commitment and dedication shown by our entire staff group and medical team, who so ably work toward our vision of 'creating healthier communities'.

Hugh Macdonald
President



Rohan Fitzgerald
Chief Executive

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 2017.

Hugh Macdonald
President
4 September 2017

Summary of our achievements against the four pillars of the 2016-20 Strategic Plan

Enhancing people's lives

We support the prevention of illness and promote the health and wellbeing of people in our community. We strive to deliver customer service excellence and continuously innovate to adapt to the needs of our community. We deliver quality services as close to home as possible.

- National Standards and Baby Friendly Accreditation achieved.
- E-credentialing system implemented to eliminate duplication of processes across the region and ensure optimal use of skilled clinical workforce.
- Victorian Stroke Telemedicine (VST) program implemented to improve stroke care.
- Orthopaedic, radiation oncology and respiratory specialists engaged to deliver more services locally.
- LGBTI Forum held and support group established, to ensure this community has a local voice.
- White Ribbon Luncheon and community forums held in response to family violence.
- Development of a sub-regional pharmacy governance system project, supported by WDHS.
- Customer Service Officer engaged to enhance the delivery of care and services.

Transforming rural health

We encourage the development and design of new and innovative practices and processes that lead to system change. We promote an environment that inspires learning, thought leadership and enables staff to actively participate in contributing to change.

- WDHS and GenR8 Change petitioned for a sugar tax to address rising levels of obesity in our community and across Australia.
- 604 participants signed on to be part of the Ripple Effect Suicide Prevention Project.
- 4 WDHS facilities participated in 20 Minute Rounding Falls Prevention Research.
- The NCFH hosted a Cholinesterase Project Symposium to help farmers better understand their level of agrichemical exposure.
- A new Nurse Practitioner lead flexible cystoscopy service is leading the way for rural health services across the state.
- NCFH signed a Memorandum of Understanding with the University of Jember, Indonesia, to develop and foster academic links.
- India's Centurion University entered into a licensing agreement to use NCFH Health and Lifestyle Protocols.

Our vision - creating healthier communities

Enriching our team

We recognise our staff are our most valuable asset and that we have an obligation to support their emotional, physical and spiritual health.

- Staff Development Grant established to support employees to take up professional development opportunities.
- Staff members and their families shared cuisine from over a dozen countries to celebrate WDHS's cultural diversity at 'Festi Kultura'.
- Senior staff participated in leadership and management training.
- 20+ staff wellbeing activities and events were delivered throughout the year.
- 50% of staff participated in the People Matter Survey - the highest response rate ever.
- Staff and community members 'walked with midwives' to celebrate International Day of the Midwife.
- $80k was invested in OH&S equipment to make our workplaces safer.

Investing in our future

We will invest in systems, infrastructure and equipment to provide an environment that supports the safe delivery of state of the art services to our community.

- $1.8m total fundraising / donations received for the year, a significant proportion of which will support the new cancer treatment and dialysis project.
- $361k government funding received to upgrade nurse call system at Hamilton Base Hospital.
- Community Transport Service part funded by the Hospital Opportunity Shop and Taylor Motors to secure the viability of this vital program.
- 5 year substantial sponsorship agreement reached between Rural Bank and NCFH.
- Woolworths community fundraiser launched to purchase cardiac monitor for ICU.
- 800 people flocked to see 3 of the Western District's premier Spring gardens for the inaugural WDHS Garden Open Day, raising over $23k.
- Two anaesthetic machines funded thanks to a Collier Foundation grant and the Charity House project.
- Day Procedure Centre feasibility study carried out to develop an exciting new facility in the Hamilton CBD.

For full strategic plan visit www.wdhs.net/strategicplan

Financial Overview

Overview

The Financial Statements have been prepared in accordance with Standing Direction 5.2 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 2017.

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 $12k ($15k in 2016), which represents 0.00017% of operating revenue. Operating revenue increased by 3.96% compared to the prior year, while expenditure increased by 3.97% compared to 2015-16.

Complexity adjusted (WIES 23) inpatient activity was 1.37% higher than the previous year. The WIES target for 2016-17 increased by an additional 210 WIES (4% increase) and the Health Service achieved 98.12% of the overall target for the financial year. Residential aged care activity was consistent with the prior year and all other activity targets across the Health Service were achieved.

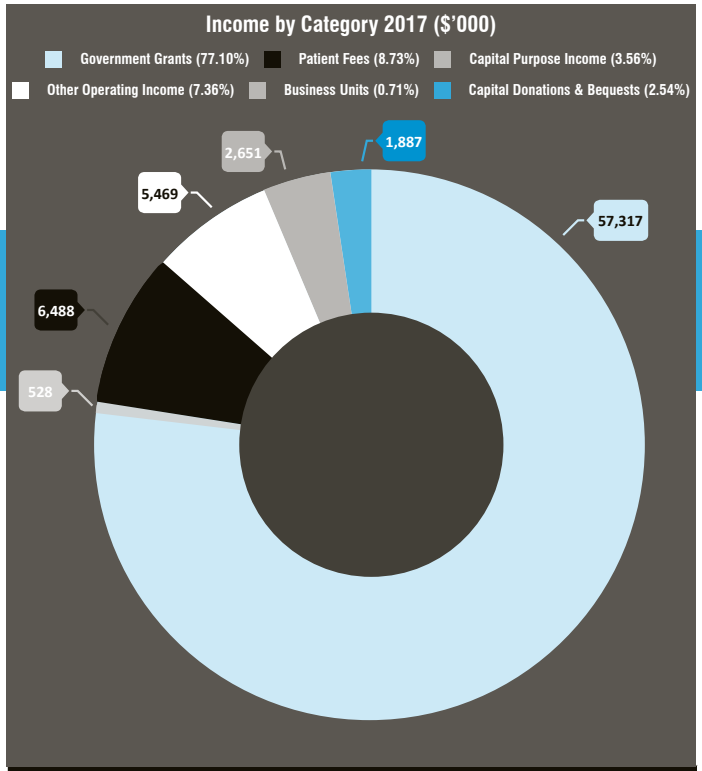
In reviewing operating performance capital purpose income, comprising capital grants ($1.3m), residential aged care capital contributions ($1.4m) and specific purpose donations and bequests ($1.9m) are excluded. These funds are provided for specific capital purposes and are not available to support operations. Depreciation and valuation changes, specific expenditure from capital purpose revenue ($37k) and the surplus on disposal of non-current assets ($85k) are also excluded, being predominantly funded from capital income sources.

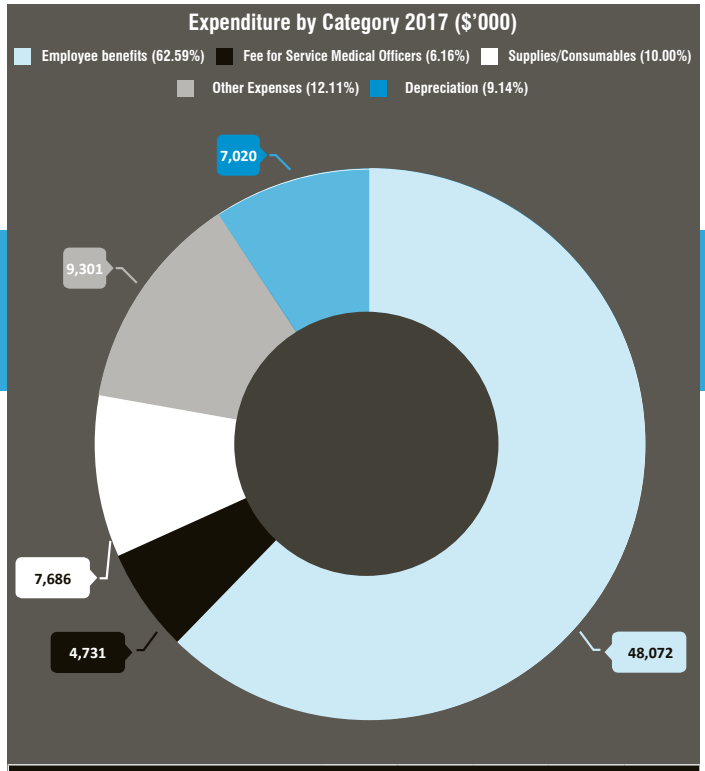
In the 2016-17 financial year, depreciation charges of $7.0m were recorded, reflecting the cost associated with the use of buildings and equipment in delivering services.

Capital income was $2.291m less than the depreciation charges. Financial asset fair value losses of $29k, lease finance costs of $108k, impairment of financial assets of $5k, revaluation of long service leave of $45k and a joint venture surplus of $4k were recognised in calculating the comprehensive result for the year.

Including all items, the Health Service net assets reduced by $2.499m for the year, representing an improvement of 8.8% or $241k compared to the prior year.

WDHS incurred a comprehensive entity deficit of $2.5m for the 2016-17 financial year. The entity deficit is largely attributable to costs associated with depreciation charges of $7.0m, as a consequence of the revaluation of buildings in 2013-14. In spite of the significant comprehensive entity deficit, overall liquidity levels and other financial indicators remained stable during the year and substantially above target levels.





Average Cost Acute Inpatient – 5 Year Comparison

	2017	2016	2015	2014	2013
Government Grants	57,317	55,433	53,557	51,204	50,258
Patient Fees	6,488	5,804	6,898	5,947	5,700
Business Units	528	473	608	655	734
Other Operating Income	5,469	5,355	5,119	8,042	8,906
Capital Purpose Income	2,651	3,048	1,379	4,001	14,181
Capital Donations & Bequests	1,887	1,425	824	1,145	1,073

Average Cost Non-admitted Occasion of Service – 5 Year Comparison

	2017	2016	2015	2014	2013
Employee Benefits	48,072	46,183	44,689	43,555	43,255
Fee for Service Medical Officers	4,731	4,382	4,247	3,785	3,501
Supplies/Consumables	7,686	7,101	6,416	6,213	5,894
Other Expenses	9,301	9,457	10,156	12,246	12,832
Depreciation	7,020	6,951	6,924	3,900	3,512

Liquidity Position

During 2016-17 the Health Service generated positive cash flows from operations of $5.0m, including $4.7m in capital purpose income, $1.209m of these funds were used to purchase property, plant and equipment and a further $27k used to repay finance leases during the year. The entity generated a positive cash flow of $3.795m for the year after capital items and applied $4.01m of the available cash to purchase investments. After purchase of investments the available cash was reduced by $221k to $8.9m at year end.

The ratio of current assets to current liabilities (excluding patient trust funds) at the end of the year was 1.76:1 compared to 1.61:1 in the previous year. This remains considerably in excess of the 0.7 target ratio.

Asset Management

$1.25m was invested during the year in building works, plant, equipment and infrastructure upgrades, in accordance with the capital works budget adopted in September by the Board of Directors. This investment was substantially less than the $7.0m depreciation expense for the year.

Significant items included in the $1.25m investment, were the purchase and replacement of endoscopy equipment for Theatre totalling $252k, cooling works to Hamilton Medical Group and HBH kitchen $77k, oven replacement for the Penshurst Campus $13k, new dental chair for the Coleraine Campus $34k, vehicle replacement program $93k and $225k for assets under construction including the Oncology / Dialysis Project, the Birches Redevelopment, the Theatre Imaging Project and fire detection works.

Community Support

The support of the community, as indicated by the outstanding $1.887m received from donations and bequests, allows WDHS to continue to invest in buildings, medical equipment and technology.

It is important to maintain the level of investment to provide a strong base for the Health Service to improve service delivery and efficiency and comply with increasingly rigorous service standards.

The Future

Although continually facing ongoing financial challenges, the Health Service is optimistic about its future and will continue to identify ways to enhance its financial performance and achieve greater operational efficiency and productivity, through continuous improvement processes.

Complexity adjusted (WIES 23) inpatient activity was 1.37% higher than the previous year.

YEAR IN BRIEF	2017	2016	2015	2014	2013
FINANCIAL ($000'S)					
Total Revenue	69,802	67,138	66,109	65,898	65,598
Total Expenses	69,790	67,123	65,508	65,799	65,482
Net Result before capital and specific items	12	15	601	99	116
Net Result for the year (inc. Capital and Specific Items)	(2,470)	(2,650)	(4,284)	1,146	11,685
Retained Surplus / (Accumulated Deficit)	11,791	17,108	22,041	27,217	26,455
Total Assets	167,861	169,361	167,842	167,613	101,836
Total Liabilities	28,697	27,698	23,439	18,850	19,301
Net Assets	139,164	141,663	144,403	148,763	82,535
Total Equity	139,164	141,663	144,403	148,763	82,535
FUNDRAISING ($000'S)					
Income	1,913	1,447	854	1,171	1,120
Expenditure	26	21	27	26	47
Surplus	1,887	1,426	827	1,145	1,073
STAFF					
Number of staff employed	716	731	716	721	818
Equivalent full time	538.82	534.11	531.05	547.63	554.12
PERFORMANCE INDICATORS (ACUTE)					
Inpatients treated (separations)	7,161	6,967	7,026	7,197	6,941
Complexity adjusted inpatients (WIES23)*	5,303	5,213	5,142	4,998	4,694
Average stay (days)	2.48	2.68	2.67	2.77	2.89
Inpatient bed days	17,773	18,201	18,758	19,971	20,038
Total occasions of non-admitted patient service	49,631	46,973	37,830	39,208	44,080

* WIES - Weighted Inlier Equivalent Separations

Service Performance at a Glance

	2017	2016	2015	2014	2013
INPATIENT STATISTICS (ACUTE PROGRAM)					
Inpatients Treated	7,161	6,967	7,026	7,197	6,941
Average Complexity (DRG Weight)	0.74	0.75	0.74	0.69	0.68
Complexity Adjusted Inpatients (WIES 22)*	5,303	5,213	5,142	4,998	4,694
Inpatient Bed Days	17,773	18,659	18,758	19,971	20,038
Average Length of Stay (days)	2.48	2.68	2.67	2.77	2.89
HITH Bed Days	420	668	671	631	776
Nursing Home Type Bed Days	604	637	1,091	1,553	1,808
Operations	3,138	2,911	3,127	2,895	2,882
Births	162	193	191	210	201
Available Bed Days	27,877	27,954	27,654	28,613	26,915
Occupancy Rate	67.4%	71.4%	71.8%	75.2%	81.1%
Average Cost Per Inpatient	$5,147	$4,909	$4,608	$4,344	$3,906
AGED CARE STATISTICS - (AGED PROGRAM)					
High Care					
Residents Accommodated	189	220	207	185	227
Resident Bed Days	50,297	52,790	51,021	39,639	50,247
Low Care					
Residents Accommodated	24	24	29	62	35
Resident Bed Days	4,405	3,100	5,665	11,803	5,968
Respite					
Residents Accommodated	182	214	133	139	129
Resident Bed Days	3,414	2,764	2,049	2,077	1,506
Occupancy Rate	91.26%	92.10%	92.48%	84.27%	90.88%
Home Care Package (HCP) clients	40	36	38	44	39
HCP Occasions of Service	10,294	9,608	9,843	9,654	10,396
ACCIDENT/EMERGENCY OCCASIONS OF SERVICE	**6,960**	**7,018**	**6,984**	**7,155**	**6,841**
Outpatient (Non-admitted) Occasions of Service					
Physiotherapy	8,047	6,855	4,114	4,360	5,549
Planned Activity Group	6,626	5,941	5,743	5,319	5,317
Speech Pathology	925	810	762	658	684
Podiatry	3,056	2,993	2,617	2,229	1,708
Occupational Therapy	1,952	1,920	1,753	1,812	2,425
Palliative Care	1,143	2,309	1,428	2,012	2,165
District Nursing Service	23,597	22,123	21,973	21,959	25,737
Other (Continence, Diabetes, Dietetics)	4,285	4,022	3,479	3,198	2,852
Total Non-admitted Occasions of Service	49,631	46,973	41,869	41,547	46,437
Cost Per Non-admitted Occasion of Service	$219	$191	$171	$169	$165
Meals on Wheels	21,006	20,382	23,078	26,933	30,733
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 7.
* Our Target WIES for 2016-17 (excluding those funded under the Small Rural Health Services Program) was 5,217. The Health Service was 1.88% below target this year.

Acute/Sub-acute

- Anaesthetics
- Chemotherapy
- Contracted Services - Pathology, Radiology and Sleep Clinic
- Coronary Care
- Day Procedure
- Ear, Nose and Throat
- Emergency
- Endocrinology
- Endoscopy
- General Medicine
- General Surgery
- Geriatric Evaluation Management
- 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
- Pharmacy
- Preadmission Service
- Psychiatry
- Rehabilitation Medicine
- Specialist Adult Medicine
- Specialist Nursing
- Stroke Medicine
- Transition Care
- Urology
- Wound Care

Primary & Preventative Health

- Audiology
- Balance Clinic
- Breast Cancer Support Group
- Cancer Care Coordinator
- Cancer Support Group
- Cancer Support Services
- Cardiac Rehabilitation
- Cardiac Support Group
- Carer's Support Group
- Chronic Disease Management Program
- Chronic Pain Service
- Complex Care
- Continence Service
- Counselling
- Diabetes Education
- Discharge Support Service
- District Nursing Service
- Domiciliary Midwifery
- Exercise Physiology
- Family Planning
- Hamilton Community Transport
- Hospital in the Home
- Lymphoedema Management
- Men's Health
- Nutrition and Dietetics
- Occupational Therapy
- Palliative Care
- Physical Activity Programs
- Physiotherapy
- Podiatry
- Short Term Support
- Public Health Medicine
- Rehabilitation in the Home
- Respiratory Education
- Respiratory Support Group
- Sexual and Reproductive Health
- Smoking Cessation
- Social Support Group
- Social Work
- Speech Pathology
- Stomal Therapy
- Telehealth
- Women's Health
- Workplace Health Programs
- Youth Programs

Aged Care

- Dementia Specific Residential Aged Care
- Geriatric Medicine
- Home Care Packages
- Leisure and Lifestyle
- Men's Out & About Activities
- Palliative Care
- Private Respite Care
- Psycho Geriatric Care
- Residential Aged Care
- Respite Care

National Centre for Farmer Health

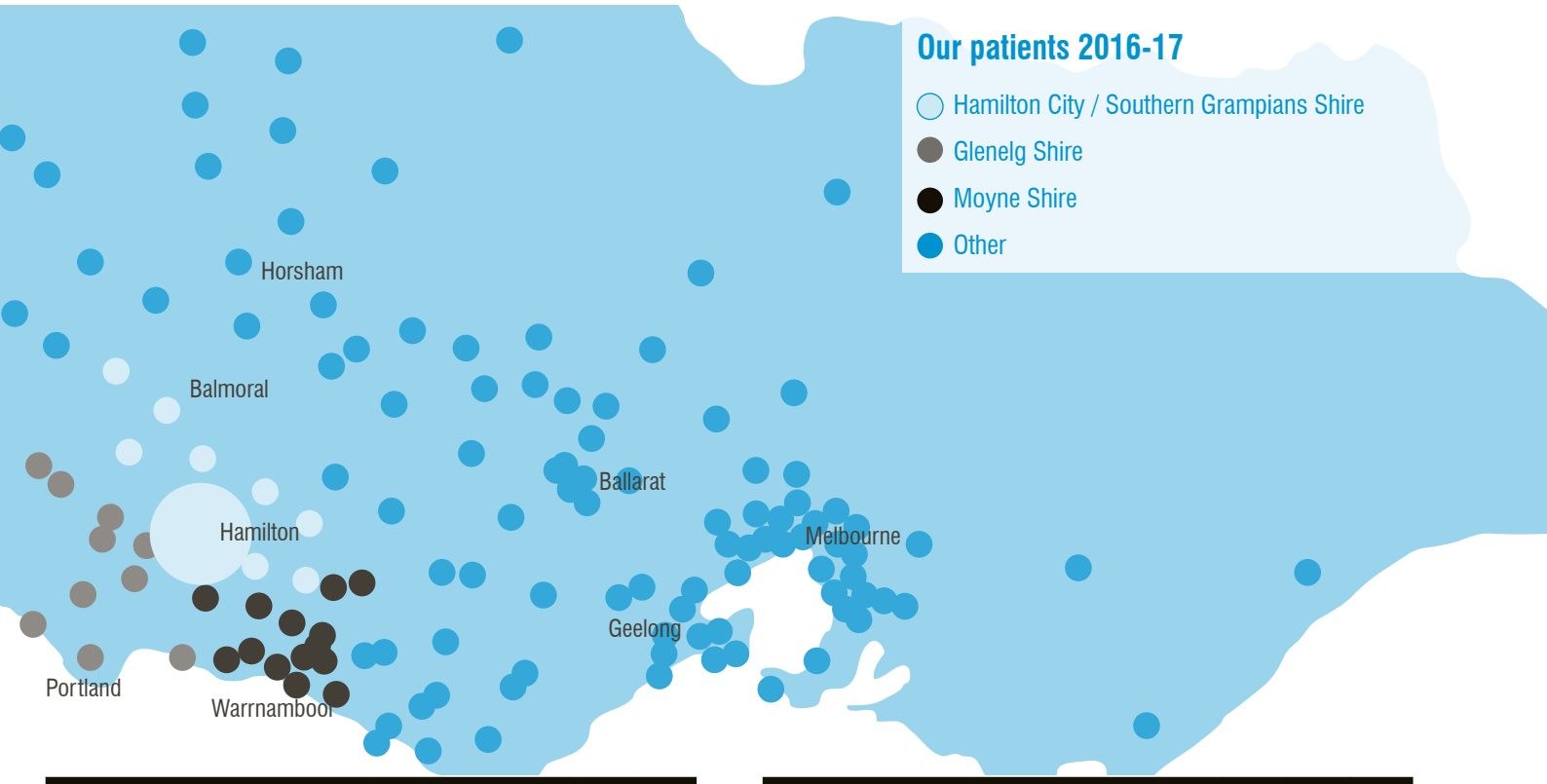
- AgriSafe™
- Health and Lifestyle Assessments
- Information and Knowledge Hub
- Research and Development
- Sustainable Farm Families™
- Training and Education

Administrative

- Auxiliaries
- Community Liaison
- Facility Management
- Finance
- Health Information
- Hotel Services
- Human Resources
- Learning and Education
- Library
- Meals on Wheels
- Medical Administration
- Occupational Health and Safety
- Quality Improvement
- Reception
- Security
- Sub Regional Corporate Services
- Volunteer Program

→ Physiotherapists Jackson Wood and Julie Tran support client Betty Annett after surgery, in the Rehabilitation Gymnasium at Hamilton Base Hospital.

Patient Admissions and Classification



Total Discharges – 5 Year Comparison					
Location	**2017**	**2016**	**2015**	**2014**	**2013**
Hamilton City	3,139	2,643	2,350	3,629	3,524
Southern Grampians	931	728	538	822	762
Glenelg Shire	1,002	807	711	1,029	1,080
Moyne Shire	779	478	393	636	559
Other	1,310	2,311	3,034	1,081	1,016
Total	**7,161**	**6,967**	**7,026**	**7,197**	**6,941**

Inpatient by Classification – 5 Year Comparison					
	2017	**2016**	**2015**	**2014**	**2013**
Public	5,580	5,274	5,193	5,418	5,171
Private	1,382	1,486	1,576	1,490	1,452
Department of Veterans Affairs	145	140	201	226	250
Transport Accident Commission	20	21	26	25	22
Workcover	34	46	30	38	46
Total	**7,161**	**6,967**	**7,026**	**7,197**	**6,941**

→ Patient Amanda Smith speaks to Dietician Emma Stubbs about post operative nutrition.

→ WDHS cleaning staff and Chief Executive, Rohan Fitzgerald celebrate the annual external cleaning audit conducted in July 2016. WDHS achieved 99% compliance, exceeding the DHHS benchmark by 9%.

AUSTRALIAN COUNCIL OF HEALTH CARE STANDARDS ACCREDITATION

WDHS achieved reaccreditation in all NSQHS Standards, on all criteria during the ACHS accreditation site visit in October 2016.

AGED CARE ACCREDITATION

Unannounced assessment visits from the AACQA, were conducted in all WDHS aged care facilities in 2016-17, with full compliance achieved.

BABY FRIENDLY HEALTH INITIATIVE ACCREDITATION

WDHS was reaccredited as a 'Baby Friendly' facility, ensuring mothers receive appropriate support and contemporary care and information.

WDHS quality and safety initiatives ensure the community receives safe, appropriate and high quality care and services.

Accreditation

Systems and processes at WDHS are periodically assessed against national standards. Accreditation is a mandatory process for all public acute health services and providers of residential aged care across the state.

WDHS participates in several comprehensive national accreditation programs, including those conducted by the Australian Council on Health Care Standards (ACHS) and the Australian Aged Care Quality Agency (AACQA).

National Standards

The National Safety & Quality Health Service (NSQHS) Standards drive the implementation of safety & quality systems to improve healthcare across Australia.

A full assessment of the NSQHS Standards was conducted at WDHS in October 2016. WDHS achieved reaccreditation in all ten of the Standards, with the organisation receiving just three minor recommendations for improvement out of 209 assessed criteria.

Baby Friendly

Following an assessment in March, WDHS achieved Baby Friendly Health Initiative (BFHI) accreditation for a further three years. The assessment process ensures that WDHS is complying with the BFHI standards, based on the *10 Steps to Successful Breastfeeding*. The standards primarily protect, promote and support breastfeeding, however more recently they have expanded to include a much broader range of assessment areas. For WDHS this means that it is supporting mothers and babies in an environment that encourages high-quality care, education and support, that is evidence-based and best-practice.

Commonwealth Home Support

The WDHS Commonwealth Home Support Program (previously Home and Community Care) met the criteria measures across the following three standards in January:

Standard 1: Effective management

Standard 2: Appropriate access and service delivery

Standard 3: Service user rights and responsibilities

The Australian Aged Care Quality Agency assessors were complimentary of the integrity of management systems, noted the excellent care delivered to clients by Primary and Preventative health (PPH) teams and found that WDHS met each of the outcome measures assessed.

Risk Management

The identification, assessment and management of risk is critical to the safety of patients, visitors & staff. Risks are monitored by the Quality Department and are regularly reviewed by the Executive Team. The WDHS risk management framework has been developed in accordance with the Risk Management Standard AS/NZS ISO 31000:2009.

Consumer Participation

WDHS has continued to seek opportunities to engage community members to actively participate in the planning and evaluation of services and improvement processes.

CHIC

This year a Consumer Health Information Committee (CHIC) was established to ensure that WDHS publications and patient information is appropriate and meets the needs of consumers.

