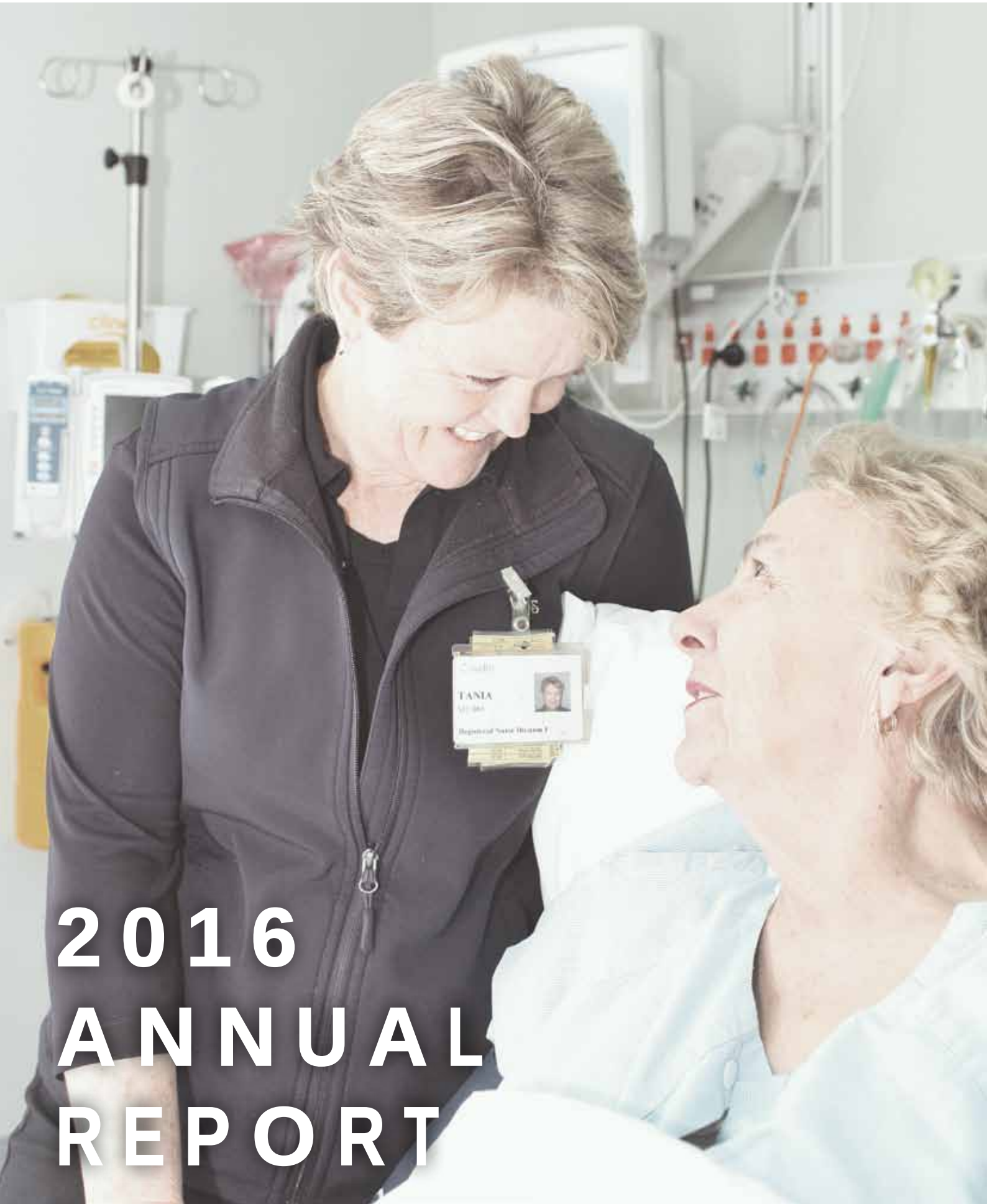
wdhs
Western District
Health Service

EXCELLENCE IN HEALTHCARE,
PUTTING PEOPLE FIRST



2016 ANNUAL REPORT

wdhs
Western District Health Service

Our Vision
Excellence in healthcare, putting people first.

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

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.

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).

About This Report

This annual report outlines the operational and financial performance of Western District Health Service (WDHS) from 1 July 2015 to 30 June 2016. 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: Registered Nurse Tania Stubbs, nursing one of our very special volunteers Roma Tully

Back cover: North Hamilton Kindergarten children touring the HBH Operating Theatres

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 (SGS), 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 91 acute and subacute beds, 175 high and low level extended care and 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 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, palliative care and care for people with special needs.
- The Grange Residential Care Service - providing 50 aged residential care beds and 28 Home Care Packages (HCPs).
- Coleraine District Health Service (CDHS) providing acute care, residential aged accommodation 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 accommodation, community services and independent living units at 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 to provide national leadership to improve the health, wellbeing and safety of farmers, farm workers and their families across Australia through research, service delivery and education.

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

Year in Brief

Highlights 2015/16:

Service Improvements and Achievements

- In February new medical oncologist visits commenced fortnightly from the Ballarat Regional Integrated Cancer Centre (BRICC).
- A new rotation of University Hospital Geelong doctors in the WDHS Emergency Department improved patient satisfaction levels and admission rates from ED to the Medical Unit.
- WDHS increased access to orthopaedic specialists with the recruitment of a new visiting orthopaedic surgeon.
- The Grange, Birches, Penshurst and Coleraine aged care facilities achieved 100% accreditation.
- WDHS partnered with Alzheimer's Australia to develop and implement a Montessori model of dementia care and facilitated training for many aged care providers in the South West.
- National Patient Transport (NPT) began providing non-emergency patient services in a new agreement with WDHS.
- Rural Bank formed a partnership with the National Centre for Farmer Health (NCFH) to support the delivery of services to farmers, farm workers and their families.
- A Sub Regional Corporate Services Project was established to look at opportunities for Health Service collaboration to create efficiencies, with WDHS the lead agency.

Research

- WDHS is leading a world first project to evaluate the effectiveness of 20-minute rounding to reduce falls in aged care.
- The Ripple Effect rural farming community suicide prevention project and research into organophosphate exposures and major on farm trauma commenced. The National Health and Medical Research Council (NHMRC) Shh Hearing Project was completed.
- A research workgroup was established at WDHS to support current and further research opportunities.
- The Western Alliance delivered workshops aimed at improving the impact, quality and quantity of health research, education and training in the western region.

Community Engagement

- WDHS was the first Public Health Service in Australia to remove sugary drinks from sale in December and 13 other health services across the South West also committed to taking this important step to address rising levels of obesity and chronic disease.

→ Acting Campus Manager / DON (Penshurst) and DON - Aged Care Services (Hamilton), Katherine Armstrong, Birches Unit Manager, Eryn Cottier and WDHS Chief Executive, Rohan Fitzgerald discuss Birches redevelopment plans.
(Photo: Hamilton Spectator)

Year in Brief / Performance at a Glance

- The community support for the Health Service was once again phenomenal, with the total fundraising result for the year $1.4m.
- Over 120 people enjoyed the inaugural WDHS International Women's Day Luncheon in March.
- World leading weight loss Surgeon and founder of the Centre for Obesity Research and Education (CORE), Professor Paul O'Brien delivered a powerful message to 'eat less' at the 17th Annual Handbury Lecture.
- A campaign to raise funds for a new cancer treatment area was launched at the Mischief with Marney Dinner in August and fundraising for the redevelopment remained a focus throughout the year.
- The GenR8 Change movement launched in Spring and gained momentum with over 50 community action ideas developed to address growing levels of obesity in the region.
- WDHS provided kindergartens, primary schools and aged care facilities with Christmas figures to decorate and display as part of the Christmas Community Art Project.