Customer Feedback

Feedback allows the organisation to monitor the quality of the care provided and assists WDHS to implement improvements to practice, facilities, systems and equipment. During 2016-17, 797 items of formal feedback were received. Of these 675 were compliments, 104 were complaints and 18 were suggestions for improvement. Of the 104 complaints, 88 were closed within 30 days (85%) and 16 within 30-60 days.

Clinical Services

→ GP Obstetrician, Dr Alan Reid has joined the Maternity Services team at WDHS and is pictured here with Graduate Midwife, Simone Gebauer and Midwife Anne Dowling.

BORN IN HAMILTON INITIATIVE

The Maternity Services team launched a 'born in Hamilton' promotion, revamping marketing material and information provided for new mums.

E-CREDENTIALING

An e-credentialing system was implemented to allow for collaborative credentialing and allocation of scope of practice to all clinicians in the region.

SOUTH WEST CLINICAL GOVERNANCE

WDHS facilitated the establishment of a Healthshare Clinical Council to standardise clinical governance strategies, systems and processes.

WDHS provides a range of high quality emergency, medical, surgical, sub-acute, midwifery, paediatric, intensive care and allied health services.

Performance

WDHS maintained a 67.4% bed occupancy rate, with patients averaging 2.48 days in hospital. 6,960 Emergency Department (ED) presentations were recorded, with 22.6% resulting in admissions to Hospital. The Operating Theatres delivered 3,138 operations and 162 new babies were born at HBH.

49,631 outpatient occasions of service were also documented across WDHS campuses.

Respiratory Medicine

Together with Manse Medical, WDHS recruited two more respiratory physicians to further develop rural respiratory capabilities in Hamilton. Our Sleep Clinic and Operating Theatres continue to support this important service.

Surgical Excellence

Bariatric Surgery

Obesity is a significant public health challenge for Australia, with research indicating that up to two thirds of all adults are overweight or obese. Over the last three decades, in collaboration with Glenelg Surgical Clinic, WDHS has developed a unique 'centre of excellence' for bariatric surgery.

WDHS is developing its capacity to provide multidisciplinary support to this highly regarded surgical team. This includes a perioperative program to prepare candidates for surgery and a postoperative follow-up to ensure achievement of desired outcomes and provide ongoing support.

Reconstructive Breast Surgery

WDHS is supporting a 'one stop breast clinic' at Glenelg Surgical Clinic, to enable a unique reconstructive breast surgery service for cancer patients to be delivered in Hamilton. A Breast Care Nurse and Theatre / Ward staff are supporting a local breast surgeon to develop this comprehensive breast surgery service.

Orthopaedics

During the year, WDHS further developed its orthopaedic surgery service, with four orthopaedic surgeons currently visiting for specialist clinics and regular orthopaedic Theatre lists.

Musculoskeletal Clinic

A Physiotherapy–lead Musculoskeletal Clinic is being developed to support the orthopaedic surgery service and to:

- Assess patients' suitability for surgery or alternate conservative management along with Orthopaedic Surgeons, Health Information, GPs and the Theatre Team.
- Centralise the administration of bookings for orthopaedic surgeries and maintain a client repository for orthopaedic / musculoskeletal clients at WDHS through Health Information and the Physiotherapy Department.
- Develop an Allied Health rehabilitation group that delivers exercise and education programs to clients who are awaiting surgery, with the aim of enhancing their recovery and the success of the surgery, or to conservatively manage their condition.

Oncology

At Hamilton Base Hospital, a public service model of providing cancer care has been developed with the Ballarat Regional Integrated Cancer Centre (BRICC).

New Chemotherapy/Hemodialysis Unit

WDHS is constructing a new chemotherapy/ hemodialysis unit at Hamilton Base Hospital. New workspaces for the Health Information team were developed to accommodate the redevelopment. The new treatment facility will provide a combination of eight chairs, consultation rooms, ample waiting areas and a redeveloped patient admissions area.

This redevelopment will strengthen the capacity of WDHS to offer comprehensive chemotherapy and dialysis services in collaboration with highly regarded visiting specialists.

Primary and Preventative Health (PPH)

→ Chief Dietician, Jodie Nelson and Dietician Danielle Lee assess the suitability of a product for a patient with renal failure.

COMMUNITY FOR YOUTH BOARD

The new C4YB is supporting youth activities including health 'pop up' shops, the FReeZA Program and the Handbury Youth Holiday Program.

NDIS PLANNING

WDHS commenced planning to become an NDIA approved provider, to deliver a range of services for people with a disability under the NDIS scheme.

FLEXIBLE CYSTOSCOPY

A new Nurse Practitioner Lead Flexible Cystoscopy Service will improve patient care and access to specialists via video link.

The Primary and Preventative Health (PPH) Division provides nursing and allied health services across acute, aged care and community settings.

Service Innovation

The Physiotherapy and Occupational Therapy teams reworked the Falls and Balance Group, to deliver a coordinated 12 week program, for both clinic and home based services.

A new Physiotherapy Patient Clinic was introduced to triage Physiotherapy clients, resulting in the removal of the Physiotherapy waiting list.

Increased Capacity

Additional Occupational Therapy and Physiotherapy services were provided on weekends and during extended hours to accommodate the needs of patients undergoing Orthopaedic Surgery.

Malnutrition WIES funded a permanent Allied Health Assistant in the Dietetics Department.

Collaboration

Speech Pathology actively participated in the regional 'Beyond the Bell Group' for Southern Grampians, which focused on Growing Greater Readers.

The Diabetes team conducted a successful 'Diabetes in School and Early Childhood Setting' study day for local teachers.

This initiative, driven by Diabetes Victoria, Royal Children's Hospital and Monash Children's Centre, is standardising diabetes education for teachers.

WDHS sponsored a major community forum with over 800 attending a presentation by Nathan Wallis on the impacts of drugs and alcohol on youth and the developing brain.

A collaboration between WDHS and the Royal Melbourne Hospital is providing chronic pain services to Hamilton Medical Group and the Coleraine and Casterton Clinics. The pain clinic runs on a monthly basis, with in excess of 30 clients accessing the service.

Improved Outcomes

The Paediatric Occupational Therapy Service exceeded the funding targets set and is applying for additional funding to expand the service.

Residents of the Grange Aged Care Facility have seen a reduction in weight loss through diet and nutrition intervention strategies.

Services provided by the Complex Care Coordination Team to clients with Chronic Health Conditions and Pain have continued to reduce unplanned admissions to hospital and ED.

Consumer Directed Care

The Palliative Care Team commenced the roll-out of *The Care Plan for the Dying Person* across WDHS and Casterton Acute Campuses, which focuses on delivering patient-centred care, integrating and coordinating existing services and improving quality end of life.

A Speech Pathology student project reviewed paediatric speech and language handouts in consultation with families. The delivery of a regular Speech Pathology clinic at Mitchell Park Kindergarten offered on-site services to families who have difficulty accessing clinic-based services.

System Improvements

The Complex Care Coordination Team reviewed service provision to clients with cancer and established two Cancer Care Coordinator Positions to enable greater access to support services.

A new Physiotherapy Allied Health Assistant outpatient program increased clinician access and lead to improved compliance with exercises.

The Occupational Therapy Department reviewed equipment loan procedures, implementing efficiencies and identifying areas for further improvement.

Enhanced Services

The Diabetes Department has embraced new technology and training opportunities and purchased two flash glucose monitoring systems, or swipe meters, for quick scanning of glucose readings. Diabetes Educators have also completed specialised training for continuous glucose monitoring (CGM), which supports clients to access these specialised services locally.

Aged Care

→ Student Christine Woods assists Grange resident, Lois Witham as part of a school based industry training program. Both students and residents enjoy the program, which not only provides valued services for clients, but creates opportunities for skill development and intergenerational communication.

Montessori

OUTCOMES

The Montessori model delivers a range of activities to ensure residents feel valued and an integral part of their community.

20 MIN ROUNDING FALLS RESEARCH

Interim data shows an initial reduction in the number of falls and related injuries with 20 minute rounding (staff supervision every 20 minutes).

BIRCHES REDEVELOPMENT

Following extensive consumer consultation, the Birches redevelopment plan was finalised, with building works set to commence in 2018.

WDHS operates six aged care facilities in Hamilton, Penshurst and Coleraine, supporting clients to maintain their independence, interests and offering comprehensive lifestyle programs.

Leading Practice

WDHS was proud to lead and implement the Leadership in Dementia Practice (Montessori Model) initiative, in partnership with Alzheimer's Australia Victoria. It involved the education and training of staff from 13 residential aged care facilities across South West Victoria. The Montessori Model of Care provides residents with choice, respecting their rights and preferences. By getting to know each resident and their individual needs, staff provide more meaningful activities that encourage a sense of value and purpose. Alzheimer's Australia is using the WDHS presentation of Montessori achievements to promote its service.

Falls Management

The 20 Minute Rounding Falls Research Project was implemented across WDHS's aged care facilities following ethics approval in November 2016. A research assistant was appointed and residents were randomised into participant and control groups. Resident, relative and staff education formed an integral part of the project. Following resident and relative consent, the project commenced in December and concluded in June. Data collation is in progress, with the final report due to be completed in September 2017.

Quality Improvement

Medication Management

WDHS has taken several different approaches to improving medication management in its aged care facilities. It has introduced an electronic portal (Meds Comm) to provide for the timely and effective dispensing of medications through the local pharmacy. An external consultant pharmacist has been contracted to conduct medication reviews and provide recommendations for inclusion in the shared clinical record. The Health Service has also implemented the National Residential Medication Chart, designed to improve medication safety.

Dementia Management

A Cognitive Impairment Workgroup was established, with multidisciplinary and consumer representation. A gap analysis against National Dementia Best Practice Standards was completed resulting in five recommendations for action including:

- Improving access to a geriatrician/psycho geriatric services.
- Further imbedding the Montessori Model of Care.
- Providing workplace support for staff diagnosed with dementia.
- A forum on Dementia to be held with a guest speaker.
- Recommendation for a risk screening tool for cognitive impairment and delirium screening.

Systems Improvements

Aged Care Services

WDHS is currently reviewing how it can ensure that aged care services, including permanent and respite care and home care packages are more accessible and comprehensive for consumers. With the aim of creating an 'Aged Care Service Centre', WDHS has completed a comprehensive review of current processes and developed an action plan which includes a multi-skilled team who are the one point of contact for aged care services.

Documentation

With the aim of aligning systems and processes across all facilities, WDHS has reviewed its resident care documentation in relation to assessment, care planning and clinical handover. Documentation audits were conducted and areas for improvement identified. Guidelines and education for clinical handover being trialled, to assist staff in effective information sharing to ensure the safety of residents.

Southern Grampians Glenelg Primary Care Partnership (SGGPCP)

→ Community members and GenR8 Change Ambassadors promote the WDHS / GenR8 Change sugar tax petition for a Herald Sun feature.

GenR8 Change

500+ CHILDREN SURVEYED

500+ children weighed, measured and surveyed to measure overweight and obesity levels in years 2, 4 and 6 across the region.

20

SOCIAL NETWORK MAPS

20 social network analysis maps created to explain PCP partner relationships.

SUGARY DRINKS

1 health service to 13 health services to an entire state of health services pledge to remove access to sugary drinks in hospitals.

Southern Grampians Glenelg Primary Care Partnership (SGGPCP) is a voluntary partnership enhancing the health and wellbeing of the community, by supporting organisations to work together.

Communities Taking Action on Childhood Obesity

The 'GenR8 Change' community movement in Southern Grampians and 'SEA Change' in Portland have continued to grow and support the community to 'make the healthy choice the easy choice'. GenR8 Change Ambassadors, initiated a petition to the Federal Government seeking a sugar tax on sugar sweetened beverages. This action stimulated widespread media coverage and interest about levels of childhood obesity in the community. It also sparked further conversations and action in the local community. One notable action is the bringing together of Hamilton secondary school principals, who are now working with their students to develop the Greater Hamilton Health Challenge. The Challenge will support students and their families to make positive changes to their lifestyles and will drive changes in the school environment.

The Hamilton Basketball Association now has a 'water only' policy for its members and joined over 250 people in the VicHealth H3O Challenge.

Three water fountains were installed in Hamilton in a partnership with Wannon Water and SGSC, to improve access to tap water.

Networks 4 Resilience

Networks in any capacity are vital to the social fabric of a community; they hold collective knowledge, history and human capital together. Rural communities in particular, are built on the back of local knowledge and experiences learned by pushing through 'tough times'. The National Strategy for Disaster Resilience acknowledges that non-government and community organisations are at the forefront of strengthening disaster resilience in Australia. The work of these organisations can be crucial in helping communities prepare, cope and recover from disasters.

This year SGGPCP used social network analysis methodology to map the SGGPCP partnership networks and others that exist between agencies and their community. They found that those with informal relationships are more likely to apply inter-organisational learning in their work and collaborate on disaster preparedness.

Shared organisational goals and understanding each organisation and its leadership were significant enablers of collaboration.

SGGPCP is well positioned to support collaboration on disaster resilience, by brokering relationships and creating shared understandings between member agencies.

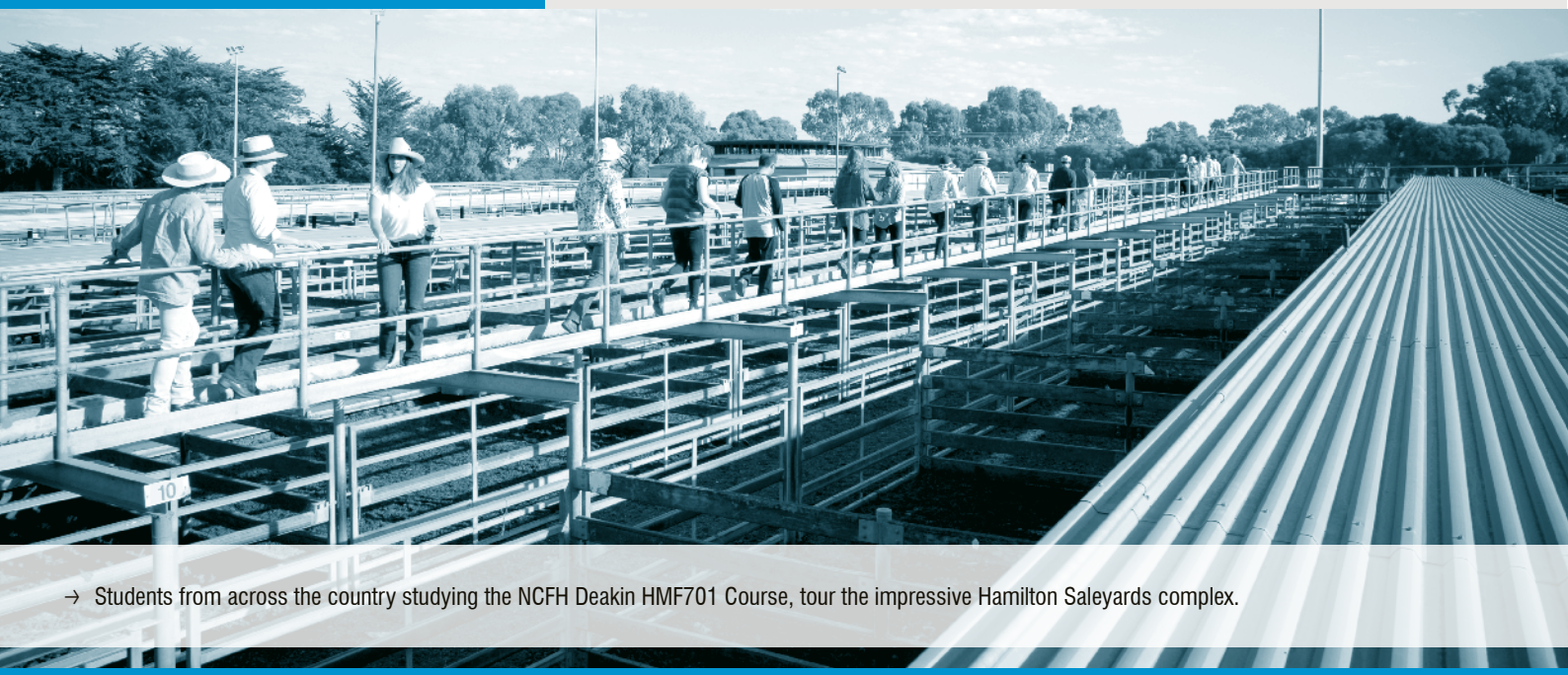
Our Partners

SGGPCP acknowledges and thanks Western District Health Service for its support as an auspicing body.

PCP Partners:

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
Portland District Health
Portland Neighbourhood House Inc
Southern Grampians Shire Council
South West Healthcare (Psychiatric Services)
Western District Health Service
Winda-Mara Aboriginal Corporation

National Centre for Farmer Health (NCFH)



→ Students from across the country studying the NCFH Deakin HMF701 Course, tour the impressive Hamilton Saleyards complex.

12,000

RIPPLE EFFECT UNIQUE USERS

The Ripple Effect suicide prevention intervention targets males from farming communities. The website launched in July '16 and 12,000 unique users visited the site during the year.

HEALTH AND WELLBEING

In response to the dairy pricing crisis and supported by the William Buckland Foundation, the NCFH delivered a full day of health and wellbeing activities at the Terang Mortlake Football Netball Club.

R4FH

RUN 4 FARMER HEALTH

The R4FH campaign at the Melbourne Marathon Festival was popular again in 2016. The addition of a marquee, physio (and less popular ice bath) supported the 112 NCFH runners.

The National Centre for Farmer Health (NCFH) provides national leadership and programs to improve the health, wellbeing and safety of farm men and women, farm workers, their families and communities across Australia.

Overview

Since receiving $4million in Victorian Government funding in 2015, the NCFH has gone from strength to strength. With a full complement of staff, the team worked tirelessly to 'make a difference to farmers' lives this year. The NCFH presented at 23 community events, conducted six education workshops and delivered its award winning Sustainable Farm Families Program at five different locations throughout Victoria. The Centre also carried out 491 farmer health and lifestyle assessments. Academic staff presented new research findings at eight academic conferences. In March, with the support of the Shepherd Foundation, the NCFH hosted 40 farmers and industry specialists for its 'Understanding Agrichemical Exposure, - Your Results and Beyond' symposium. Contributing farmers received a sneak preview of their results from the Personalised Cholinesterase Assessment Project (PCAP).

Field Days

The NCFH also attended seven different agricultural field days to deliver its renowned Health and Lifestyle Assessments to 491 farmers and field day participants. With support from Rural Bank it also delivered to interstate rural communities at the South East Field Days, Lucindale SA, Agfest in Carrick TAS and for the first time, the Dowerin Machinery Field Days in Dowerin WA. Over 90% of participants were recommended for further follow-up by NCFH agrihealth professionals for their health results or lifestyle behaviours.

The Ripple Effect

The Ripple Effect is an online intervention designed to investigate what works to reduce the self-stigma (negative attitudes people have towards themselves) and perceived-stigma (negative attitudes people believe others have about them) among males from farming communities, aged 30-64 years, who have been bereaved by suicide, attempted suicide, cared for someone who attempted suicide, have had thoughts of suicide, or been touched by suicide in some way. The Ripple Effect website was launched on 1 July 2016 and to June 2017 over 12,000 unique users have visited this interactive website. Pleasingly 604 are participating in the research, with 203 completed. This important research was supported by Beyondblue and numerous partners. A final report has been submitted and the website www.therippleeffect.com.au remains active, with international interest.

International Collaboration

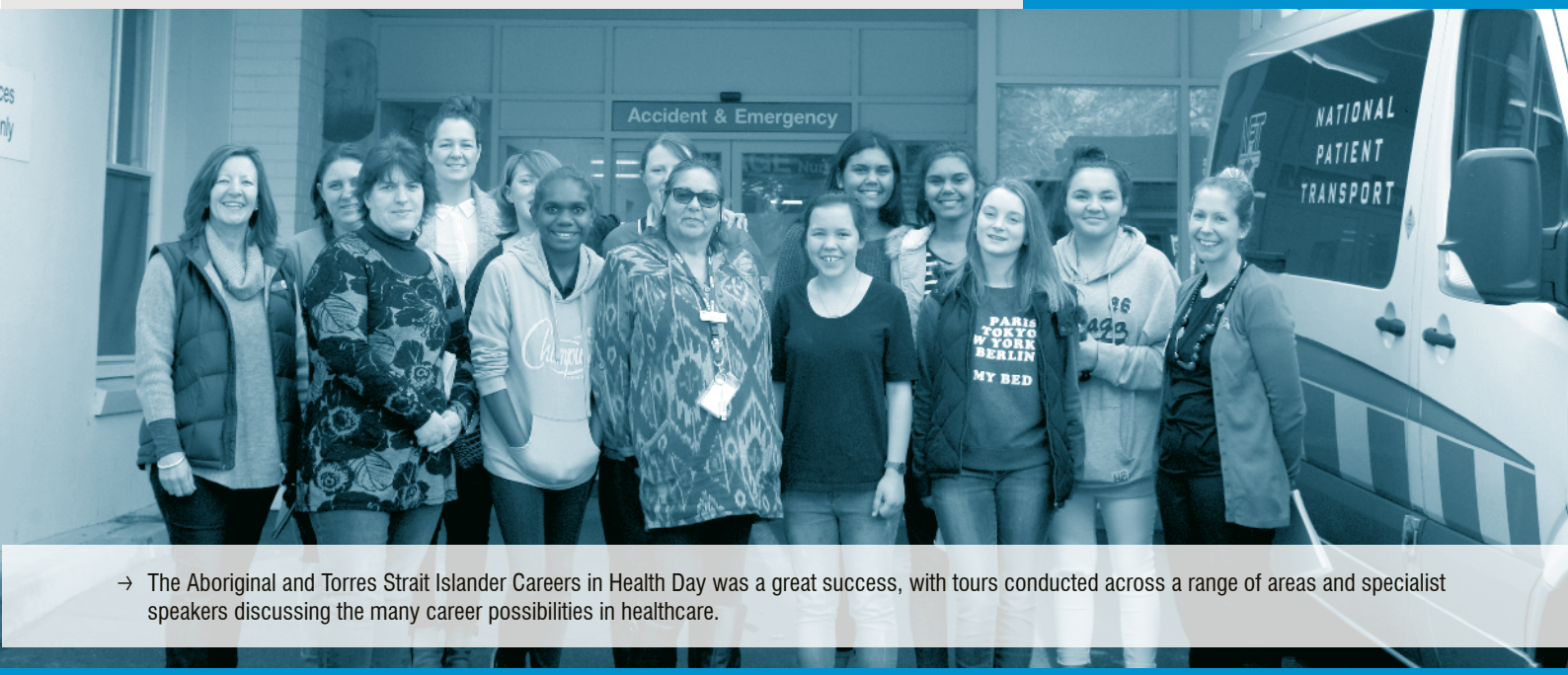
The international profile of the NCFH grew, with a licensing agreement reached with Centurion University (India) to use NCFH resources and an MOU signed by Jember University (Indonesia) to formalise their relationship with the Centre. Interactions to date have included visits to and from Indonesia, India and Ireland. Two Doctors from Jember, Indonesia studied our Post Graduate Agricultural Health and Medicine Course HMF701 at WDHS. In doing so, they will be transferring this expertise to a new audience and 'making a difference to farmers' lives' and communities in Indonesia. NCFH has also presented in Ireland and had a Nuffield Scholar from the UK visit the Centre and surrounding farms.

Education

Developing the next generation of researchers, doctors and rural health professionals is so important to healthy rural communities. The NCFH and Deakin University has worked together to provide opportunities for honours students, and long-term selective and elective placements for medical and social work students. In 2017, two new honours projects will:

(1) evaluate farmer attitudes and behaviours to prevent exposure to organophosphates; and

(2) review help seeking for social and emotional wellbeing in young rural adults.



→ The Aboriginal and Torres Strait Islander Careers in Health Day was a great success, with tours conducted across a range of areas and specialist speakers discussing the many career possibilities in healthcare.

FESTI

KULTURA

To celebrate WDHSs cultural diversity, an evening of shared food, music and dance was held, featuring cuisine from over ten countries.

STAFF DEVELOPMENT GRANT

A new Staff Development Grant was launched to support continuing education and professional development opportunities.

EMERGO

TRAIN MOCK EMERGENCY

Staff, police and CFA reps took part in a mock external emergency, using the Emergo Train Model to test WDHS's Code Brown capabilities.

WDHS is an equal opportunity employer, aspiring to attract and retain high-performing staff committed to the vision, mission and values of the Health Service.

Cultural Inclusiveness

WDHS is working to create more culturally sensitive and welcoming environments. As part of the WDHS Aboriginal Employment Plan, 26 Aboriginal artworks were purchased for display across the Health Service.

A successful 'Festi Kultura' event was held to celebrate the cultural diversity and heritage of WDHS staff and their families. Over 70 people enjoyed this multicultural feast.

People Matter Survey

WDHS participated in the 2017 state-wide People Matter Survey in May, with the response rate increasing by 11% on the previous year.

The survey is conducted by the Victorian Public Sector Commission (VPSC) and benchmarks results from WDHS to results of like organisations. It measures compliance with public sector values, employment principles and supporting measures. It also surveys staff satisfaction with change management, diversity and equality, sexual harassment and wellbeing.

HR Series

Human Resources commenced the 'HR Series' in March, to support and empower middle and senior managers to confidently manage difficult conversations, staff performance, bullying and harassment complaints, return to work issues, conduct interviews and implement child safe standards. Important processes relating to new enterprise bargaining agreements, such as the disciplinary process, flexible work arrangements and domestic violence were also covered.

Staff Wellbeing

The WDHS Wellbeing Group created the 'Inside Out' initiative to improve the overall wellbeing of WDHS employees. Its aim is to improve the resilience, optimism, productivity, efficiency and happiness of each employee. The program included the following sessions: Get Moving, Wake Up Project, Understanding Behaviours, Coping Skills to Deal with Stress, Nutrition Labels 101, Food Apps and Reading People. The Group also delivered over 20 activities throughout the year to promote staff wellbeing, including dance classes, meditation sessions and the successful Women's Meet and Greet.

WDHS is currently developing an electronic Wellbeing Dashboard.