Workforce Support and Development

- Staff health and wellbeing was a focus with three workshops facilitated by Deakin University creating the groundwork for a healthier, happier and more sustainable workplace.
- As part of the new Staff Wellbeing Program, the WDHS Rowing Challenge supported over 40 rowers (many of them beginners) to get out on the water and enjoy this unique sport.
- A training program being rolled out across the country as part of the National Lesbian, Gay, Bisexual, Trans and / or Intersex (LGBTI) Ageing and Aged Care Strategy, upskilled staff to deliver more inclusive care to the LGBTI community.
- The WDHS Aboriginal and Torres Strait Islander Careers Day was held to build confidence, simplify recruitment and application processes and increase awareness of job types and roles, with the hope of opening doors to real opportunities and experiences for Aboriginal and Torres Strait Islanders.

Infrastructure

- Plans to redevelop the current Health Information precinct and Library at Hamilton Base Hospital to accommodate a new cancer treatment area were developed and architect tenders finalised.
- The Birches Aged Care facility received a $420,000 State Government Significant Refurbishment Grant to enhance its grounds, dining and activity areas, with work to begin in early 2017.
- Department of Economic Development, Jobs, Transport and Resources (DEDJTR) grants allowed for generator upgrades to be carried out at Penshurst and the Grange, at a total cost of $191,000.
- The Penshurst Auxiliary funded a new carport, maintenance and storage shed for Penshurst District Health Service (PDHS).

YEAR IN BRIEF	2016	2015	2014	2013	2012
FINANCIAL ($000'S)					
Total Revenue	67,138	66,109	65,898	65,598	63,318
Total Expenditure	67,123	65,508	65,799	65,482	63,015
Net Result Before Capital and Specific Items	15	601	99	116	303
Net Result for the Year (Inc. Capital and Specific Items)	(2,650)	(4,284)	1,146	11,685	11,556
Retained Surplus / (Accumulated Deficit)	17,108	22,041	27,217	26,455	10,061
Total Assets	169,361	167,842	167,613	101,836	91,107
Total Liabilities	27,698	23,439	18,850	19,301	20,410
Net Assets	141,663	144,403	148,763	82,535	70,697
Total Equity	141,663	144,403	148,763	82,535	70,697
FUNDRAISING ($000'S)					
Income	1,447	852	1,171	1,120	1,314
Expenditure	21	28	26	47	19
Surplus	1,426	824	1,145	1,073	1,295
STAFF					
Number of Staff Employed	731	716	721	818	777
Equivalent Full Time	534.11	531.05	547.63	554.12	555.81
PERFORMANCE INDICATORS (ACUTE)					
Inpatients Treated (Separations)	6,967	7,026	7,197	6,941	7,562
Complexity Adjusted Inpatients (WIES22)*	5,213	5,142	4,998	4,694	4,959
Average Stay (Days)	2.68	2.67	2.77	2.89	2.88
Inpatient Bed Days	18,659	18,758	19,971	20,038	21,799
Total Occasions of Non-admitted Patient Service	46,973	41,869	39,208	44,080	48,784

* WIES - Weighted Inlier Equivalent Separations

From the President and Chief Executive

→ WDHS Chief Executive, Rohan Fitzgerald with Board President, Hugh Macdonald

Western District Health Service (WDHS) prides itself on being an innovative and transformational organisation. This year new services were added and expanded, we increased our efforts to tackle chronic disease, continued investment in research, grew our community engagement activities, focused on dementia, started work on our 2020 Strategic Plan and grew acute activity to its highest levels in many years.

Growing on the ground services is a priority for the Health Service and this year we increased the range of medical services available to our community. We recruited a Specialist Anaesthetist and new Orthopaedic and General Surgeon to our team. We commenced recruitment for a Geriatrician to support the health and wellbeing of older people in our region and introduced Australian trained medical graduates into our Emergency Department.

Cancer in our region is increasing and over the next five years on average 2,500 new diagnoses are expected annually in the Barwon Southwest region, with 25% of these occurring in the service area of WDHS. We established a new relationship with the Ballarat Regional Integrated Cancer Centre (BRICC) and now have oncologists visiting from the Andrew Love Cancer Centre and BRICC.

Evidence points to increasing rates of obesity in our community. Our work to address this issue continued with the Southern Grampians and Glenelg Primary Care Partnership (SGGPCP) and GenR8 Change movement. We became the first public health service in Australia to remove sugary drinks from sale at our campuses and inspired 13 other health services across the region to do the same.

The National Centre for Farmer Health (NCFH) continued its ground breaking work on improving farmers' health, wellbeing and safety. The Ripple Effect project was developed in collaboration with *beyondblue*, to address and reduce the stigma of suicide in our farming communities. Alison Kennedy was also recognised for her hard work, earning her Doctorate, with the thesis, 'Life, Death and the Experience of Suicide and Accidental Death Bereavement for Australia's Rural Farming Families'.

Our Falls team received funding from the Western Alliance to commence a research project that aims to reduce the number of falls and fall related injuries for residents in Aged Care through 20 minute rounding.

We celebrated International Women's Day for the first time, with over 120 guests learning about Avril Hogan's inspirational journey. A community forum on supporting same sex attracted, transgender and intersex people in our community was well attended. Our Finance and Aged Care teams held a succession planning workshop and the Consumer and Friends Network conducted a thought-provoking dementia forum.

Once again our fundraising events were a huge success. The Cocktails in the Courtyard, Mischief with Marney Dinner, Golf Day, Fun Run, Murray to Moyne, Christmas and Door Knock Appeals raised over $200,000 this year. The support of the Health Service's auxiliaries and the Aged Care Trust is tremendous and we appreciate the significant contribution they make to our overall success.

From the President and Chief Executive

Similarly our volunteers across the Health Service enhance our patient, resident and client experience and support the delivery of quality care. These 300 amazing people do so much to support their community. We are extremely grateful for the time and effort they give so freely to the organisation.

WDHS was proud to be one of the first facilities leading change in the delivery of aged care services across the region by introducing the Montessori Model of Care. This model aims to provide every person in residential aged care an opportunity to engage in meaningful activities and make contributions to their community, regardless of the level of care and support they require. It also supports people to maintain and restore function. The project was supported by Alzheimer's Australia and the Department of Health and Human Services (DHHS).

Penshurst Nursing Home, Kolor Lodge, the Birches and Grange were all successful in achieving aged care accreditation for a further three years. New generators were installed at the Grange and Penshurst courtesy of a State Government grant. We also received funding to improve the facilities available for residents at the Birches.

The Electronic Health Record development continued, as we introduced the clinical observation module across the organisation. Inspired by a patient's experience, we have also undertaken a project involving community members and staff to improve our discharge planning process.

In 2015/16, we exceeded our activity target by 2% from an acute hospital perspective. Similarly we achieved solid activity growth in our aged care and community divisions.

Financially we were pleased to achieve an operating surplus of $15,000, which is slightly ahead of our budget forecast. Wage costs continue to grow at a faster rate than revenue across each of the Health Service's Divisions. We are continually seeking to create efficiency and productivity savings through innovative practices.

With increasing non-emergency patient costs, we introduced a new private ambulance provider to the region. The new service is expected to complement the existing ambulance options provided to our community.

Work commenced on the development of our new 2020 Strategic Plan. We consulted widely with our staff and community and will roll this out later in the year. Our future vision will be 'creating healthier communities'.

Staff wellbeing was also a focus this year, with several workshops facilitated by Deakin providing the groundwork for the implementation of a new program that will deliver a range of activities, events, support services and materials to improve staff wellbeing.

We would like to thank our wonderful community for their support over the last 12 months. We also recognise the contribution of our entire staff group and medical team, who work together to provide excellence in healthcare to their community.

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 2016.

Hugh Macdonald
President
30 August 2016

→ Timboon and District Healthcare Service CEO, Gerry Sheehan, South West Healthcare CEO, John Kryger, Barwon Health Interim CEO, Paul Cohen, Heywood Rural Health CEO, Jackie Kelly, Western District Health Service CEO, Rohan Fitzgerald, Moyne Health Service CEO, David Lee, Portland District Health CEO, Chris Giles and Colac Area Health CEO Geoff Iles join together with other South West Healthcare providers to remove sugary drinks from sale at their campuses.

Overview

Reporting Against our Strategic Plan

Each year Western District Health Service reports on its major outcomes and proposed future directions against the seven key strategic areas of the 2011-2016 Five Year Strategic Plan. A summary of our achievements for 2015/16, together with proposed future directions are outlined below. Please refer to the glossary on the inside back cover for abbreviations.

	OBJECTIVE	STRATEGIES	OUTCOMES	FUTURE
Quality Improvement and Risk Management	To improve performance through a culture of continuous quality improvement and innovation	1.1 Increase participation and leadership in research and best practice opportunities	Established organisational research committee. Received $30k funding from Western Alliance for '20 minute rounding' falls project. Implemented WDHS Research Workgroup. Developed a Central Research Register.	Present research projects at the Western Alliance Forum and continue to support funded research opportunities.
	To effectively manage risk and provide a safe environment for the wellbeing and protection of consumers, staff and health service assets	1.2 Support clinical leadership and innovation that improves quality, safety and health outcomes	Clinical observations were included in the Electronic Health Record and clinical notes were further embedded. Active falls, medication, wound and pressure injury workgroups established, to monitor and reduce clinical risk. Achieved 75.2% staff flu vaccination rate - DHHS target 75%. Introduced patient e-stories.	Modules in the Electronic Health Record will be expanded to include medication management. Continue to evaluate falls, medication, wound and pressure injury strategies. Implement recommendations from HS&QA.
		1.3 Continue to implement continuous quality improvement plans to maintain and enhance our accreditation status as a teaching / training facility	Aged Care accreditation achieved at the Birches, Grange and Penshurst. Achieved full compliance in unannounced accreditation visits at all Aged Care facilities. Participation in the BPCLE project. Expanded the number of RN training opportunities.	Maintain accreditation status at all Aged Care facilities. Achieve NSQHS Accreditation in all acute facilities in October 2016. Achieve Baby Friendly Accreditation. Work towards achieving LGBTIQ Rainbow Accreditation status.
		1.4 Implement safe practice and risk management programs to ensure the wellbeing and safety of consumers, staff and assets	Achieved full compliance with external cleaning audits. Achieved full compliance with external food safety audits. Implemented Workplace Wellbeing Strategy, removed sugary drinks from sale and added 'healthy choices' to HBH Cafeteria menu.	Continue to achieve external cleaning and food safety compliance. Further implementation of the staff wellbeing strategies / program.
		1.5 Maintain and improve systems and structures to enhance clinical governance	Reviewed clinical governance structure and polices in line with the DHHS Governance Framework. Participated in a regional Maternal and Perinatal Mortality and Morbidity Review Committee. Introduced electronic system to provide timely notifications regarding changes to the published registration details of practitioners. Introduced new organisational compliance tool.	Continue to enhance and implement the revised clinical governance structure. Implement electronic AHPRA notification system.
Leadership & Innovation	Attract and retain high performing staff committed to the Vision, Mission and Values of the Health Service	2.1 Provide leadership in the planning and delivery of health services to meet the population health needs of the sub region	Expansion of oncology and geriatrician services. BRICC outreach service commenced to provide fortnightly specialist oncologist visits. New Orthopaedic Specialist visiting from Ballarat Orthopaedics. A further Specialist Anaesthetist joined the service.	Improve access to Geriatrician and oncology services. Undertake a sub regional service plan with the DHHS.
		2.2 Lead the development of innovative models of care in partnership with other service providers	VST program imbedded at Hamilton Hospital providing treatment advice on patients presenting to ED with stroke symptoms. WDHS partnered with Barwon Health, Southwest Healthcare and St Vincent's as parent hospitals to rotate Australian trained doctors in the HBH. Implemented regional Montessori Model of Care training and conducted AgriSafe clinics.	Imbed the Montessori Model of Care as core business in aged care and extend principles across WDHS. Evaluation of the Montessori model in 6 &12 months time.
		2.3 Build and foster partnerships with Universities and Research organisations to improve service capacity and health outcomes for our community	Continued strong relationship with Deakin University and Western Alliance. New research commenced with the Ripple Effect project and partners, completion of NHMRC Shh Hearing Project, commencement of In-Field PCACP research for organophosphate exposures, and major on farm trauma.	Continue to promote and foster clinical research. Poster presentation at Western Alliance Symposium. Continue to attract support and funding for NCFH to build local research. Foster relationship with Deakin University.
		2.4 Continue to lead the development and expansion of virtual services to enhance access to health care	Access to Geriatrician via telehealth in Aged Care. Participation in the Stroke Telehealth Project. Commenced investigations into the use of Health Direct technology for Telemedicine consultations.	Continue to identify opportunities to expand telehealth services.
		2.5 Participate in clinical networks to enhance knowledge, education and training and service delivery outcomes	Participation in the stroke, cardiac, paediatric, maternity, cancer and emergency clinical networks.	Continue participation in clinical networks.
Service Planning & Development	To continue to develop a contemporary health care system which focuses on person centred care and improves the health and wellbeing of our community	3.1 Enhance community access to specialist services	Expanded orthopaedic services. Exercise Physiologist joined Physiotherapy Team. Physiotherapy Outreach Service expanded to Casterton three days per week. Additional Podiatrist funded. Increased number of Nurse Pap Smear Clinics.	Enhance specialist services. Consider innovative business models to deliver more services closer to home.
		3.2 Improve the consumer's journey through the care pathway	Implemented the Sub Acute Model of Care and streamlined patient flow and pathways. Discharge Planning Workgroup established.	Engage with consumers to improve service provision.
		3.3 Continue to develop the National Centre for Farmer Health as a Centre of Excellence for farmer health, wellbeing and safety	Over 500 farmer health and lifestyle assessments conducted across Victoria, SA & Tasmania. Commencement of four AgriSafe Clinics in Western Victoria. Rural Bank Partnership established to support the delivery of NCFH programs and training provided to Rural Bank staff.	Continue to provide access to quality assessments in rural communities. Expansion of AgriSafe clinics across Victoria.
		3.4 Improve the coordination and integration of health care to ensure the person is at the centre of their own care	Implemented the Montessori Model of Care across Aged Care, respecting choice, individuality and person-centred care. Introduced 'mystery shoppers' into Aged Care facilities to identify customer service gaps. Home Referral Service expanded.	Expand the Mystery Shopper experience to identify customer service gaps. Implementation of the consumer experience project across WDHS.
		3.5 Direct resources to high risk groups and identified health priorities	Review of and increased staff training and resources in Chemotherapy and ED.	Continue to identify and direct appropriately trained resources to high risk areas.
		3.6 Develop innovative service models to improve the prevention and management of chronic disease	Expanded pain management clinics, including Coleraine. Implementation of the GenR8 Change 'Making the Healthy Choice the Easy Choice' initiative. Developed web based pilot program 'Shake Off Sugar' to improve the health and wellbeing of children.	Support strategies to prevent chronic disease, such as GenR8 Change. Run 'Shake Off Sugar' pilot program.
		3.7 Provide programs supporting healthy ageing and extend the capacity of services for our ageing population	Review of menus in consultation with Dieticians in Coleraine. Developed new aged care branding and implemented Aged Care reforms, including Consumer Directed Home Care Packages. Added private respite option for Aged Care.	Promote healthy ageing and marketing of Aged care services to achieve occupancy and revenue benchmarks.
		3.8 Develop and implement our next 5 year Service / Business Plan	Organisational values implemented. Organisational Game Plan developed and incorporated into the next 4 Year Service / Business Strategic Plan.	Continue to imbed the organisational values. Implement the 4 Year Service / Business Strategic Plan.