Employee of the Month

July
Kim Fort, Ward Clerk, District Nursing

August
David Kerr, Personal Services Assistant, Nursing

September
Raelene Koenig, Secretary / Computer Clerk, Maintenance

October
Tara-Jane Bailey, Enrolled Nurse, Coleraine

November
Kelsey McIntosh, Graduate Registered Nurse

December
Alison Kennedy, Research Fellow, NCFH

January
Kim Cameron, Enrolled Nurse, Penshurst

February
Ruben Ross, Allied Health Assistant, Social Support Group

March
Sonia Shaw, Maternity Services Program Coordinator, Nursing

April
Brian Kavanagh, Supply Manager, Corporate Services

May
Meg Watson, Complex Care Coordinator

June
Sarah Baker, Occupational Therapist

Statutory Compliance

WDHS made no mandatory reports to the Australian Health Practitioner Regulation Agency (AHPRA) regarding health professionals.
No reports were made under the Protected Disclosure Act 2012.

Code of Conduct

At monthly WDHS induction days and orientation training at departmental level, staff are asked to abide by the Victorian Public Sector Commission (VPSC) Code of Conduct and WDHS Values. Staff also receive training in WDHS policies and procedures, emphasising these values, e.g. bullying and harassment, anti-discrimination and equal opportunity, child safe standards and domestic violence.

Industrial Relations

No work hours were lost as a result of industrial action during 2016-17.

Workforce Data

Employees have been correctly classified in workforce data provided for the 2016-17 year.

Learning and Development

The WDHS Learning and Development (L&D) team has a central role in supporting staff to deliver excellence in clinical care and customer service. Our staff coordinate and support face to face and online learning for clinical and non-clinical staff and volunteers, work placements for school aged and undergraduate students and a coordinated Graduate Program for EN and RN nursing staff.

Staff Development Grant

This year, WDHS launched the new Staff Development Grant. This grant is open to all WDHS employees and supports continuing education and professional development opportunities outside the workplace. Uptake of this program has been pleasing. Supported activities to date include professional conference attendances, clinical skills upgrades and academic study at certificate, undergraduate and graduate degree level.

Best Practice Clinical Learning Environments (BPCLE)

WDHS continues to adhere to and regularly monitor its performance against the standards of the BPCLE Program.

Clinical Training

Undergraduate Workplace Training

- Nursing & Allied Health: WDHS continues to be a destination of choice for students on placement, with partnerships fostered with local, metropolitan and interstate providers.
- VCAL/VETIS/ITP students: WDHS has continued to expand its placement options for VCAL/VETIS/ITP school-aged students, including a new partnership with the Structured Workplace Learning Program at Glenelg and Southern Grampians Local Learning and Employment Network (GSGLLEN).

Graduate Program

The WDHS Graduate Programs were again very busy, with many graduates choosing to come to our rural setting to begin their careers. Participants worked across acute and aged care on all three larger campuses.

In January, the following graduates completed the 2016 twelve month programs:

- 10 General Registered Nurses
- 4 Aged Care Registered Nurses
- 7 Enrolled Nurses (with a further 4 joining mid-year)
- 3 Collaborative Program Nurses.

Newly graduating nurses commenced their transition to practice in January 2017. The programs again had excellent uptake, with the following participation levels:

- 12 General Registered Nurses
- 1 Aged Care Registered Nurse
- 4 Enrolled Nurses (with a further participant joining mid-year)
- 3 Collaborative Program Nurses.

We are fortunate to have some outstanding newly qualified graduate nurses in the program in 2017. Several were acknowledged with awards for their outstanding overall clinical and academic achievements in their undergraduate studies including:

- Glenistair Hancock - Lyndoch Living Inc. Nursing Award
- Melissa Gardner - Western District Health Service Nursing Award
- Lesley Bastock-Lewis - Vocational Student of the Year, South West TAFE and ANMF Student Award (Hamilton) South West TAFE. Lesley has recently been nominated for the Victorian Vocational Student of the Year Award (TAFE).
- The outstanding achievement graduates, as judged by Unit Managers and their peers for 2016 were: RN program – Anastasia Walsh, EN program – Jacqui Russell and Tahlia McDonald.

Collaborative Graduate Program

WDHS continues to participate in the Subregional Collaborative Graduate Nurse Program. Nurses rotate through WDHS, Portland and Moyne Health services, giving a rounded and comprehensive rural practice experience.

Sue Hindson Fund

This year Anne-Marie Wheaton was the very deserving recipient of the Sue Hindson Memorial Fund Scholarship and attended a two day trauma program. This scholarship supports professional development for staff in Intensive Care or Emergency. Learning and Development / WDHS sincerely thanks the Hindson family for their continued generous support.

Continuing Nurse and Midwifery Education (CNME)

This fund allows nurses to attend study days locally, with guest speakers delivering education on a range of topics. In 2016-17, two students studied Graduate Diplomas in Midwifery and two others Graduate Diplomas in Peri-operative Nursing. All students are developing practical experience, while gaining tertiary qualifications.

Non Clinical Education and Training

Leadership and Management Training has been a focus this year. An in-house leadership program, lead by the Chief Executive and Business Improvement Leader, Neil O'Donnell was a great success. Training on core management skills was also provided via the innovative `HR Series' and the 'IT Show and Tell Lunch and Learn Series' was also well received. 'Mental Health First Aid' and 'Domestic Violence Alert' training sessions were well attended and provided important skills and insights for staff.

Online Learning

WDHS provides an extensive catalogue of online learning opportunities to ensure that its workforce is prepared and highly skilled to meet the demands of a diverse and often highly specialised service delivery. Course material is provided from a variety of sources and is reviewed against strict criteria by in-house subject matter experts and L&D staff.

Occupational Health and Safety

WDHS has continued its commitment to improving OH&S management strategies through its ongoing equipment procurement program. During 2016-17 WDHS invested $80,000 to make the workplace safer for staff and patients, through the purchase of new equipment and minor capital works programs.

Equipment purchased included:

- An additional bariatric bed, four bariatric chairs and a new bariatric podiatry chair.
- Patient treatment chairs for the Grange and Birches aged care facilities.
- Volunteer driver mobile phones were updated to enable use of the CFA Fire Ready App.
- A new motorised transport trolley to move orthopaedic theatre sets for CSD.
- A $25,000 upgrade of acute storage areas resulted in improved efficiencies, reduced stock waste and manual handling risk to staff as well as inventory savings.

Workforce Profile 2017	June Current Month FTE		June YTD FTE	
Labour Category	2017	2016	2017	2016
Nursing	234.00	234.59	228.86	232.75
Administration and Clerical	86.72	83.60	85.72	83.48
Medical Support	25.64	25.01	26.46	28.06
Hotel and Allied Services	128.40	127.15	126.49	126.96
Medical Officers	19.68	18.54	19.53	14.38
Ancillary Staff (Allied Health)	50.19	52.78	51.76	48.48
Total	544.63	541.67	538.82	534.11

Occupational Violence Statistics	2016-17
1. Workcover accepted claims with an occupational violence cause per 100 FTE	NIL
2. Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	NIL
3. Number of occupational violence incidents reported	51
4. Number of occupational violence incidents reported per 100 FTE	9
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0

Family Violence

Strengthening the response to family violence is a state government mandate. In response, WDHS has implemented clinical and non-clinical domestic violence policies. These aim to help practitioners and managers working in a range of fields understand and identify risk factors associated with family violence and respond consistently and appropriately. WDHS also conducted two domestic violence workshops for practitioners during the year.

Worksafe Visits

WDHS participated in a Worksafe Occupational Violence and Manual handling Project, with an audit of the Penshurst campus conducted in July 2016, with no recommendations.

WorkCover Premium

The total premium for 2016-17 was $851,704. The premium rate for this period was 2.4332%.

The confirmed change for 2017-18 sees our premium rate decrease from 2.4335% to 2.16149%, representing an 11% reduction.

Chemical, Biological, Radiological (CBR) Incidents

There were no Chemical, Biological or Radiological (CBR) incidents in the past year.

Staff Service Milestones

10 Year Service Badges

Tara-Jane Bailey
Marilien Broome
Nicole Carlin
Kellie Clayton
Eryn Cottier
Trudy Cottier
Karen Forsyth
Emily Kelson
Amanda Malseed
Ann McArlein
Duncan McRae
Shirley Menz
Ann Millard
Darren Mulley
Kate O'Neill
Frances Patterson
Fiona Peach
Claire Quinn
Narelle Sambell
Allistair Steele
Natalie Tolley
Amanda Torney

15 Year Service Badges

Kelvin Anderson
Mark Atcheson
Tamara Barker
Shirley Broad
Susan Brumby
Rae Christie
Carla De Angelis
Tonia Evans
Claire Hearn
Hayley Hiatt
Margaret Meulendyks
Suzanne Millard
Monica Neeson
Karen Payne
Jennifer Sutherland
Michael Taylor
Margaret Walmsley
Meg Watson

20 Year Service Badges

Susan Dodd
Sharyn Logan
David McCabe
Lynette Monaghan
Carolyn Templeton

25 Year Service Badges

Katherine Armstrong
Tania Deutscher
Leanne Dyke
Sonja Gould
Norman Saligari

30 Year Service Badges

Margaret Baulch
Judy Hammond
Lorraine Hedley
Craig Richardson
Leanne Rigby

35 Year Service Badges

Paul Dyson
Leonie Eales
Kim Hearn
Karin McRae
Beverley Robinson
Wendy Wathen

Corporate Support Services

→ Members of the WDHS Finance Team, Bronwyn Duncan, Jodie Humphries, Manager, Nick Templeton, Georgie Dunn and Tahlia Homes.

MAJOR PROJECTS

Due diligence and planning for significant redevelopment works and projects included the Birches, Oncology / Dialysis, ED refurbishment and Day Procedure Centre.

HPV

HEALTH PURCHASING VICTORIA REFORMS

HPV reforms and policies were introduced and a HPV Customer Relationship Manager was appointed to improve systems and strengthen relationships.

SUB-REGIONAL COLLABORATIVES

Subregional Corporate Services, South West Innovation and Development Group and the Subregional Aged Care Workgroup continued to achieve efficiencies and support best practice.

Several Corporate Support Service teams work in clinical areas, including catering and environmental services, while others deliver maintenance, business, administrative, finance, payroll, human resources and IT support.

Collaboration

WDHS Corporate Services is a leader in developing sub-regional collaborative opportunities and it has continued to build partnerships and take key leads on a number of projects in 2016-17 including:

- Southern Grampians / Glenelg Health Services Subregional Corporate Services, which is building on the collaborative environment to establish more robust corporate and financial services.
- The South West Innovation and Development Group, which primarily oversees Central Supply, Procurement Reform and is currently focusing on Central Pharmacy opportunities.
- The Subregional Aged Care Workgroup, which implemented the Montessori Program. Its main focus this year was a joint submission to progress the second stage of the Montessori project, which was unsuccessful. Other focus areas included reviewing a business systems upgrade, providing a revenue budget template for all agencies and investigating a business intelligence tool for comparative aged care data purposes.

Financial Services

The Finance team was engaged by Stawell Regional Health in November to provide finance management support, while Stawell undertook a recruitment process. This support is expected to continue for a further 12 months.

Information Technology

WDHS ensures that information and communication systems are reliable and deliver the functionality required. Initiatives undertaken during 2016-17 included:

- The development of a strategy for the deployment of 'thin client' devices to replace desktop computers. Thin clients use less power, are quieter, smaller, more cost effective and have a longer lifespan.
- System upgrades to the payroll system, staff portal and the Finance budgeting system.
- Procurement for the implementation of the AHPRA Alert & Scope of Practice System and MS Antibiotic Stewardship Program.
- Changeover of ten printer and copier machines across the Health Service to machines with paper cut functionality. This will reduce the volume of printing, delivering significant cost savings.

Supply Chain Reform

Over the last 12 months WDHS transitioned to the new Victorian Procurement Policy Framework and Health Purchasing Victoria (HPV) requirements. Other procurement initiatives undertaken include:

Procurement Workgroup

WDHS introduced a Procurement Workgroup that includes key Health Service spends. The purpose of the Workgroup is to ensure ongoing probity and procurement principles are maintained and adhered to.

HPV Customer Service Officer

HPV established a new division dedicated to working with individual health services to develop and drive stronger working relationships at all levels. HPV has provided a dedicated WDHS Customer Relationship Manager who visits each month and acts as a primary point of contact for all issues.

HPV Reform Audit

WDHS was required to undertake an audit of HPV Health Purchasing Policies in accordance with the HPV schedule and submit an audit report to the HPV Chief Executive Officer by 30 June 2016. RSM Bird Cameron performed this audit, with one minor recommendation.

Building Projects

The WDHS Project Control Committee (PCG) reconvened in June 2016 to assist with the design, management and construction of major building projects and infrastructure replacement.

Building and infrastructure projects progressed during the financial year included:

Oncology & Dialysis Redevelopment

The WDHS oncology and dialysis redevelopment is expected to commence in November 2017. The new eight bay unit will be located in the current Health Information / Admissions and Library areas. This new facility will greatly improve the amenity and delivery of oncology and dialysis services. To date, architectural and staff consultation has taken place, with final design and concept plans nearing completion.

Health Information Office Relocation

The Maintenance team have commenced works for the relocation of Health Information, due to the oncology / dialysis redevelopment. These works are expected to be completed in August.

Birches Redevelopment

The Birches Aged Care Facility will undergo a significant refurbishment, following an announcement in May 2016 of $420,000 in Commonwealth Funding. WDHS will also contribute a further $680,000 to complete these works, which will involve redevelopment of the dining area, activity rooms, a new cafe lounge, hairdressing salon and therapy room.

Emergency Department Works

Planning has commenced for the redevelopment of the Emergency Department, to improve patient flows and staff safety. It is expected this project will commence in late 2017.

Chiller Replacement

Following a procurement and tender process, WDHS has entered into a contract for the supply and installation of two new chillers for the Hamilton Base Hospital site and the Birches Aged Care Facility. The new chillers, valued at $292,000 will ensure that conditions for patients, residents and staff are appropriate during the summer months.

Nurse Call Upgrade

WDHS received $361,000 in February for the upgrade of its nurse call system. An expression of interest is being completed to scope this project.

Steam Boiler Replacement

WDHS received $500,000 from DHHS in June for the replacement of three steam boilers to improve efficiencies. Work is currently being undertaken to scope this project.

Compliance

Assurance with new legislative reform and ongoing compliance remains a high priority for the Corporate Services Division.

Audit & Compliance Committee

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 is 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 2016 to June 2017 requiring governance from the Audit & Compliance Committee included:

- Audit Committee approval of the WDHS 2015-16 Annual Finance Statements
- Audit Committee approval for Risk Management Attestation
- Audit Committee approval of 2016-17 Operating Budget Assumptions & Parameters
- Internal Audit Report – Review of Revenue, Patient Fees and Accounts Receivable
- Internal Audit Report – Compliance with HPV Reform
- Legislative & Financial Policy Review

Food Compliance

The Health Service kitchens were issued with Food Premises Registrations for 2017.

All WDHS kitchens achieved 100% compliance with the WDHS Food & Safety Plans and were issued with Certificates of Compliance.

In order to achieve this, each kitchen complied with 45 mandatory food safety standards.

Cleaning Compliance

The annual external cleaning audit was conducted in July 2016 and achieved 99% compliance, exceeding the DHHS benchmark by 9%.

Maintenance Compliance

Regulatory maintenance compliance against robust building and infrastructure standards remains an ongoing priority for the Health Service.

Embracing Innovation

WDHS continues to undertake new and innovative projects including:

Systems Onboarding

With the introduction of a new Learning Management System, the opportunity arose to redesign the process for adding staff to applications. A reduction in handling staff details at multiple intervals and across different systems has reduced errors and had flow-on effects for the Human Resources, Payroll and Learning & Development teams.

Environmental Performance

WDHS is committed to reducing its environmental impact. Ongoing initiatives include:

- Installation of water saving devices, including aerators, shower restrictors and dual-flush flushometers.
- Introduction of enviro-friendly packaging in the HBH Cafeteria.
- Energy efficiency initiatives including the installation of LED lighting across campuses.

ICT Expenditure

The total ICT expenditure incurred during 2016-17 was $3,212,546 (excluding GST) with the details shown below:

Business As Usual (BAU) ICT Expenditure Total (exc. GST)	Non-Business As Usual (non-BAU) ICT Expenditure Total = Operational Expenditure & Capital Expenditure (exc.GST)	Operational Expenditure (exc.GST)	Capital Expenditure (exc.GST)
$3,047,197	$165,349	$165,349	-

Our Community Partnerships

→ Coles Store Manager, Michelle Olesen, WDHS CE Rohan Fitzgerald, SGSC CEO Michael Tudball, Hamilton Spectator Publisher, Richard Beks and Woolworths Store Manager, Wayne Millard launch the AED Project, providing life saving public defibrillator access at three locations in the Hamilton CBD.

1.8M FUNDRAISING & DONATIONS

The Health Service received a total of $1.8M in bequests, grants, appeals and fundraising in 2016-17.

23K GARDEN OPEN DAY

The first ever Western District Historic Garden Open Day was a resounding success, with over 800 people visiting three of the region's most spectacular homestead gardens.

COMMUNITY CAR

WDHS partnered with Taylor Motors and the Hospital Opportunity Shop to part fund the vital Community Transport Service.

WDHS receives fantastic community support, through donations, sponsorship and the many hours contributed by its extraordinary 300 plus volunteer team.

Supporting our Community

WDHS again delivered a range of projects and events to give back to the community this year.

AED Project

In July, three defibrillators were located in the Hamilton CBD to provide public access to these lifesaving devices. WDHS was supported in this initiative by Southern Grampians Shire, Woolworths, Coles and the Hamilton Spectator.

Inaugural White Ribbon Luncheon

WDHS joined forces with Southern Grampians Shire Council in November to highlight the issue of family violence. Over 120 people attended a lunch, with guest speakers Michael Costigan from the Tara Costigan Foundation and Inspector, Nick Finnegan.

International Women's Day Luncheon

In March over 120 local women and men celebrated International Women's Day with Guest Speaker, Leila Sweeney.

Hamilton Boomers Sponsorship

WDHS continued its major sponsorship of the Boomers all-ability football team.

Christmas Community Art Project

WDHS celebrated Christmas through art with its second Christmas Community Arts Project. This year 24 local primary schools, kindergartens and aged care facilities decorated large wooden Christmas figures constructed by the Hamilton Men's Shed. Their creations were judged by well known local artist Jasmine Mansbridge.

Fundraising Events & Appeals

Funds raised at many 2016-17 events were directed to the oncology and dialysis project:

Garden Open Day $23,189.

Arctic Blast Ball $23,208

Hamilton Vitality Fun Run $2,834

Cocktails in the Courtyard $7,335

Murray to Moyne Cycle Relay $16,300

Op Shop Golf Tournament $16,556

Christmas Appeal $13,896

WDHS Door Knock Appeal $48,350

The Door Knock Appeal also raised $9,491 for 'Cora's Way' at Penshurst and $2,815 for Coleraine.

Donors and Supporters

Our generous donors and supporters make it possible for WDHS to purchase much-needed equipment and refurbish facilities to meet the needs of patients and clients.

We sincerely thank all those who contributed, financially or in-kind in the 2016-17 year. A list of donors contributing $100 or more is shown on page 24.

Contributions over $3,000

Advantage Feeders	$12,750
ARB Company	$5,000
Mr I J Black	$5,000
Collier Charitable Fund	$47,000
Estate of Benjamin De Bruyn	$20,000
Estate of AC Dowell	$17,803
Geelong Gentleman's Lunch	$10,000
Hamilton Anglican Mothers Union	$3,500
Hamilton Base Hospital Ladies Aux	$5,000
Dr Geoff Handbury AO	$10,000
Hospital Opportunity Shop	$40,330
H Browning & H Job	$6,990
Estate of Michael Krowicky	$60,000
Mellow in the Yellow	$5,000
The Rosemary Norman Foundation	$5,000
North Hamilton Base Hospital Ladies Aux	$5,000
Estate of Leo O'Brien	$500,000
Pethard Tarax Charitable Trust	$16,000
Estate of Rupert Rentsch	$1,000,000

National Centre for Farmer Health

Donations to the NCFH totalled an amazing $58,061. The Centre sees this growing donations platform as an indicator of the increasing awareness of its important work 'making a difference to farmers' lives'.

Auxiliaries and Community Groups

WDHS is very grateful for the continued support of its hard working auxiliary members. These groups again contributed substantially to the Health Service this year.

The North Hamilton Ladies' Auxiliary

Purchased a humidifier / ventilator for ICU and an ophthalmoscope for the Emergency Department with their annual donation of $5,000.

The Hamilton Base Hospital Ladies' Auxiliary

Purchased a vital signs monitor with neonatal cuff for the Surgical and Obstetric Units and donated $1,000 to the oncology / dialysis project from the proceeds of their very successful High Tea event.

Birches Auxiliary

Assisted with the promotion and enhancement of the facility and fundraised to improve the comfort and wellbeing of Birches residents.

The Hamilton & District Aged Care Trust

Donated $1,750 for garden improvements at The Grange Residential Aged Care facility.

The Hamilton Base Hospital Opportunity Shop

Donated $15,330 to purchase a bladder scanner for the Surgical Unit and $25,000 to support the Community Transport Program, which plays a vital role in assisting community members to access medical appointments across Victoria and into South Australia. The Op Shop was again the major sponsor of the WDHS Golf Tournament.

The Coleraine District Health Service Ladies' Auxiliary

Donated $2,750 for the purchase of a medication trolley for the Coleraine Hospital.

The Coleraine Homes for the Aged

Donated $2,800 for a new mobile bain marie for the residents' dining room.

Coleraine Opportunity Shop

Donated $900 to the Coleraine Social Support Group, Community Car and Wannon Hostel.

The Penshurst and District Ladies Auxiliary

Donated $10,000 to purchase a new TV for Kolor Lodge, an air conditioner for the consulting room, a Coagu Check blood monitoring device and items for the Penshurst Social Support Group.

In-Kind Donations

Darriwill Farm continued its generous support of the Employee of the Month Program and Alexandra House sponsored the Volunteer of the Month Award. James Dean Pharmacy provided gift packs for families with new babies to private patients in Midwifery.

Volunteers

WDHS has over 300 registered, unpaid volunteers, including auxiliary members, who donate their time and skills to support patients, residents and clients. Volunteers are recruited through an interview process managed by the Volunteer Coordinator, to determine where their skills, experience and interests are best utilised. All volunteers undergo a police check and a comprehensive orientation program before commencing service. The Health Service relies heavily on the support of its volunteers and acknowledges and appreciates their dedication and tireless contribution to improving the lives of patients, clients and residents.

Volunteer Program Hours 2016-17

Program	Volunteers	Hours
Hamilton Community Transport	46	3,370
Hospital Opportunity Shop	17	5,727
Comforts Trolley	8	196
Hospital Door Knock Appeal	111	388
Golf Tournament	33	231
Vitality Fun Run	22	88
Hospital Harmonies Choir	7	287
The Grange	16	963
The Birches	12	435
Theatre Buddies	4	42
Palliative Care	10	180
Penshurst District Health Service	8	922
HBH Ward	8	1,302
Delta Dogs	3	123
Social Support Group - Hamilton	8	1,057
Social Support Group - Penshurst	5	450
Data Entry - Health Information	1	128
Coleraine Aged Care	17	1,233
Coleraine Community Transport	18	913
Merino	8	1,213
Total Hours		19,248

Communications and Publications

WDHS regularly updates the community on programs and services and promotes events, equipment purchases and facility redevelopments through a range of media and publications.

The promotion of the sugar tax petition this year, and the media interest this generated, supported our vision of 'creating healthier communities' and demonstrated the capacity for regional health services to bring about change not only at a local level but regionally and nationally.

Facebook and Instagram have become increasingly important for promotions and the Community Liaison Department has continued to use these social media platforms to build relationships with stakeholders.

WDHS produced a new format 'Talking Health' newsletter this year, Annual Report, Penshurst and Coleraine Years in Review and the Quality Account.