Human Resources	Attract and retain high performing staff committed to the Vision, Mission and Values of the Health Service	4.1 Develop and implement workforce plans and recruitment strategies to support our service plan	Retirement survey completed. Successful Graduate, Aged Care and Regional Collaborative Graduate Program implemented.	Implement transition to retirement plan and leadership program. Continue to implement the Graduate Program.
		4.2 Support and encourage education and training of staff directed at optimising skills and enhancing quality of care	Postgraduate training programs supported in Midwifery, Theatre, Aged Care, ICU and Emergency.	Centralise organisational training and development program and encourage education and training of staff.
		4.3 Promote and implement effective OH&S and healthy workforce programs	OH&S Strategic Plan developed. Return to work programs implemented. Staff Wellbeing Program initiated. Bullying and Sexual Harassment training conducted.	Implement organisational OH&S plan.
		4.4 Foster a culture of recognition and support	Organisational values implemented, along with above and below the line behaviours. Employee and Volunteer of the Month awarded. Clinical, Non-Clinical and Above and Beyond employee excellence awards achieved.	Continue to recognise staff through awards and support staff to achieve tasks / goals.
		4.5 Provide and support opportunities for staff to be innovative and excel in their area of expertise	Opportunities available for staff to be 'Executive for the Day'. The Sue Hindson Fund supported Critical Care Nurse training. Clinical Leadership Day and Working With Greater Purpose and Effectiveness training conducted. Vative systems training program introduced.	Support opportunities for staff to be innovative and excel in their area of expertise.
		4.6 Undertake Triennial Organisational Effectiveness surveys	Organisational effectiveness survey results implemented, with key themes of communication and recognition. People Matter Survey conducted.	Implement People Matter Survey outcomes in all departments.
		4.7 Build business acumen capacity within the Management group and implement subsequent action plans	Business acumen capacity developed. Draft Leadership Framework developed.	Further build business acumen capacity within the Management group and implement subsequent action plans including leadership training.
		4.8 Assist staff to improve efficiency and enhance service delivery capacity	Reviewed waste disposal practices and implemented new in-house waste management system. Introduced lean systems to improve organisational efficiency.	Continue to assist staff to improve efficiency and enhance service delivery capacity.
		4.9 Evaluate the HR Strategic Plan and develop the next 5 year cycle	HR Strategic Plan developed.	Implementation of the HR Strategic Plan.
Facilities and Equipment	To modernise and maintain facilities, equipment and infrastructure to improve the health and wellbeing of our community	5.1 Complete the modernisation and redevelopment of facilities at the Coleraine campus and Grange Residential Aged Care	Coleraine and Grange redevelopment completed 2013.	
		5.2 Review and revise the 10 year master plan for Hamilton Base Hospital and Penshurst campuses	The 10 Year Master Plan for HBH and Penshurst revised and submitted to DHHS.	Continue to lobby and apply for the redevelopment of HBH and Penshurst campuses.
		5.3 Continue to implement stages of the modernisation of Hamilton Base Hospital and Penshurst campuses in line with master plans	Birches refurbishment funding application successful. Generator upgrade at PDHS, storage / maintenance shed constructed with carport for Penshurst bus.	Complete Birches redevelopment.
		5.4 Continue to modernise and upgrade infrastructure	Penshurst Nursing Home modernised with new carpet, curtains and furniture. Planning and architect tender finalised for cancer treatment area redevelopment at HBH. Generator upgrade at the Grange. Fire system upgrade completed.	Continue to modernise and upgrade infrastructure. Refurbishment of the Birches. Redevelop cancer treatment area at HBH.
		5.5 Annually review and revise triennial asset replacement and maintenance programs	Implementation of the HPV procurement process across WDHS. Annual review and asset replacement and maintenance programs implemented. VMIA site audit conducted, with minor recommendations.	Continue to review and revise asset replacement and maintenance programs.
Community Engagement	To enhance community participation and involvement in the development and growth of our Health Service	6.1 Foster and encourage consumer participation	Consumers appointed to National Standard and Dementia Workgroups. Consumer and Friends Network Forums on LGBTI, Dementia, Cancer Care, Youth Services. NCFH involved farmer representatives in research projects and three farmers appointed to the NCFH Advisory Group.	Continue to foster and encourage consumer participation. NCFH - continue to involve and recognise farmers.
		6.2 Continue to involve and value Community and Campus Advisory Committees	Review of CAC and workgroup representation. New members on CAC and youth members appointed. Youth observers appointed to the Coleraine Advisory Committee. Plan to develop Community 4 Youth Board. CHIC group (inc consumers) established to review WDHS brochures and patient / client information.	Commence Community 4 Youth Board meetings and development.
		6.3 Continue fundraising and donor initiatives and ensure recognition of community support	Christmas and Door Knock Appeals raised 24k and 60k respectively. Mischief with Marney Dinner raised 52k. Fun Run 7k. Murray to Moyne 15k. Cocktails in the Courtyard 7k. Run 4 Farmer Health 5k. Western District Ball 10k. Total fundraising result for the year $1.4m.	Continue fundraising and donor initiatives and ensure recognition of community support. Top of the Town Charity Ball planned for October 2017.
		6.4 Enhance and value the participation and involvement of our volunteers	Monthly Volunteer awards. Minister for Health Volunteer Award nominations. Movie afternoon to celebrate Volunteer Week. Volunteer Christmas parties. Community Liaison Auxiliary support.	Continue to value and recruit volunteers.
		6.5 Provide Regional Forums for the community, focusing on education, health and wellbeing	Obesity the topic of the 17th Annual Handbury Lecture. Regional Montessori Forum held. Farmers Succession Planning for Aged Care Workshop. C&FN Forums, International Women's Day Luncheon. 12 Look Over the Farm Gate workshops held.	Continue to provide Regional Forums for the community, focusing on education, health and wellbeing.
		6.6 Communicate and engage with our community via media, internet, newsletters, brochures and annual reports	Facebook content expanded and website updated. Generic Aged Care pamphlet and information booklet developed. New fortnightly advertising contract established to better promote WDHS events and services. Over 50 media articles published for the year. New 'Talking Health' community newsletter produced. Silver Award for 2015 Annual Report. PDHS & Coleraine reports produced. QOC Report. Farmer Health website has over 120,000 unique users and HONcode accreditation.	Continue to communicate and engage with our community via media, internet, newsletters, brochures and annual reports. Maintain Farmer Health HONcode accreditation.
Business Sustainability and Innovation	To develop and implement innovative practices to strengthen our Governance, business and financial capacity to deliver efficient and effective high quality healthcare to our community	7.1 Support innovation to improve and redesign work practices	Implemented the Sub Acute Model of Care and streamlined patient flow and pathways. Sub Regional Corporate Services Collaborative - WDHS is lead agency.	Support innovation to improve and redesign work practices. Viable collaborative opportunities and priorities finalised and initiated.
		7.2 Develop and enhance ICT clinical and business systems to improve quality and efficiency outcomes for health care	Reviewed the Emergency Department medical and nursing staff profile to meet service demands. Continued implementation of Electronic Health Record elements.	Further implementation of the Electronic Health Record.
		7.3 Continue to maintain financial and health service viability	Improved aged care occupancy and revenue. HPV Procurement Workgroup established. Meals on Wheels tender successful.	Continue to maintain financial and Health Service viability.
		7.4 Support innovative opportunities that increase our funding base and capacity to service the health care needs of our community	New partnership established with Rural Bank to support NCFH work. Improved Sub Acute Rehab Model of Care implemented to improve sub acute targets. Improved aged care occupancy.	Appoint organisational ACFI Coordinator to improve staff knowledge and ACFI funding.
		7.5 Maintain flexibility in resource distribution to meet high priority needs	TrendCare utilised to allocate resources according to acuity. Aged Care resource decision making tool developed for the Birches, Grange and Penshurst.	Develop Aged Care decision making tool for Coleraine.