The Charlie Watt Volunteer of the Month Award was presented to the following volunteers in recognition of their support and loyalty:

July
Anne Milne, Comforts Trolley

August
Julia Hearn, Meal Buddy, Birches

September
Ian & Sylvia McKean, Merino

October
Rhonda Brunt, The Birches

November
Peter Menzel, Community Transport

December
Jody Stephens, Choir Master

January
Jo and Jenny Peters, Comforts Trolley

February
Janet Crampton, Meal Buddy, Birches

March
Wendy Salter, PAG & Visiting Residents, Grange

April
Neville Linke, Community Transport,

May
Di Walkenhorst, Community Transport, Events

June
Brenda Cullinane, Ward

Life Governors

Bazter CJ
Beggs HN
Boyle J
Broers M
Brown MA
Brumby A
Bunge B
Burgin E
Clifforth S
Coggins G
Dean J
Duff S
Edmonds J
Fleming JD
Fletcher J
Ford D
Fraser T
Gardiner PD
Gaussen D
Gubbins J
Gumley F PSM
Gurry AJ
Handbury G AO
Heazlewood P
Hickleton E
Holmes ES
Hope M OAM
Hutton T
Kanoniuk M
Kelsh J
Kruger N
Langley C
Lawson V
Linke N
Lyon E
McLean M
Morrison HM
Murray EM
Northcott J
O'Beirne P
Rabone M
Rensch T
Robertson M
Ross J
Runciman P
Ryan D
Scaife C
Scaife S
Scullion E
Templeton H
Thornton A
Tully R
Turnbull P
Turner J
Walker O
Wallis V
Walter R AM
Wettenhall HM
Wettenhall M
Wombwell T
Wraith L

Gifts Over $100 and Major Sponsors

Ms S Adams
Mr D Adamson
Mr & Mrs J & J Addinsall
Mrs J Aitken
Mr R Alexander
Alexandra House
Mr L Allen
Mr & Mrs M & A Archer
Mrs J Astbury
Mr T Auden
Mrs & Mrs A & J Bagnall
Mr & Mrs B & R Bamford
Bendigo Community Bank
Mrs F Barber
Mrs J Barnes
Mr & Mrs CJ & KA Baulch
Bayer CropScience Pty Ltd
Mr J Bensch
Bethlehem Lutheran Church Tabor
Mr I J Black
Mr & Mrs W & C Blackwell
Mr & Mrs G & B Botterill
Mrs B Botterill
Mrs I K Boyd
Mr & Mrs K & E Brennan
Mr G Brewis
Mr & Mrs C & C Brinkmann
Ms P Britten
Mr G Brown
Mrs M Brown
Mr & Mrs P & B Bunney
Mr & Mrs G & R Burger
Mrs E Burger
Ms A Burne
Mr & Mrs A & B Burrowes
Mr H & K Cameron
Mr & Mrs K & M Campbell
Mr & Mrs K L & H Christie
Mrs S Clarke
Ms S Clayton
Mr & Mrs I & S Colclough
Mr & Mrs D & J Coldbeck
Coleraine Opportunity Shop
Coleraine District Health Service Ladies Auxiliary
Coleraine Homes for the Aged Womens Auxiliary
Collier Charitable Fund
Concept Catering Solutions
Mrs K Coote
Mr B Cordy
Mr & Mrs J & R Crawford
Mr J Crawford
Mrs E Cummins
Ms J Cuttler
Estate of Benjamin De Bruyn
Mrs A De Vries
Mr J Dempster
Department of Environment, Land and Water
Mrs K Diana
Mrs D Douglas
Estate of AC Dowell
Mr & Mrs K & M Doyle
Mr J Duyvestyn
Mr S Eats
Mr & Mrs M & E Elliot
Mr & Mrs B & L Emsley
Equity Trustees Ltd
Mr & Mrs T & J Evans
Beaton Bamily
Ms M Fenech
Ms M Ferrier
Mr & Mrs N & F Fitzgerald
Mr & Mrs R & K Fitzgerald
Mr & Mrs G & B Fry
Mrs C Gardiner
Mr & Mrs D & H Garfoot
Misses E & H Gartner
Mrs N Gash
Glenvale School
Golden Spindle
Mr & Mrs J & M Gough
Mr & W & A Gough
Mr G Greaves
Mr & Mrs P & J Greenaway
Mr & Mrs M & J Grimwade
Mr & Mrs N & M Groves
Mrs A Gubbins
Mrs F Gumley
Hamilton Quilters Inc
Hamilton & District Aged Care Trust
Hamilton Anglican Mothers Union
Hamilton Base Hospital Ladies Auxiliary
Dr G Handbury AO
Hawkesdale CWA Branch
Mrs H Heard
Mr I Heard
Mr & Mrs C & J Heine
Mrs M Herd
Mrs M Herrmann
Mr & Mrs A & I Hill
Mr & Mrs M & P Hill
Mrs A Hindson
Mr & Mrs B & R Hines
Mr & Mrs C & S Hines
Mr & Mrs S & A Hornby
Hospital Opportunity Shop
Mr & Mrs N & R Howard
Mrs J Hudson
Mr & Mrs R & K Huf
Mr & Mrs P & J Humphries
Mr & Mrs T & J Hutton
Mr & Mrs R & L Irvine
Ms J Ivory
Mr & Mrs D & R Jaeschke
Messers H Browning & H Job
Ms N Kelly
Kellys Merchandise
Mr & Mrs J & H Kelsall
Mr & Mrs C & C Kimpton
Messrs B & J King
Mr & Mrs WJ & JM Kinnealy
Knox Grammar School
Mrs P Koenders
Estate of Michael Krowicky
Mr & Mrs N & S Kruger
Lake Repose Partnership
Mrs J Lewis
Mr & Mrs PW & PL Lewis
Mrs G Leyonhjelm
Ms M Mim
Mr & Mrs P & K Linke
Mr N Linke
Lions Club of Koroit Inc
Lions Club of Merino & Digby
Mr & Mrs R & C Lomas
Mr & Mrs K & E Lowery
Mr & Mrs R & D Luhrs
Mr J Macauslan
Mr & Mrs H & J Macdonald
Mr & Mrs I & H Macgugan
Mr & Mrs D & S Macgugan
Mr & Mrs R & E Macgugan
Mr & Mrs A & I Macgugan
Mr & Mrs HH & S Mackinnon
Mr & Mrs E & M MacLean
Mr & Mrs N & H MacLean
Mr R Mann
Mr R Marshall
Mrs E Mathews
Mr & Mrs L & M Maylor
Mr D McArthur
Mr C McAllister
Ms J McDonald
Mr & Mrs D & S McFarlane
Mr D McLaren
Mr A McLeod
Mrs J Millard
Mr & Mrs P & S Millear
Mr & Mrs C & K Mirtschin
Mrs J Morice
Mr A Morrison
Mrs G Muir
Mr R Napier
Mr R Neeson
Ms M Nolte
Mr & J & H Norris
North Hamilton Base Hospital Ladies Auxiliary
Mr & Mrs I & Z Noske
Estate Of Leo O'Brien
Ms K O'Connell
Mrs P Oliver Snell
Mr G & J Page
Mr B Page
Page Livestock
Ms J Pearse
Ms J Pearson
Penshurst Uniting Church
Penshurst Combined Churches
Penshurst Hotel & Patrons
Penshurst & Dist Health Service Ladies Auxiliary
Pethard Tarax Charitable Trust
Mr M Poels
Mr J Prust
Mr M Rees
Mr & Mrs J & M Rentsch
Mrs G Rentsch
Estate of Rupert Rentsch
Mr & Mrs J & C Roads
Mr & Mrs M & S Robertson
Mrs D Robertson
Mr & Mrs R & A Robinson
Mr & Mrs S & K Ross
Dr R Scaife
Mr & Mrs G & M Scholfield
Mr & Mrs M & R Schultz
Mrs J Scott
Sinclair Wilson
Mrs N Smooker
Mr R Somerville
Mr & Mrs F & D Soulsby
South Kolor Partnership
Sportswomen's Association of Australia Inc
Mr & Mrs P & N Stanes
Mrs E Staude
Ms A Stevenson
Mr & Mrs R & L Stewart
Mr M Stewart
Mr R Sutherland
Mr S Swain
Tarrington Women's Guild
Mrs A Tepper
The Hamilton & Alexandra College Junior School
Mr & Mrs J & C Thomson
Mrs L Toyer
Mr I S Troeth
Mr P Tung
Mr A Walsh and Ms N Turner
Mr & Mrs L & N Uebergang
Mr & Mrs M & M Uebergang
Mr & Mrs J & J Upton
Mr & Mrs J & A Vickery
Ms S Walker
Mr C Wallis
Mrs J Waters
Ms E Watt
Mr & Mrs J & J Watt
Mr & Mrs D & M Willis
Mr & Mrs I & M Willsher
Mr & Mrs P & L Young
Mr J Young

National Centre for Farmer Health

Advantage Feeders
AFL Western District Commission
ARB Company
H Browning and H Job
S Clayton
Cobden District Health Service
Cobden Football Netball Club
Geelong Gentleman's Lunch
Good Shepherd Secondary School
Henty CWA Branch
Knox Grammar School, Sydney
La Trobe Ag Society
M Lim
Lions Club of Torquay Inc.
Mellow in the Yellow
Moruya High School
Murray Goulburn
Nomad
Port Fairy CWA Branch
R4FH Team
The Rosemary Norman Foundation
Rotary Club Portland
Sinclair Wilson
Woolsthorpe CWA Branch

Artic Blast Major Sponsors

Ace Radio
Iluka
Jigsaw Farms

Fun Run Major Sponsors

Ace Radio
Australian Blue Gums
Bank of Melbourne
Hamilton Vitality
Rotary Club of Hamilton
Woodrowe Tree Technicians

Golf Day Major Sponsors

Dorevitch Pathology
Elliots Fire & Safety
Hospital Opportunity Shop
Anne Cass & Laurie Ryan

Historic Garden Open Day

I & S Whiting
M & J Winter-Cooke
H & M Youngman

WDHS was incorporated in July 1998 under The Health Services Act 1988 and is governed by a nine 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 two to 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 introduced a new Board evaluation tool in 2016, the Governance Evaluator, which 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, as required.

The BOD is responsible for the governance and strategic direction of WDHS and is committed to ensuring that the services it 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 operating 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. In order to ensure the effective operation of the BOD, the Board has membership on 12 committees, which meet as required and report back to the BOD.

Board of Directors

Hugh Macdonald

BBacc

Hugh currently owns and operates a farm growing prime lamb on the outskirts of Hamilton. From 1982 to 2016 Hugh worked in the finance industry, where he managed a debenture company and more recently worked with Rural Bank. Hugh is a Director of The Hamilton and Alexandra College Foundation, a Trustee for The Hamilton and Alexandra College Old Collegians and has been a National Centre for Farmer Health Board Member since its inception. He is a past President of the Hamilton Racing Club and Hamilton Junior Basketball Association. He chaired the fundraising committee for the Hamilton Indoor Leisure and Aquatic Centre, raising in excess of $750,000. Hugh was appointed to the WDHS Board in November 2006, and has been Chair since 2015. His current term expires 30 June 2018.

Jenny Hutton

BEd

Jenny is a past secondary teacher and is currently Director of Community Relations and Development at The Hamilton and Alexandra College. Jenny plays an active fundraising role in the community and is a Fellow of Educate Plus (Association of Development and Alumni Professionals in Education). Jenny was the President of the Penshurst Botanic Gardens (1995-2010) and was part of the Mulleraterong, Grange and Charity House fundraising committees in recent years. Appointed to the WDHS Board in November 2002, Jenny's current term expires 30 June 2018.

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. Mark is a member of the Advisory Committee for the Hamilton District Skills Centre and 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 to the WDHS Board in July 2011, Mark's current term expires 30 June 2017.

Ian Whiting

Ian is Managing Director of Bassett Estate Pty Ltd and is a Founder and Director of Club Solutions Australia Pty Ltd, Charity Bid Pty Ltd and Oxil Holdings Pty Ltd. Ian is President of the Branxholme Progress Association and was Deputy Chair of the South West Academy of Sport, VCFL Regional Manager South West Border and 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, President and past Captain of the Morven CFA RFB and past Chair of the 2010 Top of the Town Charity Ball. Appointed to the WDHS Board in July 2011, Ian's current term expires 30 June 2017.

Darren Barber

Master HRM CSU (in progress)
Cert IV Training & Assessment

Darren is the Organisational Development Manager at Warrnambool City Council. Prior to this, he was a partner at SED Advisory, a regional Victorian professional services firm. He has over 19 years' experience in organisation development and human resource management, specialising in regional workforce development in a business and regional context. Darren was born 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 and Mitchell Park Kindergarten Committee. He has also acted as a regional delegate for the VECCI Business and Employment Forum. Appointed to the Board in July 2013, Darren's current term expires 30 June 2019.

Caroline Coggins

B App Sci (Ag), Dip Ed

Caroline holds qualifications in Applied Science in Agriculture and Education. She is a past President of the Young Members of the Melbourne Cricket Club and has held positions including General Manager of a Cooperative, Consultant and Business Advisor, as well as various secondary teaching positions. She is currently the Learning Support Co-ordinator at Monivae College and also runs a mixed farming enterprise with her partner David. Appointed to the WDHS Board in July 2014, Caroline's current term expires on 30 June 2017.

Peter Besgrove

BCom, MIR

In an extensive Human Resources career with large global organisations, Peter held senior executive positions based in Australia and overseas, as a HR Business Partner and Remuneration Specialist. Peter lived and worked in the UK and China and managed teams of HR professionals across a number of countries, with diverse social, industrial and legal environments. Having retired from corporate life, he is now a resident of Dunkeld and is also currently a member of the Grampians Tourism Board. Peter was appointed to the WDHS Board in July 2014 and his current term expires on 30 June 2019.

Adele Kenneally

PhD, MEd, G Dip Bus, Dip Lib

Adele has worked in senior management roles in South West Victoria over the past 20 years and now runs her own consulting business, ASK Consulting Victoria. She is currently the Chair of the PHN Western Victoria Great South Coast Community Council, is a past member of the Women's Health and Wellbeing Barwon South West Board, and was Chair of the Glenelg Southern Grampians Primary Care Partnership 2010-2014. Appointed to the WDHS Board in July 2015, Adele's current term expires in June 2018.

Fleur Calvert

BA, Grad Dip (HR/IR), LLM(LP)

Fleur is a solicitor, specialising in construction and litigation. She was a Director of the Benjamin Andrew Footpath Library and involved with the National Gallery of Victoria, the Starlight Foundation and the Anti-Cancer Council. She has a Post-Graduate Diploma in Human Resource Management and Industrial Relations.

Appointed to the WDHS Board in July 2015, Fleur relocated and resigned in July 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 of 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.

BOARD MEMBER	BOARD MEETINGS ATTENDED	COMMITTEE MEMBERSHIP AS AT 30 JUNE 2017	COMMITTEE MEETINGS ATTENDED
Hugh Macdonald	**9 of 11**		
		Audit & Compliance	2 of 5
		CDHS Management	3 of 6
		Clinical Appointments Advisory	2 of 2
		Community 4 Youth Board	4 of 4
		Development Council	4 of 5
		Medical Consultative	3 of 4
		NCFH Board of Management	4 of 4
		Remuneration Committee	1 of 1
Jenny Hutton	**7 of 11**		
		Development Council	4 of 5
		Penshurst Advisory	3 of 5
Adele Kenneally	**11 of 11**		
		Community Advisory	4 of 4
		Quality Improvement	4 of 6
Mark McGinnity	**7 of 11**		
		Clinical Appointments Advisory	2 of 2
		Development Council	4 of 5
		Quality Improvement	4 of 6
		Remuneration Committee	1 of 1
Darren Barber	**11 of 11**		
		Audit and Compliance	3 of 5
		Community Advisory	3 of 4
		Remuneration Committee	1 of 1
Ian Whiting	**11 of 11**		
		Audit & Compliance	4 of 5
		Project Control Group	10 of 11
Caroline Coggins	**11 of 11**		
		Development Council	4 of 5
Peter Besgrove	**9 of 11**		
		Audit & Compliance	3 of 5
		Clinical Appointments Advisory	1 of 2
		Project Control Group	10 of 11

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, Director of Corporate Services, Director of Medical Services, Director of Nursing, Director of Primary and Preventative Health, Manager / Director of Nursing, Coleraine Campus, Manager / Director of Nursing, Penshurst Campus, Director, National Centre for Farmer Health. The Executive met 23 times during the year, providing regular reports to the BOD.

Risk Management

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

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 Michael Fitzpatrick were the external Committee representatives in 2016-17. The Committee received internal audit reports regarding compliance with Health Purchasing Victoria procurement policies and contracts and revenue management requirements. It reviewed the status of recommendations from audits conducted of the processes and procedures of Western District Health Service, along with Victorian Auditor General's Office reports and recommendations. The Committee was kept informed of any accounting standard updates and the progress of compliance with standards, including Related Party Disclosures and Revenue Matching along with all other legislative requirements. Notification was presented of the compliance with the Standing Directions of the Minister for Finance along with the updates to the Standing Directions. Five meetings were held during the year.

Clinical Appointments Advisory Committee

Advises the BOD on appointments, reappointments, suspensions and terminations of visiting medical practitioners and hospital medical officers and issues related to the credentialing and scope of practice of nurses and allied health workers. Two meeting 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 Management 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. Topsy Baulch was the community representative. Six meetings were held during the year.

Penshurst (PDHS) Advisory Committee

Reviews the operation, performance and strategic planning of the Penshurst campus. Community representatives were Don Adamson, Lucy Cameron, Margaret Eales, Tom Nieuwveld, Wendy Williams, Anna Watson and Rick Jacobs. Five meetings were held during the year.

NCFH Board of Management

The NCFH Board of Management reviews the operation, performance and strategic planning of the Centre. Community representatives in 2016-17 were Brendan Crotty and Jon Watson. Four meetings were held during the year.

Development Council

Oversees and guides the WDHS fundraising strategy. The Council operates in compliance with the Fundraising Appeals Act 1998. Megan Campbell, Leesa Iredell, Elizabeth Macgugan, Carly Behncke and Vicki Whyte were the community representatives on the Development Council in 2016-17. Five 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.

Coleraine (CDHS) Management Committee

Reviews operation, performance and strategic planning for the Coleraine campus. Community representatives were Kim Chintock, Lesley Kruger, Ashley Lambert, Grant Little, Alan Millard, Narelle Ness, Anne Pekin and Shannon Raymond.

Three Youth Board Observers also joined the Committee, Terrie Johnson, Jacob Mills and Tayla Ness. 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. Community representatives were Tracey McDonnell, Skye Grigg, Pastor Rick Penny and Topsy Baulch. Four meetings were held during the year.

Project Control Group

The function of the Project Control Group is to oversee and monitor the progress of specific capital projects, with particular emphasis on the scope of works, the works program, quality, cost, expenditure and completion of projects to meet service needs of consumers. Eleven meetings were held during the year.

Community 4 Youth Board (C4YB)

The Community 4 Youth Board supports youth activities and drives projects to improve the lives of young people in the region. Community representatives were Angus Campbell, Ben Hunter, Emma Nicholas, John Garland, Julie Dreschler, Karen Walsh, Katherine Granziera, Marie Walters, Melanie Russell, Nikita Ansell, Trish Munro and Wendy Dean. Four meetings were held during the year.

→ Board member Ian Whiting with wife Sally in their spectacular garden 'Bassett', which was generously opened to the public for the first time for the Western District Historic Garden Open Day.

Executive Team

→ L-R: Executive team members: Bronwyn Roberts, Dr Nic van Zyl, Nicholas Starkie, Professor Susan Brumby, Lorraine Hedley, Katherine Armstrong, Rohan Fitzgerald and Sarah Baker

Chief Executive

ROHAN FITZGERALD BCom

Rohan commenced as the Chief Executive in August 2014. He was previously the Chief Executive at Stawell Regional Health and has held senior management positions at Latrobe Regional Hospital and Central Gippsland Health Service. Rohan was previously a Health Purchasing Victoria Board Member and a Latrobe City Councillor. He is passionate about rural health and supporting communities to receive high quality services close to home. Prior to entering the health sector Rohan worked as an accountant.

Director of Corporate Services

NICHOLAS STARKIE BBus, MIPA, AFA

Nick commenced his career at WDHS in the Finance Team at Coleraine in 1994 and held the position of Manager, Finance and Budget from 2006 to 2016.

Nick has extensive experience in the healthcare sector and brings a broad range of commercial, people and financial management skills to the role. Nick's interests include improving procurement and supply chain management practices and supporting the delivery of a comprehensive range of high quality corporate and financial services across the organisation.

He is also known in the Hamilton Community for his support of community organisations and sporting clubs across the region.

Director of Medical Services

DR NIC VAN ZYL MB ChB, MMed (CH), MBL, PMP, FAFPHM

Nic is a Public Health Physician and Medical Administrator, with many years experience in public health medicine and medical management roles. Nic's background includes working in rural and academic hospitals as a specialist in community medicine and medical administration. He has also developed and provided health management training courses in partnership with universities in South Africa and the UK. Nic is a Fellow of the Australasian Faculty of Public Health Medicine.

Director of Nursing

LORRAINE HEDLEY RN, Bachelor of Nursing

Lorraine commenced her career at WDHS as a nursing student in 1986 and has worked in a variety of clinical and senior management roles across the organisation. During her career Lorraine has established strong clinical governance and leadership capabilities as well as highly developed business acumen and analytical skills. Lorraine has completed further training in oncology and emergency nursing and a Bachelor of Nursing - Post Registration through Monash University. Prior to her appointment, Lorraine had the role of Assistant Director of Nursing / Business Manager.

Director of Primary and Preventative Health (from Jun 2017)

JAMES 'MAC' MCINNES BSW, DipSW, PCHSM

Mac commenced as PPH Director on 19 June 2017. He previously held a number of positions at South West Healthcare, working in Aboriginal Health, Social Work and Counselling and as the Manager of Community Adult Mental Health Services. Mac emigrated from Scotland in 2011 with his family. In Scotland he held a number of managerial positions across the full spectrum of the Social Work field. Mac is passionate about improving health outcomes for people living in rural and regional areas.

Acting Director of Primary and Preventative Health (from April 2017 to June 2017)

SARAH BAKER B App Sci (Hons)

Sarah has 24 years' experience across both public and private health care sectors and has been with WDHS for seven years.

As a passionate patient and client advocate, Sarah has shown her commitment to the delivery of allied and community health services in regional settings and in the acting role.

Director of Primary and Preventative Health (Aug 2016 to May 2017)

MORVEN GEMMILL BSc OT

Morven began her career in health as an OT. She held senior management and clinical roles in the NHS Scotland and local government. Morven moved to Australia in 2011 to take up the position of Executive Director of Allied Health and subsequently Senior Director for Clinical Governance and Community Partnerships at Gold Coast University HHS.

Acting Director of Primary and Preventative Health (to 29 August 2016)

FRANCES PATTERSON B. App. Sci (OT), Dip VET

Fran has worked as an OT in regional Victoria for over 30 years in a variety of settings, including general hospital, community, vocational rehabilitation, project management and health promotion. Fran has worked at WDHS in a number of roles over many years, alternating with work in other organisations. Her past roles at WDHS have included Chief Occupational Therapist, Project Manager for Go for Your Life, Inaugural ADASS Manager and Manager, Primary Care Services. Fran has had ongoing involvement with community partnerships and community organisations. She maintains a long term commitment to local and regional OT and Allied Health networks and has been a member of the Allied Health Leaders Network. Fran has presented numerous papers at regional, state and national conferences during her career.

Coleraine Manager / Director of Nursing

BRONWYN ROBERTS RN ICU Cert, Grad Cert Bus Admin, MRCNA

Bronwyn has worked at WDHS and Ballarat Base Hospital for over 30 years and has held management positions in Acute Care / ICU / Emergency and led many successful projects over the last 20 years. Bronwyn was Deputy Director of Nursing (Hamilton Base Hospital) from 2004 - 2013 and DON / Manager at Penshurst before commencing her role at Coleraine in 2016.

Acting Manager / DON Penshurst and DON - Aged Care Services (Hamilton)

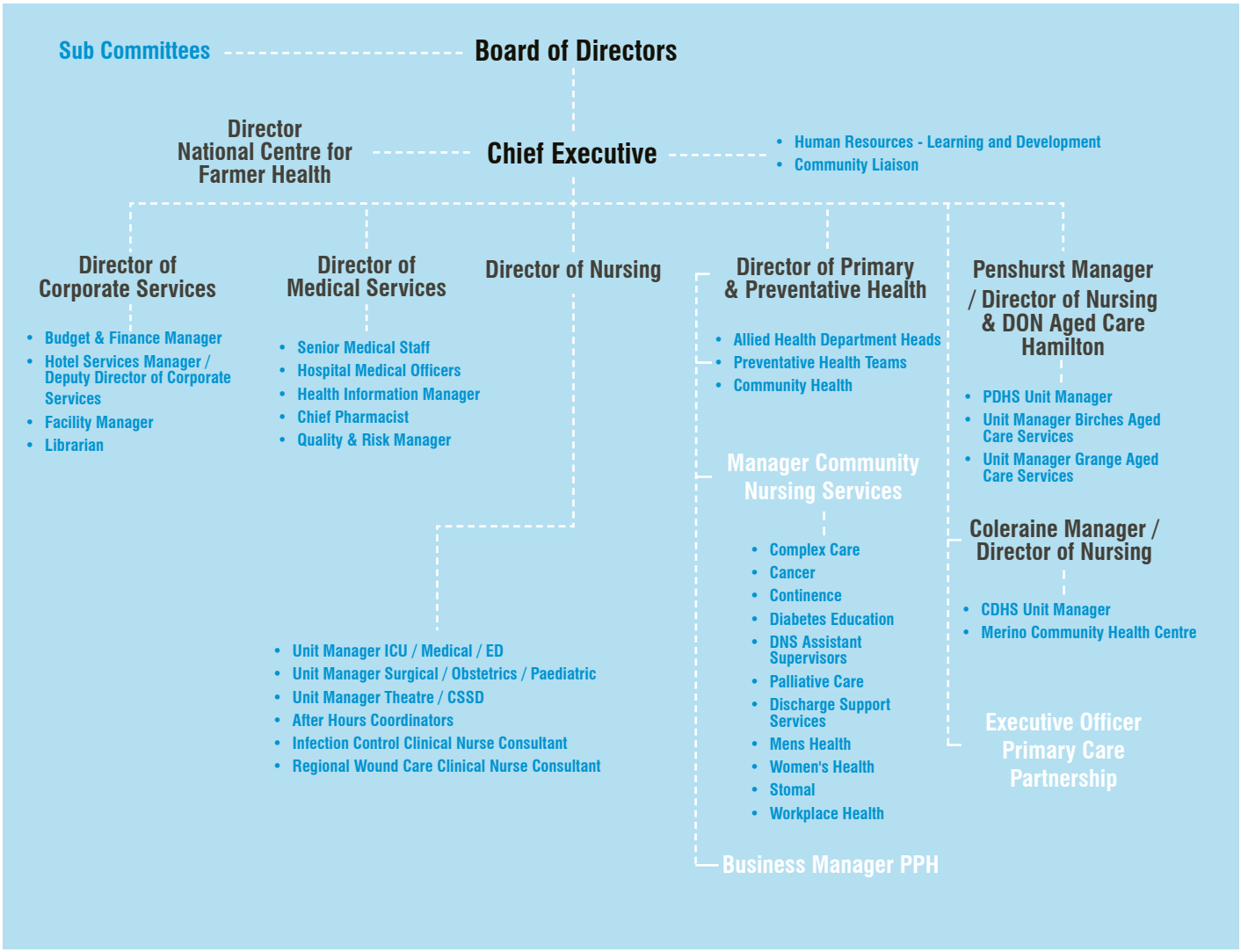
KATHERINE ARMSTRONG RN, BAppSci (Nursing), Grad Cert Bus Admin

Katherine has worked at the Hamilton Campus for 26 years in a number of positions in Aged Care, including Nurse Unit Manager, Aged Care Quality Coordinator and Director of Nursing, Aged Care (Hamilton Campus). Katherine commenced her acting role at Penshurst in June 2015, combining it with the position of Acting DON – Aged Care Services (Hamilton).

Director, National Centre for Farmer Health

PROFESSOR, SUSAN BRUMBY RN, RM, DipFMgt, MHM, PhD AFCHSE, MACN, GAICD, FARL

Sue is the founding Director of the National Centre for Farmer Health. She leads the implementation of key strategies to make a difference to farmers' lives, blending a theoretical and practical understanding of agriculture, health and rural communities. Sue is Course Director of the award winning Graduate Certificate in Agricultural Health and Medicine, and has successfully led numerous research projects on farmer health, wellbeing and safety. She has been recognised for her contribution to rural health, undertaken overseas studies and presented and published nationally and internationally on farmer health. Sue is a Graduate of the Australian Institute of Company Directors, Life Fellow of the Australian Rural Leadership Program and an appointed member of the Victorian Agricultural Advisory Council.



Senior Staff

Chief Executive
Rohan Fitzgerald BCom

CORPORATE SERVICES

Director of Corporate Services
Nicholas Starkie BBus, MIPA DipTS(Bus),GradCertBusAdmin

Manager Finance & Budget
Nick Templeton BCom, CPA

Hotel Services Manager
Peter Davies BA

Facility Manager
Trevor Wathen Dip Frontline Mgt, MFAM

Subregional Collaboration Project Manager
Patrick Turnbull BBus, BHA, FCPA

Business Improvement Leader
Neil O'Donnell Cert in Education; BIS; Cert Business Management; MBA (Technology)

Human Resources Manager
Ilze Keevy B.Iuris, LLB, LLD (Legum Doctor), Post Grad Dip in Health and Social Welfare Management

Learning and Development Manager
Dorothy McLaren BA, MA

Librarian
Louise Milne ALIA

AGED CARE SERVICES

Director of Nursing Aged Care
Katherine Armstrong (Acting) RN, BAppSci (Nursing), Grad Cert Bus Admin

Unit Manager The Birches
Eryn Cottier RN BA Nursing

Unit Manager The Grange
Leanne Donald RN, B Health Science (Nursing)

Julie Riches (Acting) RN, BA Nursing, Grad Dip Aged Care Services Management

NURSING SERVICES

Director of Nursing
Lorraine Hedley RN, Bachelor of Nursing (Post Registration)

After Hours Coordinators
Leanne Deutscher RN

Linda Donaldson RN, MACN

Tonia Evans RN

Vipin Joseph RN

Shamim Mahabeer RN, RM Graduate Diploma Critical Care, Graduate Diploma of Midwifery

Dianne Nagorcka RN, Peri-opCert, BN

Jennifer O'Donnell RN, RPN, AdvCertMgt, AdvCertWorkplace Practice Skills

Dianne Raymond RN

Kathryn Ross RN Graduate Diploma CriticalCare

Sonia Shaw RN, RM - BA Nursing, Graduate Diploma of Midwifery

Unit Manager Medical/ICU/ED
Aisling Cunningham RN

Unit Manager Surgical/ Obstetrics/Paediatrics
Amber Thomas RN

Unit Manager Theatre/CSSD
Mark Stevenson RN, PeriopCert, GradCertBusAdmin, Sterilisation & Infection Control Cert, Accredited Nurse Immuniser

Penshurst Manager / Director of Nursing
Katherine Armstrong (Acting) RN, BAppSci (Nursing), Grad Cert Bus Admin

Penshurst Unit Manager
Virginia Quirk RN, RM, Grad Dip. Family and Child Health

June Morris RGN, Dip PSN, BSC (Hons) NIP, RN

Coleraine Manager / Director of Nursing
Bronwyn Roberts RN, ICU Cert, Grad Cert Bus Admin, MACN

Coleraine Unit Manager
Suzanne Clayden BA Nursing, Post GradDip (Critical Care Nursing)

Denise Beaton RN RM

REGIONAL PROGRAMS

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

MEDICAL SERVICES

Director Medical Services
Dr Nic van Zyl MB ChB, MMed (CH), MBL, PMP, FAFPHM

Quality Manager
Dr Susan Denney PhD (Environmental Chemistry), Bsc (Hons)

Wendy Buckland RN. BaN, Grad Dip Midwifery, Adv Dip Management

Acting Enid Smith RN, Grad Dip Qual Man Health Care, Grad Dip Rural Health

Chief Pharmacist
Lynette Christie M Pharm, MPS, GradCertBusAdmin

John Okorah B. Pharm, MPS, Masters Health & Human Services Management, Adv Dip Management

Chief Health Information Manager
Sally Graham BAppSci, HIM

SENIOR MEDICAL STAFF

Anaesthetics (Director)
James Muir MBChB, FRCA

Specialist Anaesthetics
Stephen Watty MBBS, FANZCA

Doug Paxton MBBS, FCARSI, FANZCA

Michael Shaw MBBS, FANZCA, FRCA

Anaesthetists in General Practice
Craig deKievit MBBS, DRANZCOG, FACRRM

Kim Fielke MBBS, DRANZCOG, DA (UK), FRACGP

General Practitioners
Victoria Blackwell MB, ChB (UK), FRACGP MRCGP (UK), DRCOG, DFFP (UK)

John Craig deKievit MBBS (Adelaide), DRANZCOG, FACRRM

Dale Ford MBBS, FRACGP, FACRRM

Allan Mark Johnson MBBS(HON) (Sydney) Grad Dip Counselling and Psychotherapy (Essex)

Robey Joyce MB, ChB (Pretoria)

Andrew McAllan MBBS, MMed (Ophth) FRACGP

Alan Reid MBBS FRACGP Dip RANZCOG (Adv)

Susan Robertson MBBS, FRACGP, Dip Obs RACOG DipPallCare

Jan Slabbert MB, ChB (Free State), FRACGP

Amy Tai MBBS B Med Sc DRANZCOG Advanced DCH FACRRM DipCH

Amanda Teo MBBS (Honours) FRACGP

Leesa Walker MBBS, FRACGP

Brian Coulson MBBS, FACRRM, Dip O&G

Greta Prozesky MB, ChB, FRACGP

Ramin Taheri MBBS

Linda Thompson BMS, FRACGP

Steven Yuan MBBS, BMedSci

Dr Alison Brown MBBS

Dr Khaled Moussa BM

Dr Julia Jaensch MBBS

Dr Moe Aung MBBS

Dr David Chen MBBS

Dr Mei Lyn Tan MBBS

General Practitioner Registrar
Juman Al Abadi MBBS

Debra Bird MBBS (Hons) Dip Child Health

Xue Feng Hu MBBS

Sareetaa Vijayan MBBS

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

General Surgeons
Stephen Clifforth MBBS, FRACS

Uvarasen Kumarswami Naidoo MBcHB, FCS, FRACS

Richard Moore MA(Contab) MB BChir, FRCS (England)

Neurosurgery
Caroline Tan FRACS, MBBS

Nephrologist
Professor Steven Holt BSc, BBS, PHD, FRCP, FRACP

Obstetrician / Gynaecologist
Christopher Beaton MB.ChB, FRANZCOG

Rosemary Buchanan MBBS, FRANZCOG

Obstetricians in General Practice
Craig deKievit MBBS (Adelaide), DRANZCOG, FACRRM

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

Amy Tai MBBS B Med Sc DRANZCOG Advanced DCH FACRRM DipCH

Alan Reid MBBS FRACGP Dip RANZCOG (Adv)

Oncologist
David Ashley MBBS; FRACP; PHS

David Campbell MBBS, FRACP

Melanie Wuttke MBBS FRACP

Stephen Brown MBBS FRACP

Ophthalmologist
Robert Harvey MBBS, BSc, FRCOphth

Vincent Lee MBBS, MMed, FRACS, FRANZCO

Oral and Maxillofacial Surgeons
Solanki Nishtha Sureshehandra BDSc

Graeme Fowler LDS, BDSc, MDSc, FDSRCPS

Craig Gove BDSc

David Baring BDSc

Orthopaedic Surgeon
Rick Cunningham MBBS, FRACS (ORTH)

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

John Dillon MB, BAO, BCh, MD, FRCS Orth, FRACS Orth

Ulf Langraf MBBS, MD

Otolaryngologists
Anne Cass MBBS, FRACS

Paediatrician
Christian Fiedler MD, (KIEL), FRACP

Pathologist
David Clift MBBS, FRCPA

David Blaxton MBBS, FRAPA

Physicians
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), FRACP

Win Win Myint MBBS, M Med.Sc(Int Med), MRCP (UK), FRCP(Edin), FRACP

Camelia Borta MBBS, FRACP

Asma Albtoosh

Eduardo Gaio

Radiologists
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

Dr Rachel Battye MBBS, FRANZCR

Urologists
Richard Grills MBBS, FRACS

Hospital Medical Officers (visiting on rotation)
Ballarat Health - one anaesthetic registrar

Barwon Health - one general medicine intern, one medicine PGY3, six emergency PGY3, two surgical registrar, three medical registrars

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

PRIMARY & PREVENTATIVE HEALTH

Director PPH
Sarah Baker (Acting) B App Sci (Hons)

Morven Gemmill

Fran Patterson (Acting) B.App Sct OT, Dip VET

Manager Primary Care Services
Belinda Payne, GradDipBus

Fran Patterson B App Sci OT, Dip VET (Acting)

Business Manager PPH
Lena McCormack B.AppSci-HIM, GradCertBusinessAdmin

Manager Care Coordination
Robyn Beaton RN

District Nurse Assistant Supervisors
Erin Rhook RN

Anne-Marree Simmonds RN

Chief Dietitian
Jodie Nelson BHSc (Nutrition&Dietetics) Diploma of Management (2009)

Chief Occupational Therapist
Sarah Baker B.AppSci (OT) Hons

Fran Patterson BAppSci (O.T), Dip VET

Chief Physiotherapist
Lauren Davies (Acting) B Sc (Physio)

Tatum Pretorius BSc (Physio)

Speech Pathologist
Sue Cameron BAppSc(SpeechPath), MSPAA

Claire Nailon BA Speech Pathology, CPSP Dip Management

Senior Social Worker
Jaibu Philip Equiv. BA Social Work (India) AASW

Tricia Cox B.App Sci (SW)

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

Palliative Care Consultant
Susan Rees RN

Erika Fisher RN, Clinical Nurse Consultant

Men's Health Nurse Practitioner
Stuart Willder MnSc (Nurse Practitioner)
Grad Dip ICU, CCU
Grad Dip Men's Health

Women's Health Nurse Practitioner
Susan Watt MnSc (Nurse Practitioner), Grd Dip Community Health and Development, RN, RM

PRIMARY CARE PARTNERSHIP

Executive Officer SGGPCP
Janette Lowe MBA, BEng

NATIONAL CENTRE FOR FARMER HEALTH

Director NCFH
Clinical Professor Susan Brumby RN, RM, DipFMgt, MHM, PhD AFCHSE, MACN, GAICD, FARL

Statement of Priorities Agreement

Strategic Priorities for 2016-17. The Victorian Government's priorities and policy directions are outlined in the Victorian Health Priorities Framework (VHPF) 2012-2022. In 2016-17 WDHS contributed to the achievement of the priorities by:

Domain	Action	Deliverable	Outcomes
Quality and Safety	• Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	• Review the implementation of the End of Life and Palliative Care Framework and continue to improve the process for people choosing to die at home.	The review is complete and supports the implementation of the frameworks key priorities which include the delivery of coordinated person-centred services making quality end of life and palliative care everyone's responsibility.
	• Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection.	• Review and implement the "Advance Care Planning: Have the Conversation, A Strategy for Victorian Health Services 2014 – 2018" and "Not for Resuscitation" Plan. Key measurements will be the percent of patients over 65 years of age with evidence of an advance care plan, the number of training sessions and the number of attendees. Evidence of advance care planning is incorporated into the mortality and morbidity review reports, the patient experience survey and other forms of routine data collections.	WDHS implemented the plan and has measurement processes in place. Since its introduction there has been an 85% compliance rate with the 'Goals of Care' form and 38.2% of all patients deceased in acute care had an Advanced Care Plan in place.
	• Progress implementation of a whole-of hospital model for responding to family violence.	• Work in partnership with local health providers, primary care partnerships and local organisations to develop a shared action plan to respond to family violence by June 2017.	WDHS implemented an action plan which includes staff training, a variety of community forums and an ongoing commitment to collaboration with local government and other stakeholders.
	• Develop a regional leadership culture that fosters multidisciplinary and multiorganisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria.	• National Centre for Farmer Health will deliver post graduate agricultural health and medicine education programs.	Two post graduate programs delivered in collaboration with Deakin University.
	• Establish a foetal surveillance competency policy and associated procedures for all staff providing maternity care that includes the minimum training requirements, safe staffing arrangements and ongoing compliance monitoring arrangements.	• Utilise the Learning Management System to ensure that all clinicians maintain foetal surveillance competencies required for credentialing.	An online training program is available for staff use. The Foetal Surveillance Committee requires all medical and midwifery staff to attend face-to-face RANZCOG Foetal Surveillance Education Program annually.
	• Use patient feedback, including the Victorian Healthcare Experience Survey to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	• Evaluate and utilise patient feedback to drive improvements to health outcomes and experiences including the Montessori model of care.	We improved patient satisfaction levels with discharge planning from 90% to 96% and introduced a concierge program in Theatre following patient feedback.
	• Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	• The health service will update its policy and continue to monitor any form of restraint in the organisation.	Relevant policies updated.
Access and Timeliness	• Ensure the development and implementation of a plan in specialist clinics to: (1) optimise referral management processes and improve patient flow through to ensure patients are seen in turn and within time; and (2) ensure Victorian Integrated Non-admitted Health (VINAH) data accurately reflects the status of waiting patients.	• Review patient flow and Victorian Integrated Non-admitted Health dataset requirements and implement the recommendations from the review.	The review was completed and the recommendations implemented.
	• Ensure the implementation of a range of strategies (including processes and service models) to improve patient flow, transfer times and efficiency in the emergency department, with particular focus on patients who did not wait for treatment and/or patients that represented within 48 hours.	• Review patient transfer practices and trends to determine strategies to reduce the number of re-presenting patients.	Introduced a retrospective file review process for patients presenting to ED.
	• Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	• Develop alternative models of care to redirect patients away from acute services, including the extension of the Residential in Reach program to include additional support services such as psychology.	A review has been established in conjunction with RMH to enhance and improve the Pain Service.
	• Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme (NDIS) and Home and Community Care (HACC) program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	• Develop a project plan for the implementation of the National Disability Insurance Scheme in October 2017. Transition Home and Community Care clients to appropriate Commonwealth Home Support Program or National Disability Insurance Scheme stream's and implement online referrals with the aim of achieving 100 per cent uptake with clients accessing services through the MyAged Care portal.	The project plan is complete.

Domain	Action	Deliverable	Outcomes
Supporting Healthy Populations	o Support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	o Partner with Southern Grampians Shire Council to develop its Municipal Health Plan.	WDHS actively contributed to the development of the Municipal Health Plan, which is now complete.
	o Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	o Using an online survey tool, investigate ways to reduce the stigma of suicide in farming communities through the Ripple Effect project. Actively participate in the Genr8 change project to support a reduction in youth obesity levels.	The survey is complete and a final report drafted. WDHS has continued to support the GenR8 Change program at a local and national level.
	o Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	o The health service will review its diversity action plan and host an intercultural evening to celebrate cultural diversity.	Review complete and WDHS held an intercultural evening.
	o Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	o Increase the number of aboriginal artworks displayed across all Western District Health Service facilities to be more culturally inclusive and welcoming. Continue to encourage active engagement by all departments at the Winda Mara morning teas.	WDHS purchased 26 Aboriginal artworks for display.
	o Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	o Partner with Deakin University on research into how rural generalist nurses manage mental health presentations in emergency departments and to determine what contextual factors impact patient care processes.	The research project has commenced.
	o Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities.	o Deliver the regional diversity in action training program in Hamilton to support the provision of inclusive youth services for same sex attracted, intersex and gender diverse clients.	Training complete.
Governance and Leadership	o Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review	o Review the health service's clinical governance structure to ensure consistency with the statewide framework.	Review complete and clinical governance systems are consistent with Victorian frameworks.
	o Contribute to the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016 17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	o Actively engage in the development of the South West Plan.	WDHS actively contributed to the development of the South West Plan which is now complete.
	o Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	o Review the Anti-bullying and Harassment Policy against the Fair Work Commissions Anti- bullying guide and deliver organisationally based anti bullying training.	The review was completed and organisational bullying and harassment training provided.

Domain	Action	Deliverable	Outcomes
Governance and Leadership (Cont.)	• Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: (1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) Strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and (3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	• In 2016-17 an organisational wide health and safety strategy will be adopted as part of the annual Quality and Business Planning process. The 2016-17 plan includes an emphasis on prevention of occupational violence and bullying and harassment, supported by a network of contact officers, education and training.	Health and safety strategy introduced as an organisational strategy.
	• Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high quality and safe person centred care.	• Review the Aboriginal workforce plan by February 2017 and create a further designated Aboriginal and Torres Strait Islander position by November 2016.	The review was completed and a position was created within the Primary & Preventative Health Division.
	• Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	• Develop a staff communication and engagement strategy and an action plan in response to the People Matter survey results.	The health service focused on 3 aspects of the people matter survey results and developed a staff communication and engagement strategy.
	• Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	• Create an organisational statement of commitment to child safety, supported by an education program.	WDHS statement of commitment finalised and education provided to staff.
	• Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	• Review the immunisation policy against the National Health and Medical Research Council, The Australian Immunisation Handbook.	Review complete.
Financial Sustainability	• Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	• Prepare a feasibility study to consider opportunities to increase revenue streams by December 2016.	Feasibility study complete and submitted to the DHHS for consideration.
	• Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measurable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	• Seek funding opportunities to increase the solar infrastructure for power generation by June 2017. Commence replacement of incandescent lights with low energy alternatives.	Met with the DHHS to explore future solar funding opportunities. Low energy lights are progressively being introduced at WDHS.

(1) VICNISS is the Victorian Hospital Acquired Infection Surveillance System
(2) WIES is a Weighted Inlier Equivalent Separation.

Quality and Safety

Key Performance Indicator	Target	2016-17 Actual		
Accreditation				
Compliance with NSQHS Standards accreditation	Full Compliance			Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full Compliance			Achieved
Infection Prevention and Control				
Compliance with cleaning Standards	Full Compliance			Achieved
Submission of infection surveillance data to VICNISS[1]	Full Compliance			Achieved
Compliance with the Hand Hygiene Australia program	80%			87%
Percentage of healthcare workers immunised for influenza	75%			86%
Patient Experience				
Victorian Healthcare Experience Survey – data submission	Full Compliance			Achieved
Victorian Healthcare Experience Survey – patient experience	95% positive experience	Quarter 1 95.7%	Quarter 2 98.8%	Quarter 3 95.6%
Victorian Healthcare Experience Survey – discharge care	75% very positive response	Quarter 1 82.4%	Quarter 2 84.8%	Quarter 3 85.0%
Healthcare Associated Infections				
ICU central line associated blood stream infections	No outliers			Achieved
Maternity and Newborn				
Percentage of women with prearranged postnatal home care	100%			100%
Rate of singleton term infants without birth anomalies with APGAR score<7 to 5 minutes	<1.6%			0
Rate of severe foetal growth restriction in singleton pregnancy undelivered by 40 weeks	<28.6%			0

**Perinatal Service Performance Indicator (PSPI) reports should be consulted for a description on the utility and business rules for these indicators. Note that data for 2016 and 2017 is provisional.*

Governance, Leadership and Culture Performance

Key Performance Indicator	Target	2016-17 Actual
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	93%

Access and Timeliness

Key Performance Indicator	Target	2016-17 Actual
Emergency Care		
Percentage of ambulance patients transferred within 40 minutes	90%	99%
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%	93%
Percentage of emergency patients with a length of stay less than four hours	81%	84%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	0

Financial Sustainability Performance

Key Performance Indicator	Target	2016-17 Actual
Finance		
Operating result ($m)	0	0.012
Trade creditors	60	47
Patient fee debtors	60	62
Public & private WIES[2] performance to target	100%	100%
Adjusted current asset ratio	0.7	1.7
Number of days with available cash	14 days	97
Asset Management		
Basic asset management plan	Full Compliance	Achieved

Funding Type	2016-17 Activity Achieved
ACUTE ADMITTED	
WIES Public	3954
WIES Private	1159
WIES (PUBLIC AND PRIVATE)	
WIES DVA	153
WIES TAC	14
WIES TOTAL	
ACUTE NON-ADMITTED	
Rehab Public	96
Rehab Private	25
GEM Public	29
GEM Private	8
Palliative Care Public	19
Palliative Care Private	5
Sub Acute DVA	12
Transition Care - Beddays	842
Transition Care - Homeday	1063
SUB ACUTE NON-ADMITTED	
Health Independence Program	15826
AGED CARE	
Residential Aged Care	56832
HACC	33853
Small Rural HACC	3213
MENTAL HEALTH & DRUG SERVICES	
Residential Aged Care	1095
PRIMARY HEALTH	
Community Health / Primary Care Programs	3926
SMALL RURAL	
Small Rural Acute	817

Legislative Compliance

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.

Declarations of Pecuniary Interest

All necessary declarations have been completed. Refer to Note 8.6 of the Financial Statements.

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 86 FOI requests were received and of these, all were granted in full. No requests were denied.

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 2016-17.

Compliance with DataVic Access Policy

Consistent with the DataVic Access Policy issued by the Victorian Government in 2012, the information all data tables included in this Annual Report will be available at http://www.data.vic.gov.au/ in machine readable format.

Safe Patient Care Act 2015

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

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.

FRD 25C VIPP Disclosure - Contracts

WDHS abides by the Victorian Participation Policy Act 2003. In 2016-17 no contracts required disclosure under the Victorian Participation Policy.

Building and Maintenance

All building works have been designed in accordance with DHHS 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 building permit was issued for an office refurbishment in the Supply building to relocate Health Information staff due to the Oncology / Dialysis redevelopment.

Infrastructure Projects

Current planning and status of capital works:

- Oncology / Dialysis redevelopment project plans being finalised.
- Office relocation Health Information due for completion August 2017.
- Birches redevelopment planning underway.
- Concept design developed for ED to improve workflow and overall security.
- Chiller replacements approved.
- Nurse call system – expression of interest being developed.
- Quotes sourced for Boiler replacements.
- New reverse osmosis filtration system approved for Theatre / CSSD – metering in progress to determine size of unit required.
- Other minor works have occurred at the Hamilton site include addressable fire detection to five main areas.
- The Grange - new automatic door replacement near completion.
- Penshurst driveway kerbing & resealing near completion.

Building Compliance

Not Applicable.

Consultancies

In 2016-17 WDHS engaged 4 consultancies where the total fees payable to the consultants were less than $10,000, with a total expenditure of $11,218 (excl.GST). In 2016-17 there were 4 consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2016-17 in relation to these consultancies is $208,859 (excl. GST). For details of the consultancies greater than $10,000, refer to the table below.

Consultancies > $10,000

Consultant	Purpose of Consultancy	Start Date	End Date	Total Approved Project Fee (ex GST)	Expenditure 2016-17 (ex GST)	Future Expenditure (ex GST)
Elizabeth Rankin	Feasibility Study - DSC	1/6/2016		$25,000	$15,000	-
Mirus Australia	ACFI Package Support Service			$38,428	$38,428	-
Currie Communications	NCFH Marketing & Branding			$57,762	$57,762	-
Siggins Miller	NCFH Program Evaluation			$97,669	$97,669	-
Total	**4**			**$218,859**	**$208,859**	**-**

Additional Information Available on Request

Consistent with FRD 22H (Section 6.19) the items listed below have been retained by WDHS and are available to the relevant Ministers, Members of Parliament and the public on request (subject to freedom of information requirements, if applicable):

(a) Declarations of pecuniary interests have been duly completed by all relevant officers;

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

(c) Details of publications produced by the entity about itself, and how these can be obtained;

(d) Details of changes in prices, fees, charges, rates and levies charged by the Health Service;

(e) Details of any major external reviews carried out on the Health Service;

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

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

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

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

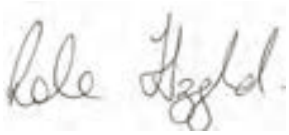
(j) General statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations;

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

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

Attestation for HPV Compliance

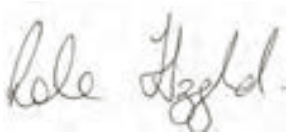
I, Rohan Fitzgerald, certify that Western District Health Service has put in place appropriate internal controls and processes to ensure that it has complied with all requirements set out in the HPV Health Purchasing Policies, including mandatory HPV collective agreements as required by the Health Services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



Rohan Fitzgerald
CHIEF EXECUTIVE
4 September 2017

Attestation on Data Integrity

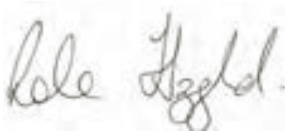
I, Rohan Fitzgerald, certify that Western District Health Service has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. Western District Health Service has critically reviewed these controls and processes during the year.



Rohan Fitzgerald
CHIEF EXECUTIVE
4 September 2017

Attestation for compliance with the Ministerial Standing Direction 3.7.1– Risk Management Framework and Processes

I, Rohan Fitzgerald certify that the Western District Health Service has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. The Western District Health Service Audit Committee has verified this.



Rohan Fitzgerald
CHIEF EXECUTIVE
4 September 2017

Board Members', Accountable Officers' and Chief Finance & Accounting Officers' Declaration

The attached financial statements for Western District Health Service have been prepared in accordance with Direction 5.2 of the Standing Directions of the Minister for Finance under the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2017 and the financial position of Western District Health Service at 30 June 2017.

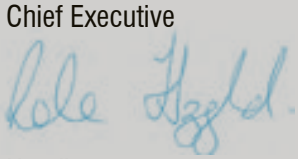
At the time of signing, we are not aware of any circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

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

Hugh Macdonald
President

Hamilton
4 September 2017

Rohan Fitzgerald
Chief Executive



Hamilton
4 September 2017

Nicholas Starkie
Chief Finance and Accounting Officer

Hamilton
4 September 2017

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.