Financial Overview

Overview

The Financial Statements have been prepared in accordance with Standing Direction 4.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards and Australian Accounting Interpretations and other mandatory professional reporting requirements for the year ended 30 June 2016.

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 $15k ($601k in 2015), which represents 0.0002% of operating revenue. Operating revenue increased by 1.56% compared to the prior year, while expenditure increased by 2.46% compared to 2014/15.

Complexity adjusted (WIES 22) inpatient activity was 1.3% higher than the previous year, with the Health Service exceeding its 2015/16 WIES target by 2%. 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 ($1.1m), residential aged care capital contributions ($1.9m) and specific purpose donations and bequests ($1.4m) 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 ($103k) and the loss on disposal of non-current assets ($36k) are also excluded, being predominantly funded from capital income sources.

In the 2015/16 financial year, depreciation charges of $6.9m were recorded, reflecting the cost associated with the use of buildings and equipment in delivering services.

Capital income was $2.515m less than the depreciation charges. Financial asset fair value losses of $90k, lease finance costs of $44k and a joint venture loss of $3k were recognised in calculating the comprehensive result for the year. Including all items, the Health Service net assets reduced by $2.740m for the year, representing an improvement of 37.1% compared to the prior year (decrease of $4.360m – 2.9% in 2014/15).

WDHS incurred a comprehensive entity deficit of $2.7m for the 2015/16 financial year. The entity deficit is largely attributable to costs associated with depreciation charges of $6.9m, as a consequence of the revaluation of buildings in 2013/14. In spite of the significant comprehensive entity deficit, overall liquidity levels improved by $5.2m during the year and remain substantially above target levels.