Legislation	Requirement	Page Ref
Ministerial Directions		
Report of Operations		
Charter and Purpose		
FRD 22H	Manner of Establishment and the Relevant Ministers	Inside front cover, 1, 64
FRD 22H	Purpose, Functions, Powers and Duties	1
FRD 22H	Initiatives and Key Achievements	2-5
FRD 22H	Nature and Range of Services Provided	1, 7
Management and Structure		
FRD 22H	Organisational Structure	29
Financial and Other Information		
FRD 10A	Disclosure Index	39
FRD 11A	Disclosure of Ex Gratia Expenses	N/A
FRD 21C	Responsible Person and Executive Officer Disclosures	65-66
FRD 22H	Application and Operation of Protected Disclosure 2012	36
FRD 22H	Application and Operation of Carers Recognition Act 2012	36
FRD 22H	Application and Operation of Freedom of Information Act 1982	36
FRD 22H	Compliance with Building and Maintenance Provisions of Building Act 1993	36
FRD 22H	Details of Consultancies Over $10,000	36
FRD 22H	Details of Consultancies Under $10,000	36
FRD 22H	Employment and Conduct Principles	18
FRD 22H	Major Changes or Factors Affecting Performance	2, 6-7
FRD 22H	Occupational Violence	19
FRD 22H	Operational and Budgetary Objectives and Performance Against Objectives	6-7
FRD 24C	Reporting of Office-Based Environmental Impacts	20-21
FRD 22H	Significant Changes in Financial Position During the Year	6-7
FRD 22H	Statement on National Competition Policy	36
FRD 22H	Subsequent Events	67
FRD 22H	Summary of the Financial Results for the Year	6-7
FRD 22H	Additional Information Available on Request	37
FRD 22H	Workforce Data Disclosures Including a Statement on the Application of Employment and Conduct Principles	18-19
FRD 25C	Victorian Industry Participation Policy disclosures	36
FRD 29B	Workforce Data Disclosures	24, 18-19
FRD 103F	Non-financial Physical Assets	
FRD 110A	Cash Flow Statements	43
FRD 112D	Defined Benefit Superannuation Obligations	49
SD 5.2.3	Declaration in Report of Operations	38
SD 3.7.1	Risk Management Framework and Processes	37

Legislation	Requirement	Page Ref
Other Requirements Under Standing Directions 5.2		
SD 5.2.2	Declaration in Financial Statements	38
SD 5.2.1(a)	Compliance with Australian Accounting Standards and Other Authoritative Pronouncements	38
SD5.2.1(a)	Compliance with Ministerial Directions	38
Legislation		
Freedom of Information Act 1982		36
Protected Disclosure Act 2012		36
Carers Recognition Act 2012		36
Victorian Industry Participation Policy Act 2003		36
Building Act 1993		36
Financial Management Act 1994		36
Safe Patient Care Act 2015		36

VAGO
Victorian Auditor-General's Office

Independent Auditor's Report

To the Board of Western District Health Service

Opinion

I have audited the financial report of Western District Health Service (the health service) which comprises the:

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

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

Basis for Opinion

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

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

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

Board's responsibilities for the financial report

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

In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, and using the going concern basis of accounting unless it is inappropriate to do so.

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
5 September 2017

Ron Mak
as delegate for the Auditor-General of Victoria

Comprehensive Operating Statement For the Year Ended 30 June 2017	Note	Total 2017 $'000	Total 2016 $'000
Revenue from operating activities	2.1	68,355	65,756
Revenue from non-operating activities	2.1	1,447	1,382
Employee expenses	3.1	(48,072)	(46,183)
Non salary labour costs	3.1	(4,731)	(4,382)
Supplies and consumables	3.1	(7,686)	(7,166)
Other expenses	3.1	(9,301)	(9,392)
Net result before capital and specific items		**12**	**15**
Capital purpose income	2.1	4,729	4,436
Impairment of financial assets	3.1	(5)	-
Depreciation and Amortisation	4.4	(7,020)	(6,951)
Finance Costs	3.3	(108)	(44)
Expenditure for Capital Purpose	3.1	(37)	(103)
Share of net result of associates and joint ventures accounted for using the Equity Method	4.2	4	(3)
Net result after capital and specific items		**(2,425)**	**(2,650)**
Other economic flows included in net result			
Revaluation of Long Service leave	3.1	(45)	-
Total other economic flows included in tnet result		**(45)**	**-**
NET RESULT FOR THE YEAR		**(2,470)**	**(2,650)**
Other comprehensive income			
Items that may be reclassified subsequently to net result			
Changes to financial assets available-for-sale revaluation surplus	**8.1**	**(29)**	**(90)**
Total other comprehensive income		**(29)**	**(90)**
Comprehensive result		**(2,499)**	**(2,740)**

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

Balance Sheet As at 30 June 2017	Note	Total 2017 $'000	Total 2016 $'000
Current assets			
Cash and cash equivalents	6.2	8,957	9,178
Receivables	5.1	4,538	4,254
Investments and other financial assets	4.1	24,649	19,723
Inventories	5.2	154	153
Prepayments and Other assets	5.4	325	1,326
Total current assets		**38,623**	**34,634**
Non-current assets			
Receivables	5.1	1,463	1,166
Investments and other financial assets	4.1	2,317	2,341
Investments accounted for using the equity method	4.2	97	93
Property, plant & equipment	4.3	125,361	131,127
Total non-current assets		**129,238**	**134,727**
TOTAL ASSETS		**167,861**	**169,361**
Current liabilities			
Payables	5.5	4,828	5,200
Borrowings	6.1	338	358
Provisions	3.4	9,720	9,053
Other current liabilities	5.3	11,751	10,718
Total current liabilities		**26,637**	**25,329**
Non-current liabilities			
Borrowings	6.1	410	543
Provisions	3.4	1,650	1,826
Total non-current liabilities		**2,060**	**2,369**
TOTAL LIABILITIES		**28,697**	**27,698**
NET ASSETS		**139,164**	**141,663**
EQUITY			
Property, plant & equipment revaluation surplus	8.1a	67,366	67,366
Financial asset available for sale revaluation surplus	8.1a	59	88
Restricted specific purpose surplus	8.1b	10,413	7,566
Contributed capital	8.1b	49,535	49,535
Accumulated surpluses/(deficits)	8.1c	11,791	17,108
TOTAL EQUITY	8.1c	**139,164**	**141,663**
Commitments	6.3		

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

Statement of Changes in Equity for the Year Ended 30 June 2017

	Note	Property, Plant & Equipment Revaluation Surplus $'000	Financial Asset Available for Sale Revaluation Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2015		**67,366**	**178**	**5,283**	**49,535**	**22,041**	**144,403**
Net result for the year		-	-	-	-	(2,650)	(2,650)
Other comprehensive income for the year	8.1a	-	(90)	-	-	-	(90)
Transfer to accumulated surplus	8.1b, 8.1c	-	-	2,283	-	(2,283)	-
Balance at 30 June 2016		**67,366**	**88**	**7,566**	**49,535**	**17,108**	**141,663**
Net result for the year		-	-	-	-	(2,470)	(2,470)
Other comprehensive income for the year	8.1a	-	(29)	-	-	-	(29)
Transfer to accumulated surplus	8.1b, 8.1c	-	-	2,847	-	(2,847)	-
Balance at 30 June 2017		**67,366**	**59**	**10,413**	**49,535**	**11,791**	**139,164**

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

Cash Flow Statement For the Year Ended 30 June 2017	Note	Total 2017 $'000	Total 2016 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		48,630	46,304
Capital grants from government		1,368	1,146
Patient and resident fees received		14,279	14,364
Donations and bequests received		1,970	1,426
GST received from/(paid to) ATO		65	1,340
Interest received		717	506
Dividend received		2	31
Other capital receipts		2,250	2,213
Other receipts		5,493	3,458
Total receipts		**74,774**	**70,788**
Employee expenses paid		(47,726)	(45,434)
Non salary labour costs		(4,731)	(4,382)
Payments for supplies & consumables		(8,544)	(9,774)
Finance costs		(108)	(44)
Other payments		(8,634)	(5,860)
Total payments		**(69,743)**	**(65,494)**
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	8.2	**5,031**	**5,294**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments		(4,016)	(5,760)
Payments for non-financial assets		(1,290)	(1,576)
Proceeds from sale of non-financial assets		81	147
NET CASH FLOW FROM/(USED IN) INVESTING ACTIVITIES		**(5,225)**	**(7,189)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of finance leases		(27)	(394)
NET CASH FLOW FROM/(USED IN) FINANCING ACTIVITIES		**(27)**	**(394)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**(221)**	**(2,289)**
Cash and cash equivalents at beginning of financial year		**9,178**	**11,467**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	**8,957**	**9,178**

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

CONTENTS

Basis of presentation

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

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

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

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

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

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

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

Note 1: Summary of significant accounting policies

These annual financial statements represent the audited general purpose financial statements for Western District Health Service for the period ending 30 June 2017. The report provides 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 AASBs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 Presentation of Financial Statements.

The financial statements also comply with relevant Financial Reporting Directions (FRDs) issued by the Department of Treasury & 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 AASBs.

The annual financial statements were authorised for issue by the Board of Western District Health Service on 4/09/2017.

(b) Reporting entity

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

Its principal address is:

20 Foster Street

Hamilton

Victoria 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's overall objective 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.

(c) Basis of accounting preparation and measurement

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

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

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

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

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

The financial statements are prepared in accordance with the historical cost convention, except for:

- non-current physical assets, which subsequent to acquisition, are measured at 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 when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- available-for-sale investments 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 amounts 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 AASBs that have significant effects on the financial statements and estimates relate to:

- the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.1);
- superannuation expense (refer to Note 3.5);
- 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 3.4); and
- equities and management investment schemes classified at level 3 of the fair value hierarchy

Intersegment Transactions

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

Note 2: Funding Delivery of Our Services

The hospital's overall objective is to deliver programs and services that support and enhance the wellbeing of all Victorians.
To enable the hospital to fulfil its objective it receives income based on parliamentary appropriations. The hospital also receives income from the supply of services.

Structure

2.1 Analysis of revenue by source

Note 2.1: Analysis of Revenue by Source

	Admitted Patients 2017 $'000	RAC incl. Mental Health 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Government Grant	38,437	11,634	3,880	1,480	1,818	57,249
Indirect contributions by Department of Health and Human Services	45	14	5	2	2	68
Patient & Resident Fees	1,883	4,207	398	-	-	6,488
Commercial Activities	-	501	-	-	4,049	4,550
Total Revenue from Operating Activities	**40,365**	**16,356**	**4,283**	**1,482**	**5,869**	**68,355**
Interest	-	-	-	-	682	682
Dividends	-	-	-	-	2	2
Other Revenue from Non-Operating Activities	-	-	-	-	763	763
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**1,447**	**1,447**
Capital Purpose Income (excluding Interest)	-	-	-	-	4,729	4,729
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**4,729**	**4,729**
Share of Net Result of Associates & Joint Ventures Accounted for using the Equity Method (refer note 4.2)	-	-	-	-	4	4
Total Revenue	**40,365**	**16,356**	**4,283**	**1,482**	**12,049**	**74,535**

	Admitted Patients 2016 $'000	RAC incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Government Grant	36,435	10,858	6,715	1,361	-	55,369
Indirect contributions by Department of Health and Human Services	40	18	4	2	-	64
Patient & Resident Fees	2,037	3,384	383	-	-	5,804
Commercial Activities	-	449	-	-	4,070	4,519
Total Revenue from Operating Activities	**38,512**	**14,709**	**7,102**	**1,363**	**4,070**	**65,756**
Interest	-	-	-	-	506	506
Dividends	-	-	-	-	31	31
Other Revenue from Non-Operating Activities	-	-	-	-	845	845
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**1,382**	**1,382**
Capital Purpose Income (excluding Interest)	-	-	-	-	4,436	4,436
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**4,436**	**4,436**
Share of Net Result of Associates & Joint Ventures Accounted for using the Equity Method (refer note 4.2)	-	-	-	-	(3)	(3)
Total Revenue	**38,512**	**14,709**	**7,102**	**1,363**	**9,885**	**71,571**

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

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 are where applicable, net of returns, allowances and duties and taxes.

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

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

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

Indirect Contributions from the Department of Health and Human Services

- Insurance is recognised as revenue following advice from the Department of Health and Human Services.
- 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 04/2017.

Patient and Resident Fees

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

Private Practice Fees

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

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 the specific restricted purpose surplus.

Dividend Revenue

Dividend revenue is recognised when the right to receive payment is established. Dividends represent the income arising from Western District Health's investments in financial assets.
Western District Health does not recognise dividends received or receivable from its associates and joint ventures as income. Instead, dividends from associates and joint ventures are adjusted directly against the carrying amount of the investments using the equity method.

Interest Revenue

Interest revenue is recognised on a time proportionate basis that takes in account the effective yield of the financial asset, which allocates interest over the relevant period.

Sale of investments

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

Other income

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

Category Groups

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

- Admitted Patient Services (Admitted Patients) comprises all acute and subacute admitted patient services, where services are delivered in public hospitals.
- 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 the department 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 and secure extended care units.
- Aged Care comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.
- Primary Health comprises a range of home based, community based, community, primary health and dental services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health service.
- Other Services not reported elsewhere - (Other) comprises services not separately classified above, including: Public Health Services including blood borne viruses / sexually transmitted infections clinical services, immunisation and screening services, drugs services including drug withdrawal, counselling, 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 3: The Cost of Delivering Our Services

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

Structure

3.1 Analysis of expenses by source
3.2 Analysis of expense and revenue by internally managed and restricted specific purpose funds
3.3 Finance Costs
3.4 Employee Benefits in the Balance Sheet
3.5 Superannuation

Note 3.1: Analysis of Expenses by Source

	Admitted Patients 2017 $'000	RAC incl. Mental Health 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Employee Expenses	26,700	13,246	3,890	2,599	1,637	48,072
Other Operating Expenses						
Non Salary Labour Costs	4,731	-	-	-	-	4,731
Supplies & Consumables	5,304	1,384	461	308	230	7,686
Other Expenses	6,846	1,171	684	293	307	9,301
Total Expenditure from Operating Activities	**43,581**	**15,801**	**5,035**	**3,200**	**2,173**	**69,790**
Finance Costs (refer note 3.3)	59	32	5	7	5	108
Other Non-Operating Expenses						
Revaluation of Long Service Leave	-	-	-	-	45	45
Expenditure for Capital Purposes	-	-	-	-	37	37
Impairment of Financial Assets	-	-	-	-	5	5
Depreciation & Amortisation (refer note 4.4)	3,828	2,068	297	510	317	7,020
Total other expenses	**3,887**	**2,100**	**302**	**517**	**409**	**7,215**
Total Expenses	**47,468**	**17,901**	**5,337**	**3,717**	**2,582**	**77,005**

	Admitted Patients 2016 $'000	RAC incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Employee Expenses	26,083	12,293	3,737	2,497	1,573	46,183
Other Operating Expenses						
Non Salary Labour Costs	4,382	-	-	-	-	4,382
Supplies & Consumables	4,945	1,290	430	287	214	7,166
Other Expenses	6,916	1,183	691	296	306	9,392
Total Expenditure from Operating Activities	**42,326**	**14,766**	**4,858**	**3,080**	**2,093**	**67,123**
Finance Costs (refer note 3.3)	24	13	2	3	2	44
Other Non-Operating Expenses						
Expenditure for Capital Purposes	-	-	-	-	103	103
Depreciation & Amortisation (refer note 4.4)	3,790	2,048	294	505	314	6,951
Total other expenses	**3,814**	**2,061**	**296**	**508**	**419**	**7,098**
Total Expenses	**46,140**	**16,827**	**5,154**	**3,588**	**2,512**	**74,221**

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

Grants and other transfers
Grants and other transfers to third parties (other than contribution to owners) are recognised as an expense in the reporting period in which they are paid or payable. They include transactions such as: grants, subsidies and personal benefit payments made in cash to individuals.

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

Non Salary Labour Costs
Costs of visiting medical officers not paid via employee expenses.

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

Other Expenses
Operating costs including utilities which are recognised as an expense in the reporting period in which they are incurred.

Bad and doubtful debts
Refer to Note 4.1 Investments and other financial assets.

Other economic flows are changes in the volume or value of assets or liabilities that do not result from transactions.

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

Revaluation gains/ (losses) of non-financial physical assets
Refer to Note 4.4 Property plant and equipment.

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

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

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

Revaluations of financial instrument at fair value
Refer to Note 7.1 Financial instruments.

Other gains/ (losses) from other economic flows
Other gains/ (losses) include:

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

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

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.

Note 3.2: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds for Services Supported by Hospital and Community Initiatives

	Expense		Revenue	
	Total 2017 $'000	Total 2016 $'000	Total 2017 $'000	Total 2016 $'000
Commercial Activities				
Private Practice and Other Patient Activities	17	9	-	-
Catering	274	262	280	223
Laundry	129	133	15	9
Cafeteria	98	94	233	241
Property Expense/Revenue	132	131	681	772
Specific Revenue	-	-	4,105	4,046
TOTAL	**650**	**629**	**5,314**	**5,291**

Note 3.3: Finance Costs

	Total 2017 $'000	Total 2016 $'000
Finance Charges on Finance Leases (i)	108	44
Total Finance Costs	**108**	**44**

(i) Of the balance in 'interest on finance lease', $108 [$44 in 2016] related to assets contracted under the SWARH arrangements.

Finance costs are recognised as expenses in the period in which they are incurred.
Finance costs include:

- finance charges in respect of finance leases recognised in accordance with AASB 117 Leases.

Note 3.4: Employee Benefits in the Balance Sheet

	Total 2017 $'000	Total 2016 $'000
Current Provisions		
Employee Benefits (i)		
Annual leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	2,765	2,716
Long service leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	800	800
- Unconditional and expected to be settled wholly after 12 months (iii)	4,114	3,356
Accrued Days Off		
- Unconditional and expected to be settled within 12 months (ii)	85	80
Accrued Wages and Salaries		
- Unconditional and expected to be settled within 12 months (ii)	521	857
	8,285	7,809
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months (ii)	965	871
- Unconditional and expected to be settled after 12 months (iii)	470	373
	1,435	1,244
Total Current Provisions	**9,720**	**9,053**
Non-Current Provisions		
Employee Benefits (i)	1,470	1,644
Provisions related to Employee Benefit On-Costs	180	182
Total Non-Current Provisions	**1,650**	**1,826**
Total Provisions	**11,370**	**10,879**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional LSL Entitlement	5,413	4,617
Annual Leave Entitlements	3,701	3,499
Accrued Wages and Salaries	521	857
Accrued Days Off	85	80
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (ii)	1,650	1,826
Total Employee Benefits and Related On-Costs	**11,370**	**10,879**
On-Costs		
Current On-Costs	9,076	8,840
Non-Current On-Costs	459	392
Total On-Costs	**9,535**	**9,232**
Total Employee Benefits and Related On-Costs	**11,370**	**10,879**

Notes:
(i) Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by employees, not including on-costs.
(ii) The amounts disclosed are nominal amounts
(iii) The amounts disclosed are discounted to present values

Note 3.4: Employee Benefits in the Balance Sheet (Cont.)

Movements in Provisions

	Total 2017 $'000	Total 2016 $'000
Movement in Long Service Leave:		
Balance at start of year*	6,443	6,278
Provision made during the year		
- Revaluations	45	93
- Expense recognising Employee Service	1,375	872
Settlement made during the year	(800)	(800)
Balance at end of year*	**7,063**	**6,443**

Provisions
Provisions are recognised when the Health Service has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.
The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.
When some or all of the economic benefits required to settle a provision are expected to be received from a third party, the receivable is recognised as an asset if it is virtually certain that recovery will be received and the amount of the receivable can be measured reliably.

Employee benefits
This provision arises for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered 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, and 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 wholly 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. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; and
- Present value – where the entity does not expect to settle a component of this current liability within 12 months

Conditional LSL is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. This non-current LSL liability is measured at present value.
Any gain or loss followed revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in estimations e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flow.

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.

On-costs related to employee expense
Provision for on-costs, such as payroll tax, workers compensation and superannuation are recognised together with provisions for employee benefits.

Note 3.5: Superannuation

	Paid Contribution for the Year		Contribution Outstanding at Year End	
	Total 2017 $'000	Total 2016 $'000	Total 2017 $'000	Total 2016 $'000
(i) Defined benefit plans:				
First State Super	143	172	-	11
Defined contribution plans:				
First State Super	2,832	2,296	-	213
HESTA	879	689	-	63
Other	107	78	-	6
TOTAL	**3,961**	**3,235**	**-**	**293**

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

Employees of the Health Service are entitled to receive superannuation benefits and the Health Services 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.

Superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Health Service.

The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Services are as follows:

Defined contribution superannuation plans

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

Defined benefit superannuation plans

The amount charged to the comprehensive operating statement in respect of defined benefit superannuation plans represents the contributions made by the Health Service to the superannuation plans in respect of the services of current Health Service 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 Western District Health Service are entitled to receive superannuation benefits and Western District Health Service contributes to both the defined benefit and defined contribution plans. The defined benefit plan(s) provide benefits based on years of service and final average salary.

Superannuation liabilities

Western District 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.

Note 4: Key Assets to Support Service Delivery

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

Structure

4.1 Investments & Other Financial Assets

4.2 Investments accounted for using the equity method

4.2(a) Investments in jointly controlled assets and operations

4.3 Property, plant & equipment

4.4 Depreciation and amortisation

Note 4.1: Investments and Other Financial Assets

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000
CURRENT								
Loans and receivables								
Term Deposit								
Aust. Dollar Term Deposits > 3 months (i)	5,500	-	19,149	19,723	-	-	24,649	19,723
Total Current	**5,500**	**-**	**19,149**	**19,723**	**-**	**-**	**24,649**	**19,723**
NON CURRENT								
Loans and receivables								
Term Deposit								
Aust. Dollar Term Deposits > 12 months	-	-	-	-	437	653	437	653
Available for sale								
Equities and Managed Investment Schemes								
Australian Listed Equity Securities (ii)	-	-	1,880	1,688	-	-	1,880	1,688
Total Non Current	**-**	**-**	**1,880**	**1,688**	**437**	**653**	**2,317**	**2,341**
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**5,500**	**-**	**21,029**	**21,411**	**437**	**653**	**26,966**	**22,064**
Represented by:								
Health Service Investments	5,500	-	9,860	11,160	437	653	15,797	11,813
Monies Held in Trust								
Patient Monies	-	-	11,169	10,251	-	-	11,169	10,251
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**5,500**	**-**	**21,029**	**21,411**	**437**	**653**	**26,966**	**22,064**

Notes:

(i) Term deposits under 'investments and other financial assets' class include only term deposits with maturity greater than 90 days.
(ii) The Health Service designated all its equities and managed investment schemes at fair value through profit or loss. Therefore, unless they are part of a disposal group held for sale, all equities and managed investments are classified as non-current.

(a) Ageing analysis of investments and other financial assets

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

(b) Nature and extent of risk arising from investments and other financial assets

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

Investments and other financial assets

Hospital investments must be in accordance in Standing Direction 3.7.2 – Treasury and Investment Risk Management. Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned, and are initially measured at fair value, net of transaction costs. Investments are classified in the following categories:

- financial assets at fair value through profit or loss;
- held-to-maturity;
- loans and receivables;

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

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

Derecognition of financial assets

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

the rights to receive cash flows from the asset have expired; or

the Health Service retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or

the Health Service has transferred its rights to receive cash flows from the asset and either:

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

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

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

Impairment of financial assets

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

The allowance is the difference between the financial asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

Note 4.2: Investments Accounted for Using the Equity Method

Name of Entity	Principal Activity	Country of Incorporation	Ownership Interest		Published Fair Value	
			2017 %	2016 %	2017 %	2016 %
Jointly Controlled Entities						
Southern Grampians/Glenelg Shire PCP [(a)(b)]	Primary Health	Australia	45	45	97	93

(a) As at 30 June 2017, the fair value of the agency's interest in Southern Grampians/Glenelg Shire PCP was 97,000 based on the fair value measurement approach of AASB 13 Fair Value Measurement.
(b) The financial year end date of Southern Grampians/Glenelg Shire PCP is 30 June. This was the reporting date established when that company was incorporated. For the purpose of applying the equity method of accounting, the financial statements of Southern Grampians/Glenelg Shire PCP have been used, and appropriate adjustments have been made for the effects of significant transactions between that date and 30 June 2017.

Note 4.2: Investments Accounted for Using the Equity Method (Cont.)

Summarised financial information in respect of the agency's material associate is set out below. The summarised financial information below represents amounts shown in the associate's financial statements prepared in accordance with AASBs, adjusted by the agency for equity accounting purposes

	2017 $'000	2016 $'000
Summarised Financial Information of Joint Venture:		
Current Assets	415	479
Total Assets	**415**	**479**
Current Liabilities	156	206
Non-Current Liabilities	42	66
Total Liabilities	**198**	**272**
Net Assets	**217**	**207**
Share of Joint Venture's Net Assets	**97**	**93**
Summarised operating statement		
Total income from transaction	479	740
Net result from continuing operation	**4**	**(3)**
Net Result	**4**	**(3)**
Total comprehensive income	**4**	**(3)**
Share of Jointly Controlled Entities' Net Result After Income Tax	**4**	**(3)**

Movements in carrying amount of interests in the Joint Venture	2017 $'000	2016 $'000
Carrying amount at the beginning of the year	93	96
Share of associate's net result after tax	4	(3)
Total income	479	740
Net result	4	(3)
Share of associate's result after tax	4	(3)
Carrying amount at the end of the year	**97**	**93**

Dividends Received from Associates and Joint Ventures

During the 2017 financial year, Western District Health Service received dividends of $0 (2015/2016: $0) from its associates.

Contingent Liabilities and Capital Commitments

There are no contingent liabilities and capital commitments arising from associates and joint ventures.

The investment in the associate is accounted for using the equity method of accounting. Under the equity method for accounting, the investment in the associate is recognised at cost on initial recognition, and the carrying amount is increased or decreased in subsequent years to recognise Western District Health Service's share of the profits or losses of the associates after the date of acquisition. Western District Health Service's share of the associate's profit or loss is recognised in Western District Health Service's net result as 'other economic flows'. The share of post-acquisition changes in revaluation surpluses and any other reserves, are recognised in both the comprehensive operating statement and the statement of changes in equity. The cumulative post acquisition movements are adjusted against the carrying amount of the investment, including dividends received or receivable from the associate.

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control. Joint ventures are joint arrangements whereby Western District Health Service, via its joint control of the arrangement, has rights to the net assets of the arrangements.

Interests in joint ventures are accounted for in the financial statements using the equity method, as applied to investments in associates and are disclosed as required by AASB 12.