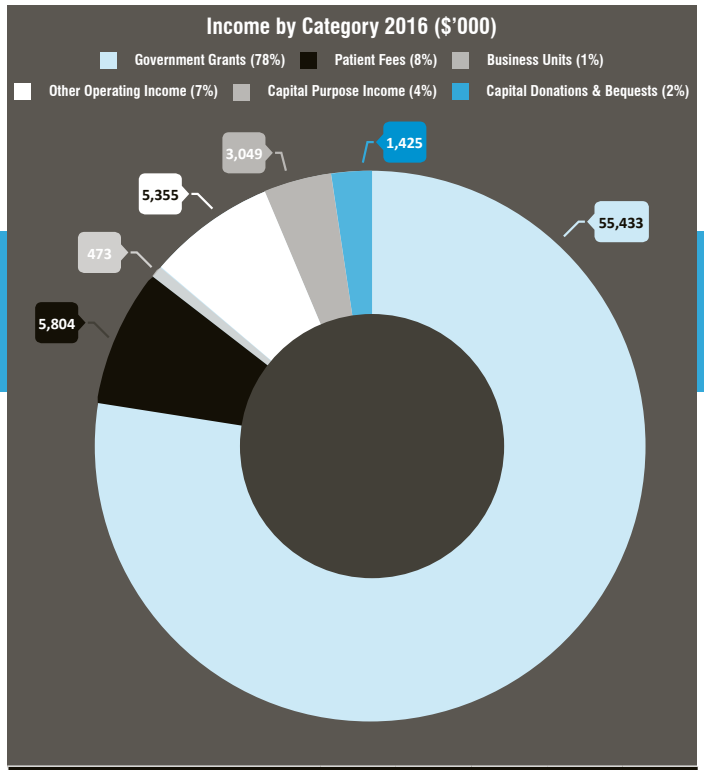
Liquidity Position

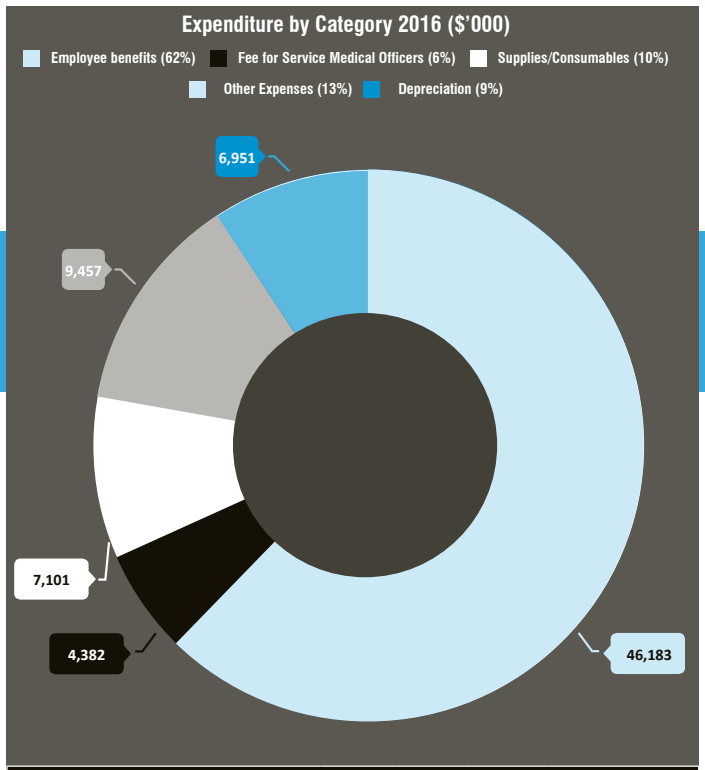
During 2015/16 the Health Service generated positive cash flows from operations of $5.3m, including $4.7m in capital purpose income, $1.429m of these funds were used to purchase property, plant and equipment and a further $394k used to repay finance leases during the year. The entity generated a positive cash flow of $3.471m for the year after capital items and applied $5.8m of the available cash to purchase investments. After purchase of investments the available cash was reduced by $2.3m to $9.2m at year end.

The ratio of current assets to current liabilities (excluding patient trust funds) at the end of the year was 1.61:1 compared to 1.52:1 in the previous year. This remains considerably in excess of the 0.7 target ratio.

Asset Management

$1.51m 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 $6.9m depreciation expense for the year.





Average Cost Acute Inpatient – 5 Year Comparison

	2016	2015	2014	2013	2012
Government Grants	55,433	53,557	51,204	50,258	50,172
Patient Fees	5,804	6,898	5,947	5,700	5,358
Business Units	473	608	655	734	1,048
Other Operating Income	5,355	5,119	8,042	8,906	6,740
Capital Purpose Income	3,049	1,379	4,001	14,181	13,255
Capital Donations & Bequests	1,425	827	1,145	1,073	1,314

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

	2016	2015	2014	2013	2012
Employee benefits	46,183	44,689	43,555	43,255	42,786
Fee for Service Medical Officers	4,382	4,247	3,785	3,501	3,298
Supplies/Consumables	7,101	6,416	6,213	5,894	5,890
Other Expenses	9,457	10,552	12,246	12,832	11,041
Depreciation	6,951	6,570	3,900	3,512	3,302

Financial Overview and Analysis

Significant items included in the $1.51m investment, were the final stage of the Fire Sprinkler System upgrade at the Hamilton Base Hospital site ($55k), generator upgrades to the Grange Residential Service and Penshurst Campus($191k), implementation of an in-house waste disposal arrangement ($70k), cooling system works ($38k), lift upgrade works ($23k), purchase of new anaesthetic monitors ($55k) and the replacement of a CTG fetal monitor ($32k).

Community Support

The support of the community, as indicated by the outstanding $1.425m 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

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 22) inpatient activity was 1.3% higher than the previous year, with the Health Service exceeding its 2015/16 WIES target by 2%.

Financial Analysis of Operating Revenues and Expenses REVENUE	2016 $'000	2015 $'000	2014 $'000	2013 $'000	2012 $'000
SERVICES SUPPORTED BY HEALTH SERVICE AGREEMENT					
Government Grants	55,369	53,497	51,137	49,596	50,030
Indirect Contributions by Department of Health and Human Services	64	60	67	662	142
Patient Fees	5,804	6,898	5,947	5,700	5,358
Other Revenue	610	766	740	732	950
	61,847	61,221	57,891	56,690	56,480
SERVICES SUPPORTED BY HOSPITAL/COMMUNITY INITIATIVES					
Business Units	473	608	655	734	1,048
Property Income	772	818	858	803	708
Other Revenue	4,046	3,462	6,494	7,371	5,082
	5,291	4,888	8,007	8,908	6,838
Total revenue	67,138	66,109	65,888	65,598	63,318
EXPENDITURE					
SERVICES SUPPORTED BY HEALTH SERVICE AGREEMENT					
Employee Entitlements	45,767	44,157	42,756	42,651	41,620
Fee for Service Medical Officers	4,382	4,247	3,785	3,501	3,298
Supplies and Consumables	6,995	6,281	6,083	5,763	5,740
Other Expenses	9,350	10,019	12,082	12,487	10,716
	66,494	64,704	64,706	64,402	61,374
SERVICES SUPPORTED BY HOSPITAL / COMMUNITY INITIATIVES					
Employee Entitlements	416	532	799	604	1,166
Supplies and Consumables	106	135	130	131	150
Other Expenses	107	137	164	345	325
	629	804	1,093	1,080	1,641
Total Expenditure	67,123	65,508	65,799	65,482	63,015
SURPLUS FOR THE YEAR BEFORE CAPITAL PURPOSE INCOME, DEPRECIATION AND SPECIFIC ITEMS	15	601	99	116	303
Capital Purpose Income	1,145	615	3,474	13,258	11,646
Donations and Bequests	1,353	753	1,105	1,073	1,314
Residential Aged Care - Capital Purpose Income	1,974	911	443	848	1,575
Surplus/(Loss) on Disposal of Fixed Assets	(36)	(70)	84	75	34
Impairment of Financial Assets					(14)
Share of Net Result Joint Ventures	(3)	(23)	(10)		
Assets Provided Free of Charge					
Finance Costs	(44)	(42)			
Expenditure Using Capital Purpose Income	(103)	(105)	(149)	(173)	
Depreciation	(6,951)	(6,924)	(3,900)	(3,512)	(3,302)
Entity Surplus for the Year	(2,650)	(4,284)	1,146	11,685	11,556

Service Performance at a Glance

	2016	2015	2014	2013	2012
INPATIENT STATISTICS (ACUTE PROGRAM)					
Inpatients Treated	6,967	7,026	7,197	6,941	7,562
Average Complexity (DRG Weight)	0.75	0.74	0.69	0.68	0.66
Complexity Adjusted Inpatients (WIES 22)*	5,213	5,142	4,998	4,694	4,959
Inpatient Bed Days	18,659	18,758	19,971	20,038	21,799
Average Length of Stay (days)	2.68	2.67	2.77	2.89	2.88
HITH Bed Days	668	671	631	776	492
Nursing Home Type Bed Days	637	1,091	1,553	1,808	1,823
Operations	2,911	3,127	2,895	2,882	2,764
Births	193	191	210	201	219
Available Bed Days	27,954	27,654	28,613	26,915	27,854
Occupancy Rate	71.4%	71.8%	75.2%	81.1%	84.8%
Average Cost Per Inpatient	$4,909	$4,608	$4,344	$3,906	$3,476
AGED CARE STATISTICS - (AGED PROGRAM)					
High Care					
Residents Accommodated	220	207	185	227	211
Resident Bed Days	52,790	51,021	39,639	50,247	51,696
Low Care					
Residents Accommodated	24	29	62	35	45
Resident Bed Days	3,100	5,665	11,803	5,968	7,137
Respite					
Residents Accommodated	214	133	139	129	138
Resident Bed Days	2,764	2,049	2,077	1,506	1,967
Occupancy Rate	92.10%	92.48%	84.27%	90.88%	97.72%
Community Aged Care Package (CAP) clients	36	38	44	39	40
CAPS Occasions of Service	9,608	9,843	9,654	10,396	10,891
ACCIDENT/EMERGENCY OCCASIONS OF SERVICE	**7,018**	**6,984**	**7,155**	**6,841**	**7,221**
Outpatient (Non-admitted) Occasions of Service					
Physiotherapy	6,855	4,114	4,360	5,549	6,689
Planned Activity Group	5,941	5,743	5,319	5,317	5,406
Speech Pathology	810	762	658	684	709
Podiatry	2,993	2,617	2,229	1,708	1,819
Occupational Therapy	1,920	1,753	1,812	2,425	3,439
Palliative Care	2,309	1,428	2,012	2,165	1,765
District Nursing Service	22,123	21,973	21,959	25,737	25,204
Other (Continence, Diabetes, Dietetics)	4,022	3,479	3,198	2,852	2,796
Total Non-admitted Occasions of Service	46,973	41,869	41,547	46,437	47,827
Cost Per Non-admitted Occasion of Service	$191	$171	$169	$165	$174
Meals on Wheels	20,382	23,078	26,933	30,733	32,346
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 2015/16 (excluding those funded under the Small Rural Health Services Program) was 5,007. The Health Service was 2% above target this year.

Our Services and Programs

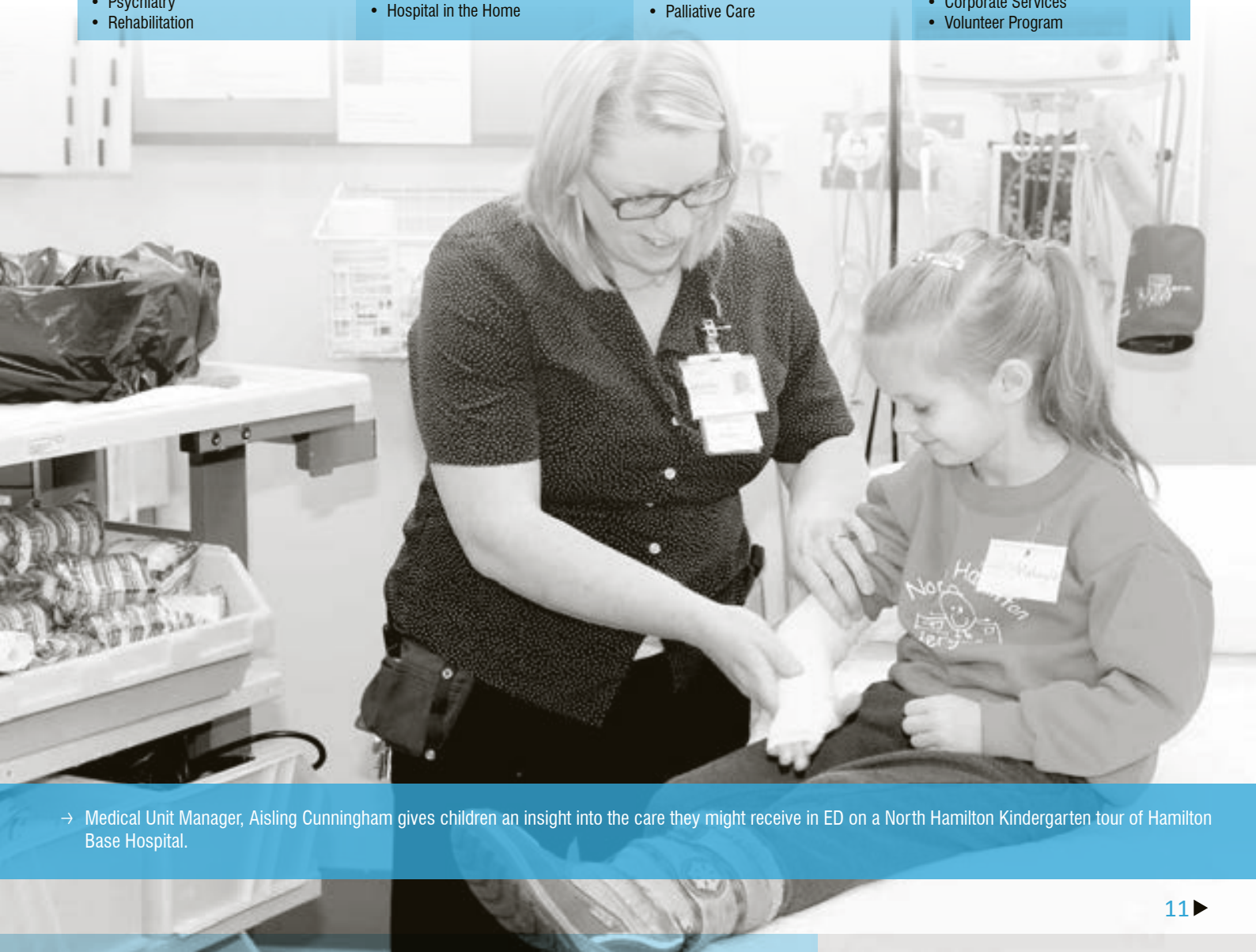
Acute/Sub-acute
- Anaesthetics
- Chemotherapy
- Coronary Care
- Day Procedure
- Ear, Nose and Throat
- Emergency
- Endoscopy
- General Medicine
- General Surgery
- Geriatric Evaluation Management
- Gynaecology
- Haemodialysis
- High Dependency Care
- Hospital in the Home
- Infection Control
- Intensive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

Primary & Preventative Health
- Audiology
- Balance Clinic
- Breast Cancer Support Group
- Cancer Link Nurse
- Cancer Support Group
- Cancer Support Services
- Cardiac Rehabilitation
- Cardiac Support Group
- Carer's Support Group
- Chronic Disease Management
- Complex Care
- Coordinated Care
- Continence Service
- Counselling
- Diabetes Education
- District Nursing Service
- Domiciliary Midwifery
- Family Planning
- Hamilton Community Transport
- Home Referral
- Home Services Team
- Hospital in the Home
- Men's Health
- Nutrition and Dietetics
- Occupational Therapy
- Palliative Care
- Physical Activity Programs
- Physiotherapy
- Planned Activity Group
- Podiatry
- Post-Acute Care
- Pulmonary Rehabilitation
- Rehabilitation in the Home
- Residential In Reach
- Respiratory Education
- Respiratory Support Group
- Sexual and Reproductive Health
- Smoking Cessation
- Social Work
- Speech Pathology
- Stomal Therapy
- Telehealth
- Women's Health
- Workplace Health Programs
- Youth Programs