Note 4.2(a) Investments in Jointly Controlled Assets and Operations

Name of Entity	Principal Activity	Ownership Interest	
		2017 %	2016 &
South West Alliance of Rural Health	Information Systems	12.80	12.80

Western District District Health's interest in assets and liabilities employed in the above jointly controlled operations, assets and liabilities is detailed below. The amounts are included in the financial statements under their respective asset categories:

	2017 $'000	2016 $'000
South West Alliance of Rural Health		
Current Assets		
Cash at Bank	671	267
Receivables	2,360	1,911
Inventories	2	9
Other Current Assets	-	37
Total Current Assets	**3,033**	**2,224**
Non Current Assets		
Property, Plant and Equipment	71	29
Leased Assets	697	901
Total Non Current Assets	**768**	**930**
Total Assets	**3,801**	**3,154**
Current Liabilities		
Payables	2,559	1,909
Leased Liabilities	338	358
Employee Benefits	220	230
Deferred Income	142	-
Total Current Liabilities	**3,259**	**2,497**
Non Current Liabilities		
Employee Benefits	38	45
Leased Liabilities	410	543
Total Non Current Liabilities	**448**	**588**
Total Liabilities	**3,707**	**3,085**
Net Assets	**94**	**69**

Western District District Health's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

	2017 $'000	2016 $'000
South West Alliance of Rural Health		
Revenues		
Revenue from Operating Activities	2,888	2,873
Revenue from Non Operating Activities	8	-
Capital Purpose Income	64	-
Other Economic Flows	5	-
Total Revenue	**2,965**	**2,873**
Expenses		
Employee Benefits	833	783
Maintenance Contract & IT Support	1,008	1,561
Operating Lease Costs	59	
Other Expenses from Ordinary Activities	454	85
Finance Costs	108	44
Impairment of Non Financial Assets	9	-
Depreciation	470	399
Total Expenses	**2,941**	**2,872**
Net Result	**24**	**1**

Investments in joint operations

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

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

Note 4.3: Property, Plant & Equipment

(a) Gross Carrying Amount and Accumulated Depreciation

	Total 2017 $'000	Total 2016 $'000
Land		
Land at Fair Value	4,837	4,837
Total Land	**4,837**	**4,837**
Buildings		
Buildings Under Construction at cost	279	53
Buildings at Fair Value	124,805	124,805
Less Acc'd Depreciation	15,126	10,081
Leasehold Improvements at cost	1,897	1,897
Less Acc'd Depreciation	149	99
Total Buildings	**111,706**	**116,575**
Plant and Equipment		
Plant and Equipment at Fair Value	6,327	6,167
Less Acc'd Depreciation	2,452	2,229
Total Plant and Equipment	**3,875**	**3,938**
Medical Equipment		
Medical Equipment at Fair Value	8,267	8,213
Less Acc'd Depreciation	5,388	5,112
Total Medical Equipment	**2,879**	**3,101**
Computers and Communication		
Computers and Communication at Fair Value	1,243	1,174
Less Acc'd Depreciation	1,015	900
Total Cultural Assets	**228**	**274**
Furniture and Fittings		
Furniture and Fittings at Fair Value	1,326	1,292
Less Acc'd Depreciation	964	828
Total Cultural Assets	**362**	**464**
Motor Vehicles		
Motor Vehicles at Fair Value	1,973	2,006
Less Acc'd Depreciation	1,196	971
Total Cultural Assets	**777**	**1,035**
Leased Assets		
Computers and Communication	1,912	1,648
Less Acc'd Amortisation	1,215	745
Total Leased Assets	**697**	**903**
TOTAL	**125,361**	**131,127**

Note 4.3: Property, Plant & Equipment (Cont.)

(b) Reconciliations of the Carrying Amounts of Each Class of Asset

	Land $'000	Buildings $'000	Plant and equipment $'000	Medical equipment $'000	Computers & Communications $'000	Furniture and Fittings $'000	Motor Vehicles $'000	SWARH JV $'000	Leasesd Assets $'000	Assets Under Construction $'000	TOTAL $'000
Balance at 1 July 2015	**4,837**	**121,546**	**2,706**	**3,419**	**352**	**563**	**899**	**31**	**1,072**	**1,143**	**136,568**
Additions	-	69	93	307	20	25	515	3	224	321	1,577
Disposals	-	-	-	-	-	(25)	(42)	-	-	-	(67)
Net Transfers between Classes	-	-	1,364	-	-	47	-	-	-	(1,411)	-
Depreciation (Note 4.4)	-	(5,093)	(225)	(625)	(126)	(146)	(337)	(6)	(393)	-	(6,951)
Balance at 1 July 2016	**4,837**	**116,522**	**3,938**	**3,101**	**246**	**464**	**1,035**	**28**	**903**	**53**	**131,127**
Additions	-	-	180	389	20	34	120	52	264	226	1,285
Disposals	-	-	-	(1)	(2)	-	(28)	-	-	-	(31)
Depreciation (Note 4.4)	-	(5,095)	(243)	(610)	(107)	(136)	(350)	(9)	(470)	-	(7,020)
Balance at 30 June 2017	**4,837**	**111,427**	**3,875**	**2,879**	**157**	**362**	**777**	**71**	**697**	**279**	**125,361**

Land and buildings carried at valuation

An independent valuation of the Health Service's land and buildings was performed by the Valuer-General Victoria to determine the fair value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.

The effective date of the valuation is 30 June 2014.

Note 4.3: Property, Plant & Equipment (Cont.)

(c) Fair Value Measurement Hierarchy for Assets

	Carrying amount as at 30 June 2017 $'000	Fair value measurement at end of reporting period using: Level 1 (i) $'000	Level 2 (i) $'000	Level 3 (i) $'000
Land at fair value				
Non-specialised land	618	-	618	-
Specialised land	4,219	-	-	4,219
Total of Land at Fair Value	**4,837**	**-**	**618**	**4,219**
Buildings at Fair Value				
Assets under Construction	279	-	-	279
Non-specialised buildings	585	-	585	-
Specialised buildings	110,508	-	-	110,508
Heritage assets	334	-	-	334
Total of Building at Fair Value	**111,706**	**-**	**585**	**111,121**
Plant and Equipment at Fair Value				
- Vehicles	777	-	-	777
- Plant and equipment	3,875	-	-	3,875
Total Plant, Equipment and Vehicles at Fair Value	**4,652**	**-**	**-**	**4,652**
Medical Equipment at Fair Value				
Medical Equipment at Fair Value	2,879	-	-	2,879
Total Medical Equipment at Fair Value	**2,879**	**-**	**-**	**2,879**
Computers and Communication at Fair Value				
Computers and Communication at Fair Value	228	-	-	228
Total Computers and Communication at Fair Value	**228**	**-**	**-**	**228**
Furniture and Fittings at Fair Value				
Furniture and Fittings at Fair Value	362	-	-	362
Total Furniture and Fittings at Fair Value	**362**	**-**	**-**	**362**
Leased Assets				
Leased Assets at Fair Value	697	-	-	697
Total Leased Assets at Fair Value	**697**	**-**	**-**	**697**
TOTAL	**125,361**	**-**	**1,203**	**124,158**

	Carrying amount as at 30 June 2016 $'000	Fair value measurement at end of reporting period using: Level 1 (i) $'000	Level 2 (i) $'000	Level 3 (i) $'000
Land at Fair Value				
Non-specialised land	618	-	618	-
Specialised land	4,219	-	-	4,219
Total of Land at Fair Value	**4,837**	**-**	**618**	**4,219**
Buildings at Fair Value				
Assets Under Construction	53	-	-	53
Non-specialised Buildings	585	-	585	-
Specialised Buildings	115,576	-	-	115,576
Heritage assets	361	-	-	361
Total of Building at Fair Value	**116,575**	**-**	**585**	**115,990**
Plant and Equipment at Fair Value				
- Vehicles	1,035	-	-	1,035
- Plant and equipment	3,938	-	-	3,938
Total Plant and Equipment at Fair Value	**4,973**	**-**	**-**	**4,973**
Medical Equipment at Fair Value				
Medical Equipment at Fair Value	3,101	-	-	3,101
Total Medical Equipment at Fair Value	**3,101**	**-**	**-**	**3,101**
Computers and Communication at Fair Value				
Computers and Communication at Fair Value	274	-	-	274
Total Computers and Communication at Fair Value	**274**	**-**	**-**	**274**
Furniture and Fittings at Fair Value				
Furniture and Fittings at Fair Value	464	-	-	464
Total Furniture and Fittings at Fair Value	**464**	**-**	**-**	**464**
Leased Assets				
Leased Assets at Fair Value	903	-	-	903
Total Leased Assets at Fair Value	**903**	**-**	**-**	**903**
TOTAL	**131,127**	**-**	**1,203**	**129,924**

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

Note 4.3: Property, Plant & Equipment (Cont.)

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 judgement is directly or indirectly observable
- Level 3 – Valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

For the purpose of fair value disclosures, 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.

Fair value measurement

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

The fair value measurement is based on the following assumptions:

- that the transaction to sell the asset or transfer the liability takes place either in the principal market (or the most advantageous market, in the absence of the principal market), either of which must be accessible to the Health Service at the measurement date;

- that the Health Service uses the same valuation assumptions that market participants would use when pricing the asset or liability, assuming that market participants act in their economic best interest.

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

Consideration of highest and best use (HBU) for non-financial physical assets

Judgements about highest and best use must take into account the characteristics of the assets concerned, including restrictions on the use and disposal of assets arising from the asset's physical nature and any applicable legislative/contractual arrangements.

In considering the HBU for non-financial physical assets, values are probably best placed to determine highest and best use (HBU) in consultation with Health Services. Health Services and their valuers therefore need to have a shared understanding of the circumstances of the assets. A Health Service has to form its own view about a valuer's determination, as it is ultimately responsible for what is presented in its audited financial statements.

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

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

These indicators, as a minimum, include:

External factors:

- Changed acts, regulations, local law or such instrument which affects or may affect the use or development of the asset;

- Changes in planning scheme, including zones, reservations, overlays that would affect or remove the restrictions imposed on the asset's use from its past use;

- Evidence that suggest the current use of an asset is no longer core to requirements to deliver a Health Service's service obligation;

- Evidence that suggests that the asset might be sold or demolished at reaching the late stage of an asset's life cycle.

In addition, Health Services need to assess the HBU as part of the 5-year review of fair value of non-financial physical assets. This is consistent with the current requirements on FRD 103F Non-financial physical assets and FRD 107B Investment properties.

Valuation hierarchy

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

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

Note 4.3: Property, Plant & Equipment (Cont.)

(d) Reconciliation of Level 3 Fair Value

30 June 2017	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Computers & Communications $'000	Furniture and Fittings $'000	Motor Vehicles $'000	Leases Assets $'000
Opening Balance	**4,219**	**115,990**	**3,938**	**3,101**	**274**	**464**	**1,035**	**903**
Purchases (sales)	-	226	180	388	70	34	92	264
Gains or losses recognised in net result								
- Depreciation	-	(5,095)	(243)	(610)	(116)	(136)	(350)	(470)
Subtotal	**4,219**	**111,121**	**3,875**	**2,879**	**228**	**362**	**777**	**697**
Closing Balance	**4,219**	**111,121**	**3,875**	**2,879**	**228**	**362**	**777**	**697**

30 June 2016	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Computers & Communications $'000	Furniture and Fittings $'000	Motor Vehicles $'000	Leases Assets $'000
Opening Balance	**4,219**	**122,035**	**2,706**	**3,419**	**383**	**563**	**899**	**1,072**
Purchases (sales)	-	459	93	307	23	-	473	224
Transfers in (out) of Level 3	-	(1,411)	1,364	-	-	47	-	-
Gains or losses recognised in net result								
- Depreciation	-	(5,093)	(225)	(625)	(132)	(146)	(337)	(393)
Subtotal	**4,219**	**115,990**	**3,938**	**3,101**	**274**	**464**	**1,035**	**903**
Closing Balance	**4,219**	**115,990**	**3,938**	**3,101**	**274**	**464**	**1,035**	**903**

Note 4.3: Property, Plant & Equipment (Cont.)

Identifying unobservable inputs (level 3) fair value measurements

Level 3 fair value inputs are unobservable valuation inputs for an asset or liability. These inputs require significant judgement and assumptions in deriving fair value for both financial and non-financial assets.

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

Assumptions about risk include the inherent risk in a particular valuation technique used to measure fair value (such as a pricing risk model) and the risk inherent in the inputs to the valuation technique. A measurement that does not include an adjustment for risk would not represent a fair value measurement if market participants would include one when pricing the asset or liability i.e., it might be necessary to include a risk adjustment when there is significant measurement uncertainty. For example, when there has been a significant decrease in the volume or level of activity when compared with normal market activity for the asset or liability or similar assets or liabilities, and the Health Service has determined that the transaction price or quoted price does not represent fair value.

A Health Service shall develop unobservable inputs using the best information available in the circumstances, which might include the Health Service's own data. In developing unobservable inputs, a Health Service may begin with its own data, but it shall adjust this data if reasonably available information indicates that other market participants would use different data or there is something particular to the Health Service that is not available to other market participants. A Health Service need not undertake exhaustive efforts to obtain information about other market participant assumptions.

However, a Health Service shall take into account all information about market participant assumptions that is reasonably available. Unobservable inputs developed in the manner described above are considered market participant assumptions and meet the object of a fair value measurement.

Non-specialised land, non-specialised buildings

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

For non-specialised land and non-specialised buildings, an independent valuation was performed by the Valuer General Victoria to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other 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.

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

Specialised land and specialised buildings

The market approach is also used for specialised land and specialised buildings although 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.

Vehicles

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

Plant and equipment

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

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

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

Note 4.3: Property, Plant & Equipment

(e) Description of Significant Unobservable Inputs to Level 3 Valuations:

	Valuation technique	Significant unobservable inputs
Specialised land	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings	Depreciated replacement cost	Useful life of specialised buildings
Plant and equipment at fair value	Depreciated replacement cost	Cost per unit
		Useful life of PPE
Vehicles	Depreciated replacement cost	Cost per unit
		Useful life of vehicles
Medical equipment at fair value	Depreciated replacement cost	Cost per unit
		Useful life of medical equipment
Assets under construction at fair value	Depreciated replacement cost	Cost per unit

(i) CSO adjustments of 20% were applied to reduce the market approach value for the Health Service's specialised land.

The significant unobservable inputs have remain unchanged from 2016.

Property, plant and equipment

All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and accumulated impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. 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 4.3 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 physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

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

Restrictive nature of cultural and heritage assets, Crown land and infrastructure assets

During the reporting period, Western District Health Service also holds cultural assets, heritage assets, and other non-financial physical assets (including crown land and infrastructure assets) that it intends to preserve because of their unique historical, cultural or environmental attributes.

In general, the fair value of those assets is measured at the depreciated replacement cost. However, the cost of some heritage and iconic assets may be the reproduction cost rather than the replacement cost if those assets' service potential could only be replaced by reproducing them with the same materials. In addition, as there are limitations and restrictions imposed on those assets use and/or disposal, they may impact the fair value of those assets, and should be taken into account when the fair value is determined.

Revaluations of non-current physical assets

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

Revaluation increments are recognised in 'other comprehensive income' and are credited directly in equity to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net result, the increment is recognised as income in the net result.

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

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

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

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

Note 4.4: Depreciation

	Total 2017 $'000	Total 2016 $'000
Depreciation		
Buildings	5,095	5,093
Plant & Equipment	243	225
Medical Equipment	610	625
Leased Assets	470	393
Computers & Communication	116	132
Furniture & Fittings	136	146
Motor Vehicles	350	337
Total Depreciation	**7,020**	**6,951**

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.

Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of $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.

	2017	2016
Buildings		
- Structure Shell Building Fabric	20 to 50 years	20 to 50 years
- Site Engineering Services and Central Plant	20 to 40 years	20 to 40 years
Central Plane		
- Fit Out	10 to 25 years	10 to 25 years
- Trunk Reticulated Building Systems	20 to 25 years	20 to 25 years
Plant and Equipment	12 to 20 years	12 to 20 years
Medical Equipment	5 to 15 years	5 to 15 years
Computers and Communication	4 to 10 years	4 to 10 years
Furniture and Fittings	4 to 20 years	4 to 20 years
Motor Vehicles	5 to 10 years	5 to 10 years
Leasehold Improvements	2 to 10 years	2 to 10 years

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

Note 5: Other Assets and Liabilities

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

Structure

5.1 Receivables
5.2 Inventories
5.3 Other liabilities
5.4 Prepayments and other assets
5.5 Payables

Note 5.1: Receivables

	Total 2017 $'000	Total 2016 $'000
CURRENT Contractual		
Inter Hospital Debtors	184	202
Trade Debtors	2,681	2,126
Patient Fees	1,129	1,234
Accrued Revenue	427	546
Less Allowance for Doubtful Debts		
Trade Debtors	(27)	(16)
Patient Fees	(31)	(68)
	4,363	**4,024**
Statutory		
GST Receivable	175	230
	175	**230**
TOTAL CURRENT RECEIVABLES	**4,538**	**4,254**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	1,463	1,166
TOTAL NON-CURRENT RECEIVABLES	**1,463**	**1,166**
TOTAL RECEIVABLES	**6,001**	**5,420**

Note 5.1(a): Movement in the Allowance for Doubtful Debts

	Total 2017 $'000	Total 2016 $'000
Balance at beginning of year	84	66
Amounts written off during the year	(41)	(22)
Increase/(decrease) in allowance recognised in net result	15	40
Balance at end of year	**58**	**84**

(b) Ageing analysis of receivables
Please refer to note 7.1 for the ageing analysis of contractual receivables

(c) Nature and extent of risk arising from receivables
Please refer to note 7.1 for the nature and extent of credit risk arising from contractual receivables

Receivables consist of:

- contractual receivables, which includes mainly debtors in relation to goods and services, loans to third parties, accrued investment income, and finance lease receivables; and
- statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax ("GST") input tax credits recoverable.

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

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

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

Doubtful debts

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

Note 5.2: Inventories

	Total 2017 $'000	Total 2016 $'000
Pharmaceuticals		
At cost	146	133
Engineering Stores		
At Cost	5	11
Administration Stores		
At Cost	3	9
TOTAL INVENTORIES	**154**	**153**

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

Inventories held for distribution are measured at cost, adjusted for any loss of service potential. All other inventories, 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 for all other inventory is measured on the basis of weighted average cost.

Note 5.3: Other Liabilities

	Total 2017 $'000	Total 2016 $'000
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust*	318	444
- Accommodation Bonds (Refundable Entrance Fees)*	10,851	9,807
Other - Income Received in Advance	582	467
Total Current	**11,751**	**10,718**
TOTAL OTHER LIABILITIES	**11,751**	**10,718**
*** Total Monies Held in Trust Represented by the following assets:**		
Investments and other Financial Assets		
(refer to Note 4.1)	11,169	10,251
TOTAL	**11,169**	**10,251**

Note 5.4: Prepayments and Other Non-Financial Assets

	Total 2017 $'000	Total 2016 $'000
CURRENT		
Prepayments	325	1,289
Other	-	37
TOTAL OTHER ASSETS	**325**	**1,326**

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.

Note 5.5: Payables

	Total 2017 $'000	Total 2016 $'000
CURRENT		
Contractual		
Trade Creditors (i)	4,039	4,242
Accrued Expenses	497	816
Other	-	2
	4,536	**5,060**
Statutory		
GST Payable (iii)	37	27
Department of Health and Human Services (ii)	255	113
	292	**140**
TOTAL CURRENT	**4,828**	**5,200**
TOTAL PAYABLES	**4,828**	**5,200**

(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 x% per year on the outstanding balance.

(ii) Terms and conditions of amounts payable to the Department of Health and Human Services 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].

(iv) Contractual payables that are not Statutory obligations

(a) Maturity analysis of payables

Please refer to Note 7.1 for the ageing analysis of contractual payables

(b) Nature and extent of risk arising from payables

Please refer to note 7.1 for the nature and extent of risks arising from contractual payables

Payables consist of:

- - contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the Health Service prior to the end of the financial year that are unpaid, and arise when the Health Service becomes obliged to make future payments in respect of the purchase of those goods and services. The 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.

Note 6: How We Finance Our Operations

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

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

Structure

6.1 Borrowings

6.2 Cash and cash equivalents

6.3 Commitments for expenditure

Note 6.1: Borrowings

	Total 2017 $'000	Total 2016 $'000
CURRENT		
Australian Dollar Borrowings		
– Finance Lease Liability (i)	338	358
Total Australian Dollars Borrowings	**338**	**358**
Total Current	**338**	**358**
NON CURRENT		
Australian Dollar Borrowings		
– Finance Lease Liability	410	543
Total Australian Dollars Borrowings	**410**	**543**
Total Non-Current	**410**	**543**
Total Borrowings	**748**	**901**

(i) Secured by the assets leased. Finance leases are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

The approved Bank Overdraft limit is $0.5m, none of which has been utilised during 2016-17.

Finance costs of the Health Service incurred during the year are accounted for as follows:

	$'000
Amount of finance costs recognised as expenses	**108**

(a) Maturity analysis of borrowings

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

(b) Nature and extent of risk arising from borrowings

Please refer to Note 7.1 for the nature and extent of risks arising from borrowings.

(c) Defaults and breaches

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

Note 6.1: Borrowings (Cont.)

(a) Finance Lease Liabilities

	Minimum future lease payments (i)		Present value of minimum future lease payments	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000
Other finance lease liabilities payable (ii)				
Not longer than one year	338	358	338	358
Longer than one year but not longer than five years	410	543	410	543
Minimum future lease payments	**748**	**901**	**748**	**901**
Present value of minimum lease payments	**748**	**901**	**748**	**901**
Included in the financial statements as:				
Current borrowings lease liabilities	338	358	338	358
Non-current borrowing lease liabilities	410	543	410	543
	748	**901**	**748**	**901**

(i) Minimum future lease payments include the aggregate of all base payments and any guaranteed residual

(ii) Other finance lease liabilities include obligations that are recognised on the balance sheet; the future payments related to operating and lease commitments are disclosed in Note 6.3

The weighted average interest rate implicit in leases is 5.52% (2016 - 4.90%)

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.

Note 6.1: Borrowings (Cont.)

(a) Finance Lease Liabilities (Cont.)

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.

Finance leases

Entity as lessee

Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease.

If there is certainty that the health service will obtain the ownership of the lease asset by the end of the lease term, the asset shall be depreciated over the useful life of the asset. If there is no reasonable certainty that the lessee will obtain ownership by the end of the lease term, the asset shall be fully depreciated over the shorter of the lease term and its useful life.

Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the comprehensive operating statement. Contingent rentals associated with finance leases are recognised as an expense in the period in which they are incurred.

Western District Health Service recognises the leasing arrangements for local area network equipment, workstations and peripherals (purchased through group buying arrangements with SWARH) as finance leases. Finance leases are regarded as a financial accommodation and under the Section 30 of Health Services Act 1988, the Minister for Health and the Treasurer must declare a registered funded agency to be an approved borrower for the purposes of this section. An approved borrower may, with the approval of the Minister and the Treasurer, obtain financial accommodation, whether within or outside Victoria, secured or arranged in a manner and for a period approved by the Treasurer. Western District Health Service has been declared an approved borrower in relation to these finance leases.

Note 6.2: Cash and Cash Equivalents

	Total 2017 $'000	Total 2016 $'000
Cash on hand	23	23
Cash at bank	8,934	9,155
Total Cash and Cash Equivalents	**8,957**	**9,178**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	8,957	9,178
Total Cash and Cash Equivalents	**8,957**	**9,178**

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

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.

Note 6.3: Commitments for Expenditure

(a) Commitments

	Total 2017 $'000	Total 2016 $'000
Capital expenditure commitments		
Payable:		
Land and buildings	94	38
Total capital expenditure commitments	94	38
Lease commitments		
Commitments in relation to leases contracted at the reporting date:		
Finance leases	748	901
Total lease commitments	748	901
Finance Leases		
Commitments in relation to finance leases are payable as follows:		
Current	338	358
Non-current	410	543
Minimum Lease Payments	748	901
Total finance lease commitments	748	901
Total lease commitments	748	901
Total Commitments (inclusive of GST)	842	939

All amounts shown in the commitments note are nominal amounts inclusive of GST.

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

Note 6.3: Commitments (Cont.)

(b) Commitments Payable

	Total 2017 $'000	Total 2016 $'000
Nominal Values		
Capital expenditure commitments payable		
Less than 1 year	94	38
Total capital expenditure commitments	**94**	**38**
Lease commitments payable		
Less than 1 year	338	358
Longer than 1 year but not longer than 5 years	410	543
Total lease commitments	**748**	**901**
Total commitments (inclusive of GST)	**842**	**939**
Less GST recoverable from the Australian Tax Office	(9)	(3)
Total commitments (exclusive of GST)	**833**	**936**

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

Note 7: Risks, Contingencies and Valuation Uncertainties

Introduction

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

Structure

7.1 Financial instruments

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

7.3 Fair value determination

7.4 Contingent assets and contingent liabilities

Note 7.1: Financial Instruments

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 and managed investment schemes
- payables (excluding statutory payables)
- finance lease 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 4 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.

Categorisation of financial instruments

Details of each categories in accordance with AASB 139, shall be disclosed either on the face of the balance sheet or in the notes.

2017	Contractual financial assets - loans and receivables $'000	Contractual financial assets - available for sale $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets				
Cash and cash equivalents	8,957	-	-	8,957
Receivables				
- Trade Debtors	2,865	-	-	2,865
- Other Receivables	1,556	-	-	1,556
Other Financial Assets				
- Term Deposit	25,086	-	-	25,086
- Shares in Other Entities	-	1,880	-	1,880
Total Financial Assets	**38,464**	**1,880**	**-**	**40,344**
Financial Liabilities				
Payables	-	-	4,536	4,536
Borrowings	-	-	748	748
Other Financial Liabilities				
- Accommodation bonds	-	-	10,851	10,851
- Other	-	-	900	900
Total Financial Liabilities	**-**	**-**	**17,035**	**17,035**

2016	Contractual financial assets - loans and receivables $'000	Contractual financial assets - available for sale $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets				
Cash and cash equivalents	9,178	-	-	9,178
Receivables				
- Trade Debtors	2,328	-	-	2,328
- Other Receivables	1,780	-	-	1,780
Other Financial Assets				
- Term Deposit	20,376	-	-	20,376
- Shares in Other Entities	-	1,668	-	1,668
Total Financial Assets	**33,662**	**1,668**	**-**	**35,350**
Financial Liabilities				
Payables	-	-	5,060	5,060
Borrowings	-	-	901	901
Other Financial Liabilities				
- Accommodation bonds	-	-	9,807	9,807
- Other	-	-	911	911
Total Financial Liabilities	**-**	**-**	**16,679**	**16,679**

Note 7.1: Financial Instruments (Cont.)

(b) Net Holding Gain/(Loss) on Financial Instruments by Category

2017	Net holding gain/(loss) $'000	Total interest income / (expense) $'000	Impairment loss $'000	Total $'000
Financial Assets				
Cash and Cash Equivalents (i)	-	684	-	684
Available for Sale (i)	(29)	-	(5)	(34)
Total Financial Assets	**(29)**	**684**	**(5)**	**650**
Financial Liabilities				
At Amortised Cost (ii)	-	108	-	108
Total Financial Liabilities	**-**	**108**	**-**	**108**

2016	Net holding gain/(loss) $'000	Total interest income / (expense) $'000	Impairment loss $'000	Total $'000
Financial Assets				
Cash and Cash Equivalents (i)	-	537	-	537
Available for Sale (i)	(84)	-	(6)	(90)
Total Financial Assets	**(84)**	**537**	**(6)**	**447**
Financial Liabilities				
At Amortised Cost (ii)	-	44	-	44
Total Financial Liabilities	**-**	**44**	**-**	**44**

(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, plus or minus foreign exchange gains 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 calculated by taking the movement in the fair value of the financial asset or liability.

Note 7.1: Financial Instruments (Cont.)

(c) 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's maximum exposure to credit risk without taking account of the value of any collateral obtained.

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

2017	Financial institutions (AA- credit rating) $'000	Government agencies (AAA credit rating) $'000	Other (min BBB credit rating) $'000	Other (not rated) $'000	Total $'000
Financial Assets					
Cash and Cash Equivalents	1,257	7,700	-	-	8,957
Loans and Receivables					
- Trade Debtors	-	-	-	2,865	2,865
- Other Receivables (i)	-	-	-	1,556	1,556
- Term Deposit	8,352	10,500	6,234	-	25,086
Available for sale					
- Shares in Other Entities	-	-	-	1,880	1,880
Total Financial Assets	**9,609**	**18,200**	**6,234**	**6,301**	**40,344**

2016	Financial institutions (AA- credit rating) $'000	Government agencies (AAA credit rating) $'000	Other (min BBB credit rating) $'000	Other (not rated) $'000	Total $'000
Financial Assets					
Cash and Cash Equivalents	2,178	7,000	-	-	9,178
Loans and Receivables					
- Trade Debtors	-	-	-	2,328	2,328
- Other Receivables	-	-	-	1,780	1,780
- Term Deposit	5,730	7,751	6,895	-	20,376
Available for sale					
- Shares in Other Entities	-	-	-	1,688	1,688
Total Financial Assets	**7,908**	**14,751**	**6,895**	**5,796**	**35,350**

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

Note 7.1: Financial Instruments (c) Credit Risk (Cont.)

Ageing Analysis of Financial Assets as at 30 June

2017	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	
Financial Assets						
Cash and Cash Equivalents	8,957	8,957	-	-	-	-
Loans and Receivables						
- Trade Debtors	2,865	2,346	270	58	164	27
- Other Receivables	1,556	-	1,263	34	228	31
- Term Deposit	25,086	25,086	-	-	-	-
Available for sale						
- Shares in Other Entities	1,880	1,880	-	-	-	-
Total Financial Assets	**40,344**	**38,269**	**1,533**	**92**	**392**	**58**

2016	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	
Financial Assets						
Cash and Cash Equivalents	9,178	9,178	-	-	-	-
Loans and Receivables						
- Trade Debtors	2,328	1,911	220	47	134	16
- Other Receivables	1,780	-	1,418	38	256	68
- Term Deposit	20,376	20,376	-	-	-	-
Available for sale						
- Shares in Other Entities	1,688	1,688	-	-	-	-
Total Financial Assets	**35,350**	**33,153**	**1,638**	**85**	**390**	**84**

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

Contractual financial assets that are either past due or impaired

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

There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired, and they are stated at their 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 7.1: Financial Instruments (Cont.)

(d) 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 accomdation bonds are refunded when the resident departs the aged care facility.

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

Maturity analysis of Financial Liabilities as at 30 June

2017	Carrying Amount $'000	Nominal Amount $'000	Maturity Dates			
			Less than 1 Month $'000	1-3 Months $'000	3 months - 1 Year $'000	1-5 Years $'000
Financial Liabilities						
At amortised cost						
Payables	4,536	4,536	4,536	-	-	-
Borrowings	748	748	-	-	338	410
Other Financial Liabilities (i)						
- Accommodation Bonds	10,851	10,851	-	-	3,010	7,841
- Other	900	900	582	260	58	-
Total Financial Liabilities	**17,035**	**17,035**	**5,118**	**260**	**3,406**	**8,251**

2016	Carrying Amount $'000	Nominal Amount $'000	Maturity Dates			
			Less than 1 Month $'000	1-3 Months $'000	3 months - 1 Year $'000	1-5 Years $'000
Financial Liabilities						
At amortised cost						
Payables	5,060	5,060	5,060	-	-	-
Borrowings	901	901	-	-	358	543
Other Financial Liabilities (i)						
- Accommodation Bonds	9,807	9,807	-	-	2,720	7,087
- Other	911	911	467	363	81	-
Total Financial Liabilities	**16,679**	**16,679**	**5,527**	**363**	**3,159**	**7,630**

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

Note 7.1: Financial Instruments (Cont.)

(e) Market Risk

The 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

The 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 Western District 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.

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

2017	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	1.88	8,957	-	8,957	-
Loans and Receivables (i)					
- Trade Debtors		2,865	-	-	2,865
- Other Receivables		1,556	-	-	1,556
- Term Deposit	2.07	25,086	25,086	-	-
Available for sale					
- Shares in Other Entities		1,880	-	-	1,880
		40,344	**25,086**	**8,957**	**6,301**
Financial Liabilities					
At amortised cost					
Payables(i)		4,536	-	-	4,536
Borrowings		748	748	-	-
Other Financial Liabilities					
- Accommodation Bonds	2.07	10,851	-	-	10,851
- Other		900	-	-	900
		17,035	**748**	**-**	**16,287**

2016	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	2.09	9,178	-	9,178	-
Loans and Receivables (i)					
- Trade Debtors		2,328	-	-	2,328
- Other Receivables		1,780	-	-	1,780
- Term Deposit	2.87	20,376	20,376	-	-
Available for sale					
- Shares in Other Entities		1,688	-	-	1,688
		35,350	**20,376**	**9,178**	**5,796**
Financial Liabilities					
At amortised cost					
Payables(i)		5,060	-	-	5,060
Borrowings		901	901	-	-
Other Financial Liabilities					
- Accommodation Bonds	2.87	9,807	-	-	9,807
- Other		911	-	-	911
		16,679	**901**	**-**	**15,778**

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

Note 7.1: Financial Instruments (Cont.)

(e) Market Risk (Cont.)

Sensitivity disclosure analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the 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 100 basis points up and down in market interest rates (AUD) from year-end rates of 1.5%;
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 1.5%
- A movement of 15% up and down (2016: 15%) for the top ASX 200 index.

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

2017	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-15%		+15%	
	$'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
Financial Assets									
Cash and Cash Equivalents(i)	8,957	(90)	(90)	90	90	-	-	-	-
Loans and Receivables (i)									
- Trade Debtors	2,865	-	-	-	-	-	-	-	-
- Other Receivables	1,556	-	-	-	-	-	-	-	-
- Term Deposit	25,086	(251)	(251)	251	251	-	-	-	-
Available for sale									
- Shares in Other Entities	1,880	-	-	-	-	(282)	(282)	282	282
Financial Liabilities									
At amortised cost									
Payables	4,536	-	-	-	-	-	-	-	-
Borrowings	748	7	7	(7)	(7)	-	-	-	-
Other Financial Liabilities(ii)	-	-	-	-	-	-	-	-	-
- Accommodation Bonds	10,851	-	-	-	-	-	-	-	-
- Other	900	-	-	-	-	-	-	-	-
		(333)	**(333)**	**333**	**333**	**(282)**	**(282)**	**282**	**282**

2016	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-15%		+15%	
	$'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
Financial Assets									
Cash and Cash Equivalents(i)	9,178	(92)	(92)	92	92	-	-	-	-
Loans and Receivables (i)									
- Trade Debtors	2,328	-	-	-	-	-	-	-	-
- Other Receivables	1,780	-	-	-	-	-	-	-	-
- Term Deposit	20,376	(204)	(204)	204	204	-	-	-	-
Available for sale									
- Shares in Other Entities	1,688	-	-	-	-	(253)	(253)	253	253
Financial Liabilities									
At amortised cost									
Payables	5,060	-	-	-	-	-	-	-	-
Borrowings	901	9	9	(9)	(9)	-	-	-	-
Other Financial Liabilities(ii)	-	-	-	-	-	-	-	-	-
- Accommodation Bonds	9,807	-	-	-	-	-	-	-	-
- Other	911	-	-	-	-	-	-	-	-
		(287)	**(287)**	**287**	**287**	**(253)**	**(253)**	**253**	**253**

(i) eg. Sensitivity of cash and cash equivalents to a +1% movement in interest rates: [$8,957k*0.02]-[$8,957k*0.01] = $90k. Similar for a -1% movement in interest rate, impact = $(90k).
(ii) The carrying amount must exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable).

Note 7.1: Financial Instruments (Cont.)

(f) Fair Value

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

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

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

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 2017 $'000	Fair value 2017 $'000	Carrying Amount 2016 $'000	Fair value 2016 $'000
Financial Assets				
Cash and Cash Equivalents	8,957	8,957	9,178	9,178
Loans and Receivables (i)				
- Trade Debtors	2,865	2,865	2,328	2,328
- Other Receivables	1,556	1,556	1,780	1,780
- Term Deposit	25,086	25,086	20,376	20,376
Available for sale				
- Shares in Other Entities	1,880	1,880	1,688	1,688
Total Financial Assets	**40,344**	**40,344**	**35,350**	**35,350**
Financial Liabilities				
At amortised cost				
Payables	4,536	4,536	5,060	5,060
Borrowings	748	748	901	901
Other Financial Liabilities(i)				
- Accommodation Bonds	10,851	10,851	9,807	9,807
- Other	900	900	911	911
Total Financial Liabilities	**17,035**	**17,035**	**16,679**	**16,679**

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

Financial assets measured at fair value 2017	Carrying Amount as at 30 June	Fair value measurement at end of reporting period using:		
		Level 1* $'000	Level 2* $'000	Level 3 $'000
Financial assets at fair value through profit or loss				
- Equities and managed funds	1,880	1,025	855	-
Total Financial Assets	**1,880**	**1,025**	**855**	**-**
2016				
Financial assets at fair value through profit or loss				
- Equities and managed funds	1,688	866	822	-
Total Financial Assets	**1,688**	**866**	**822**	**-**

*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 financial 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:

Listed securities

The listed share assets are valued at fair value with reference to a quoted (unadjusted) market price from an active market. The Health Service categorises these instruments as Level 1.

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 diligence prior to 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, future commitments and other specific factors of the funds. In measuring fair value, consideration is also paid to any transaction in the 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 Level 2.

Note 7.2: Net Gain/(Loss) on Disposal of Non-Financial Assets

	Total 2017 $'000	Total 2016 $'000
Proceeds from Disposals of Non-Current Assets*		
Land	-	104
Medical Equipment	-	8
Motor Vehicles	81	139
Total Proceeds from Disposal of Non-Current Assets	**81**	**251**
Less: Written Down Value of Non-Current Assets Sold*		
Land	-	220
Motor Vehicles	31	67
Total Written Down Value of Non-Current Assets Sold	**31**	**287**
Net gain/(loss) on Disposal of Non-Financial Assets	**50**	**(36)**

Disposal of non-financial assets

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement.

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;

- non-current physical assets held for sale.

If there is an indication of impairment, the assets concerned are tested as to whether their carrying amount exceeds their possible recoverable amount. Where an asset's carrying amount exceeds its recoverable amount, the difference is written-off as an expense except to the extent that the write-down can be 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 of disposal. Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less costs of disposal.

Note 7.3: Fair Value Determination

Asset class	Examples of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
Non-specialised land	In areas where there is an active market: - vacant land - land not subject to restrictions as to use or sale	Level 2	Market approach	N/A
Specialised land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market approach	CSO adjustments
Non-specialised buildings	For general/commercial buildings that are just built	Level 2	Market approach	N/A
Specialised buildings	Specialised buildings with limited alternative uses and/or substantial customisation e.g. prisons, hospitals, and schools	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Dwellings	Social/public housing/employee housing	Level 2, where there is an active market in the area	Market approach	N/A
		Level 3, where there is no active market in the area	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Vehicles	If there is an active resale market available;	Level 2	Market approach	N/A
	If there is no active resale market available	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life

Note 7.4: Contingent Assets and Contingent Liabilities

As at balance date, the Board of Directors is unaware of the existence of any 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 (2016-Nil).

Note 8: Other Disclosures

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

Structure

8.1 Equity

8.2 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities

8.3 Operating segments

8.4 Responsible persons disclosures

8.5 Executive officer disclosures

8.6 Related parties

8.7 Remuneration of auditors

8.8 Events occurring after the balance sheet date

8.9 Alternative presentation of comprehensive operating statement

8.10 AASs issued that are not yet effective

Note 8.1: Equity

	Total 2017 $'000	Total 2016 $'000
(a) Surpluses.		
Property, Plant & Equipment Revaluation Surplus		
Balance at the beginning of the reporting period	67,366	67,366
Balance at the end of the reporting period*	**67,366**	**67,366**
*Represented by:		
- Land	3,688	3,688
- Buildings	63,302	63,302
- Plant and Equipment	376	376
	67,366	**67,366**
Financial Assets Available-for-Sale Revaluation Surplus		
Balance at the beginning of the reporting period	88	178
Valuation gain/(loss) recognised	-	(51)
Cumulative (gain)/loss transferred to Operating Statement on Sale of Financial Assets	(34)	(32)
Cumulative (gain)/loss transferred to Operating Statement on Impairment of Financial Assets	5	(7)
Balance at end of the reporting period	**59**	**88**

	Total 2017 $'000	Total 2016 $'000
(b) Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	7,566	5,283
Transfer to and from Restricted Specific Purpose Surplus	2,847	2,283
Balance at the end of the reporting period	**10,413**	**7,566**
Total Surpluses	**77,838**	**75,020**
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	17,108	22,041
Net Result for the Year	(2,470)	(2,650)
Transfers to and from Restricted Specific Purpose Surplus	(2,847)	(2,283)
Balance at the end of the reporting period	**11,791**	**17,108**
Total Equity at end of financial year	**139,164**	**141,663**

Contributed capital

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

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 asset available-for-sale revaluation surplus

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

Note 8.2: Reconciliation of Net Result for the Year to Net Cash Inflow / (Outflow) from Operating Activities

	Total 2017 $'000	Total 2016 $'000
Net result for the period	**(2,470)**	**(2,650)**
Non-cash movements:		
Depreciation and amortisation	7,020	6,951
Impairment of financial and non financial assets	(5)	-
Provision for doubtful debts	15	48
Movements included in investing and financing activities		
Net (gain)/loss from disposal of non financial physical assets	(50)	36
Net (gain)/loss from disposal of financial assets	34	-
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/decrease in receivables	(594)	(1,575)
(Increase)/decrease in other assets	37	72
(Increase)/decrease in prepayments	964	(289)
Increase/(decrease) in payables	(525)	1,243
Increase/(decrease) in provisions	491	823
Increase/(decrease) in other liabilities	115	861
Change in inventories	(1)	(3)
Other - Lease Payments Reclassified as finance lease	-	(223)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**5,031**	**5,294**

Note 8.3: Operating Segments

	Hospital		RAC		Linen Service		Primary Care		Eliminations		Total	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000
REVENUE												
External Segment Revenue	54,665	53,041	17,694	16,624	10	9	1,478	1,363	-	-	73,847	71,037
Intersegment Revenue	1,089	1,034	-	-	68	65	-	-	(1,157)	(1,099)	-	-
Unallocated Revenues	-	-	-	-	-	-		-			-	-
Total Revenue	**55,754**	**54,075**	**17,694**	**16,624**	**78**	**74**	**1,478**	**1,363**	**(1,157)**	**(1,099)**	**73,847**	**71,037**
EXPENSES												
External Segment Expenses	(55,321)	(53,739)	(17,901)	(16,827)	(66)	(67)	(3,717)	(3,588)	-		(77,005)	(74,221)
Intersegment Expenses	(1,094)	(1,034)	-	-	(63)	(65)	-	-	1,157	1,099	-	-
Unallocated Expense	-	-	-	-	-	-		-	-	-	-	-
Total Expenses	**(56,415)**	**(54,773)**	**(17,901)**	**(16,827)**	**(129)**	**(132)**	**(3,717)**	**(3,588)**	**1,157**	**1,099**	**(77,005)**	**(74,221)**
Net Result from ordinary activities	**(661)**	**(698)**	**(207)**	**(203)**	**(51)**	**(58)**	**(2,239)**	**(2,225)**	**-**	**-**	**(3,158)**	**(3,184)**
Interest Income	684	537	-	-	-	-		-	-	-	684	537
Share of Net Result of Associates & Joint Ventures using Equity Method	-	-	-	-	-	-	4	(3)	-	-	4	(3)
Net Result for Year	**23**	**(161)**	**(207)**	**(203)**	**(51)**	**(58)**	**(2,235)**	**(2,228)**	**-**	**-**	**(2,470)**	**(2,650)**
OTHER INFORMATION												
Unallocated Assets	113,742	114,758	42,491	42,871	625	631	11,003	11,101	-	-	167,861	169,361
Total Assets	**113,742**	**114,758**	**42,491**	**42,871**	**625**	**631**	**11,003**	**11,101**	**-**	**-**	**167,861**	**169,361**
Unallocated Liabilities	15,562	15,020	12,662	12,221	32	31	441	426	-	-	28,697	27,698
Total Liabilities	**15,562**	**15,020**	**12,662**	**12,221**	**32**	**31**	**441**	**426**	**-**	**-**	**28,697**	**27,698**
Investments in Associates and Joint Venture Partnership	-	-	-	-	-	-	97	93	-	-	97	93
Acquisition of Property, Plant and Equipment and Intangible Assets	1,075	1,302	208	252	-	-	4	3	-	-	1,287	1,557
Depreciation & Amortisation Expense	4,401	4,358	2,068	2,048	40	40	510	505	-	-	7,020	6,951
Non Cash Expenses other than Depreciation	48	40	21	18	-	-	7	6	-	-	76	64
Impairment of Inventories	-	-	-	-	-	-	-	-	-	-	-	-

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

Business Segments	Services
Hospital	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 relate to operations in Western Victoria.

Note 8.4: 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.

Responsible Ministers:	Period
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	1/7/2016 - 30/6/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	1/7/2016 - 30/6/2017
Governing Boards	
Mr D Barber	1/7/2016 - 30/6/2017
Mr P Besgrove	1/7/2016 - 30/6/2017
Ms F Calvert	1/7/2016 - 20/7/2016
Ms C Coggins	1/7/2016 - 30/6/2017
Ms J Hutton	1/7/2016 - 30/6/2017
Ms A Kenneally	1/7/2016 - 30/6/2017
Mr H Macdonald	1/7/2016 - 30/6/2017
Mr M McGinnity	1/7/2016 - 30/6/2017
Mr I Whiting	1/7/2016 - 30/6/2017
Accountable Officers	
Mr. R. Fitzgerald	1/7/2016 - 30/6/2017

Remuneration of Responsible Persons

Remuneration received or receivable by responsible persons was in the range: $300,000 - $309,999 ($270,000 - 279,999 in 2015-16).

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Parliamentary Services.

Note 8.5: Executive Officer Disclosures

Remuneration of Executives

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

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

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

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

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

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

Note 8.5: Executive Officer Disclosures Remuneration

	2017 $'000
Remuneration	
Short-term benefits	**1,034**
Post-employment benefits	101
Other long-term benefits	109
Total remuneration	**1,244**
Total number of executives	**7**
Total annualised employee equivalent (AEE)	**7**

Notes

(a) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD 21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursements of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-16 reporting period.
(b) Remuneration represents the expenses incurred by the entity in the current reporting period for the employee, in accordance with AASB 119 Employee benefits

(c) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are also reported within related parties note disclosure (Note 8.6).

(d) Annualised employee equivalent is based on the time fraction worked over the reporting period. This is calculated as the total number of days the employee is engaged to work during the week by the total number of full-time working days per week (this is generally five full working days per week).

Note 8.6: Related Parties

The health service is a wholly owned and controlled entity of the State of Victoria. Related parties of the hospital include:

. all key management personnel and their close family members;

. all cabinet ministers and their close family members; and

. all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

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

Key management personnel (KMP) of the hospital include the Portfolio Ministers and KMP as determined by the Health Service, which is determined to be the Board and CEO as listed in Note 8.4 along with Executives whose remuneration is shown in Note 8.5. The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Ministers remuneration and allowances is set by the Parliamentary Salaries and Superannuation Act 1968, and is reported within the Department of Parliamentary Services' Financial Report.

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

Compensation	2017 $'000
Short-term benefits	1,304
Post-employment benefits	123
Other long-term benefits	117
Total remuneration	**1,544**
Total number of executives	**8**
Total annualised employee equivalent (AEE)	**8.0**

(i) Annualised employee equivalent is based on the time fraction worked during the reporting period. This is calculated as the total number of days the employee is engaged to work during the week by the total number of full-time working days per week.

Transactions with key management personnel and other related parties

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

Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

Other Transactions of Responsible Persons and their Related Parties
There were no transactions with Responsible Persons or their Related Parties.

Significant transactions with government-related entities
Western District Health Service received funding from the Department of Health and Human Services of $46,259,603 (2016: $46,135,339).

During the year, Western District Health Service had the following other government-related entity transactions:
- Commonwealth Government funding received for health related programs totalling $13,243,558 (2016 $11,333,186).

Transactions with key management personnel and other related parties

Given the breadth and depth of State procurement activities, related parties transact with the Victorian public sector in a manner consistent with other members of the pubic e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the Public Administration Act 2004 and Codes of Conduct and Standards isssued by the Victorian public Sector Commission.

Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel and theire close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

Note 8.7: Remuneration of Auditors

	2017 $'000	2016 $'000
Victorian Auditor-General's Office		
Audit of financial statement	34	34
Total Paid and Payable	**34**	**34**

Note 8.8: Events Occurring after the Balance Sheet Date

There were no events occurring after reporting date which require additional information to be disclosed.

Note 8.9: Alternate Presentation of Comprehensive Operating Statement
For the Year Ended 30 June 2017

	Note	2017 $'000	2016 $'000
Grants			
Operating	2.1	57,317	55,433
Capital	2.1	1,368	1,146
Interest and Dividends	2.1	684	537
Sales of Goods and Services	2.1	11,038	10,323
Other income	2.1	763	845
Other capital income	2.1	3,361	3,290
Revenue from Transactions		**74,531**	**71,574**
Employee Expenses	3.1	(48,072)	(46,183)
Operating Expenses			
Supplies and consumables	3.1	(7,686)	(7,166)
Non salary labour costs	3.1	(4,731)	(4,382)
Other	3.1	(9,301)	(9,392)
Non-Operating Expenses			
Impairment of non-financial assets	3.1	(5)	-
Finance Costs - Other	3.3	(108)	(44)
Expenditure for Capital Purpose	3.1	(37)	(103)
Share of net result of associates and joint ventures accounted for using the Equity Method	4.2	4	(3)
Depreciation and Amortisation	4.4	(7,020)	(6,951)
Expenses from Transactions		**(76,956)**	**(74,224)**
Net Result from Transactions		**(2,425)**	**(2,650)**
Other economic flows included in net result			
Revaluation of Long Service Leave		(45)	-
Total other economic flows included in net result		**(45)**	**-**
Net result from continuing operations		**(2,470)**	**(2,650)**
NET RESULT FOR THE YEAR		**(2,470)**	**(2,650)**
Other comprehensive income			
Items that may be reclassifed subsequently to net result			
Changes to financial assets available-for-sale revaluation surplus	8.1	(29)	(90)
Total other comprehensive income		**(29)**	**(90)**
Comprehensive result		**(2,499)**	**(2,470)**

Note 8.10: AASs Issued That Are Not Yet Effective

Certain new Australian accounting standards have been published that are not mandatory for 30 June 2017 reporting period.

DFT assesses the impact of all these new standards and advises South West Healthcare of their applicability and early adoption where applicable.

As at 30 June 2017, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. South West Healthcare has not and does not intend to adopt these standards early.

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 9 *Financial Instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 January 2018	While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 2010-7 *Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)*	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: - The change in fair value attributable to changes in credit risk is presented inother comprehensive income (OCI); and - Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1 January 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals.
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 January 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. A potential impact will be the upfront recognition of revenue from licenses that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.
AASB 2014-1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 January 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 *Amendments to Australian Accounting Standards arising from AASB 9*	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 January 2018	The assessment has indicated there will be no significant impact for the public sector.
AASB 2016-8 *Amendments to Australian Accounting Standards - Effective Date of AASB 15*	This standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 January 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities in the cash flow statement. No change for lessors.
AASB 2015-8 *Amendments to Australian Accounting Standards - Effective Date of AASB 15*	This standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period.
AASB 2016-7 *Amendments to Australian Accounting Standards - Deferral of AASB 15 for Not-for-Profit Entities*	This standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019	1 January 2019	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period.
AASB 1058 *Income of Not-for-Profit Entities*	This standard will replace AASB 1004 *Contributions* and establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objectives.	1 January 2019	The impact of this Standard is yet to be fully assessed.

Glossary of Terms

AHSSQA
Australian Health Service Safety and Quality Accreditation

ACFI
Aged Care Funding Instrument

ACHSE
Australian College of Health Service Executives

AFPHM
Australasian Faculty of Public Health Medicine

Best Practice
The way leading edge organisations deliver world class performance

BOD
Board of Directors

BRICC
Ballarat Regional Integrated Cancer Centre

BSI
Business Support and Innovation

C4YB
Community 4 Youth Board

CDHS
Coleraine District Health Service

CE
Chief Executive

C&FN
Consumer and Friends Network

CSSD
Central Sterile Supply Department

DHHS
Department of Health and Human Services

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

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

GS
Glenelg Shire

HACC
Home and Community Care

HBH
Hamilton Base Hospital

HCP
Home Care Package

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

LGBTI
Lesbian, Gay, Bisexual, Transgender and / or Intersex

NCFH
National Centre for Farmer Health

NHMRC
National Health and Medical Research Council

NSQHS Standards
National Safety and Quality Health Service Standards

OH&S
Occupational Health and Safety

OT
Occupational Therapy

PDHS
Penshurst & District Health Service

PPH
Primary & Preventative Health

QI
Quality Improvement

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

SGSC
Southern Grampians Shire Council

SWARH
South West Alliance of Rural Health

VET
Vocational Education and Training

VHA
Victorian Healthcare Association Ltd

VICNISS
Victorian Hospital Acquired Infection Surveillance System

VMIA
Victorian Managed Insurance Authority

VMO
Visiting Medical Officer

VPSM
Victorian Patient Satisfaction Monitor

VST
Victorian Stroke Telemedicine

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.

Index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ort Service
Community Tran
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