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

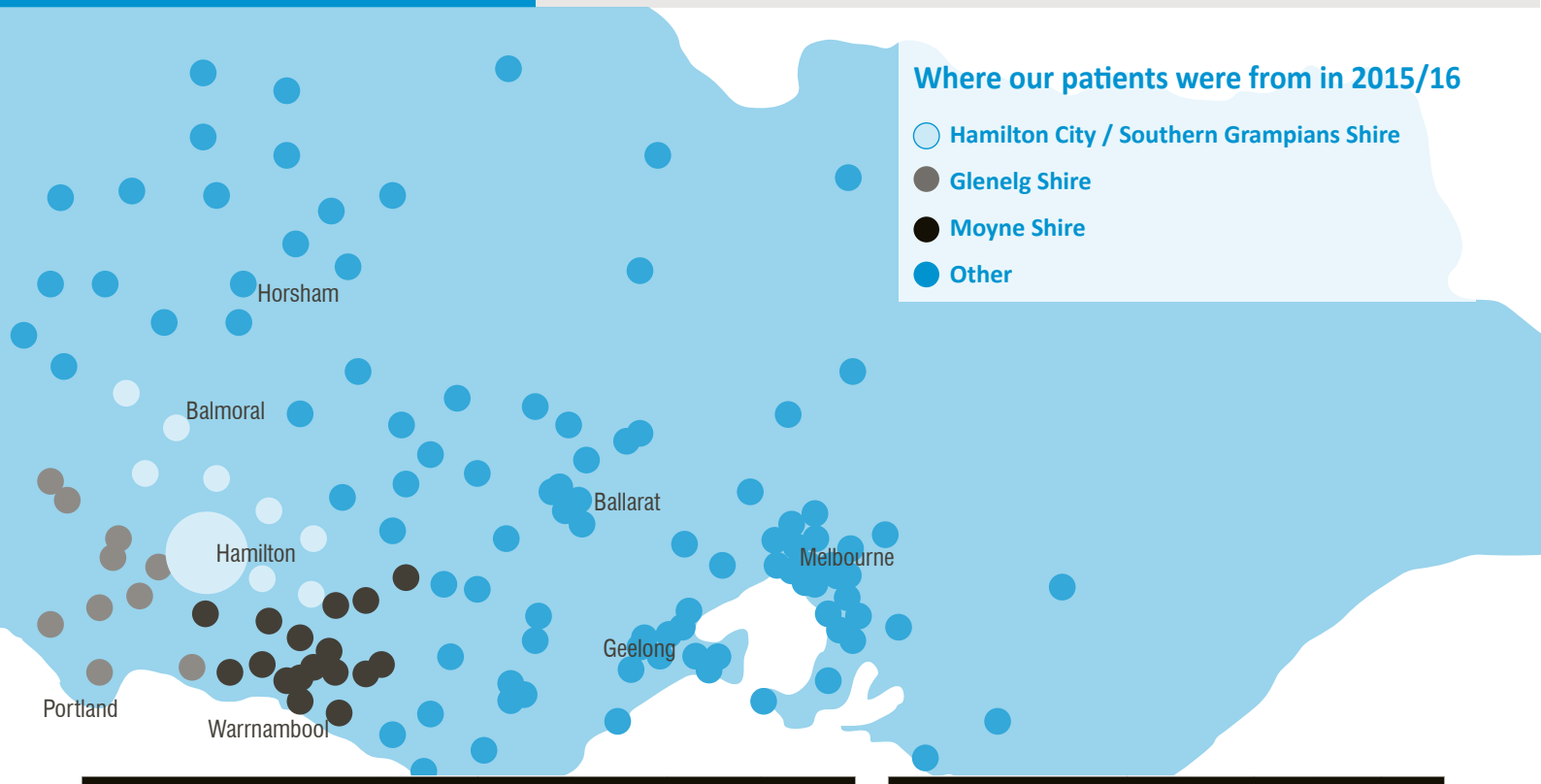
National Centre for Farmer Health
- AgriSafe™
- Health and Lifestyle Assessments
- Information and Knowledge Hub
- Research and Development
- Sustainable Farm Families™
- Training and Education

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



→ Medical Unit Manager, Aisling Cunningham gives children an insight into the care they might receive in ED on a North Hamilton Kindergarten tour of Hamilton Base Hospital.

Patient Admissions and Classification



Total Number of Admissions – 5 Year Comparison					
Location	**2016**	**2015**	**2014**	**2013**	**2012**
Hamilton City	3,181	3,528	3,649	3,489	3,751
Southern Grampians	1,369	1,302	1,411	1,362	1,567
Glenelg Shire	987	963	971	897	937
Moyne Shire	343	220	221	296	359
Other	997	372	310	332	367
Total	**6,877**	**6,385**	**6,562**	**6,376**	**6,981**

Inpatient by Classification – 5 Year Comparison					
	2016	**2014**	**2013**	**2012**	**2011**
Public	5,274	5,193	5,418	5,171	5,733
Private	1,486	1,576	1,490	1,452	1,513
Department of Veterans Affairs	140	201	226	250	255
Transport Accident Commission	46	26	25	22	27
Workcover	21	30	38	46	34
Total	**6,967**	**7,026**	**7,197**	**6,941**	**7,562**

→ Registered Nurse Carmen Jacobs delivers chemotherapy treatment to patient, Gerard Lucas.

AUSTRALIAN TRAINED MEDICAL SERVICES MODEL INTRODUCED

BRICC

OUTREACH CANCER CARE PARTNERSHIP ESTABLISHED

2,911

OPERATIONS WERE PERFORMED IN HBH OPERATING THEATRES

NEW

DISCHARGE PLANNING WORKGROUP ESTABLISHED

ECG

PURCHASED WITH 2015 GOLF TOURNAMENT FUNDS

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

Performance

WDHS maintained a 71.4% bed occupancy rate in 2015/16, with patients averaging 2.68 days in hospital. 7,018 Emergency Department (ED) presentations were recorded, with 23.6% of these resulting in admissions to Hamilton Base Hospital (HBH). 46,973 outpatient occasions of service were documented across WDHS campuses. The Operating Theatres delivered 2,911 operations and 193 new babies were born at HBH.

Consumer feedback

95% of consumers were positive about their care at WDHS in 2015/16, as reflected in the Victorian Healthcare Experience Survey results.

Feedback on adult emergency care was a catalyst for developing a range of new strategies to improve the patient experience in ED.

A focus on 'person-centred care' in managing patient complaints lead to more timely acknowledgement and resolution of issues.

Discharge Planning

A new Discharge Planning Workgroup was established following feedback from consumers. This group, in partnership with clinicians and managers is working to review and improve the discharge process. The consumer representation on this workgroup assists WDHS to focus on what is really important to patients and the group works together to find practical solutions to problems.

Clinical Handover

WDHS provides a consistent, standardised and structured clinical and bedside handover procedure to provide safe and effective management of patients, clients and residents.

The importance of patient, client / resident involvement in this process is essential to achieving the aims of 'person-centred care'. This procedure minimises the risk of adverse outcomes for patients that might occur as a result of poor handover of clinical information. The handover process confirms the accountability and responsibility of care moving from one health professional to another.

Partnerships and Achievements

Oncology Services

A new partnership with Ballarat Regional Integrated Cancer Centre (BRICC) is delivering more regular specialist oncologist visits to HBH. This partnership is growing and the chemotherapy service will be further enhanced following the redevelopment of the cancer treatment area in 2017. A radiation oncologist from the new South West Cancer Centre (Epworth in Warrnambool) will also begin visiting the Cancer Suite in July 2016 to extend the service further and provide more options for radiation therapy, closer to home.

Additional nursing staff have completed further training at Peter MacCallum Cancer Institute to support the expanding service.

Orthopaedic Services

An additional orthopaedic surgeon began fortnightly visits from Ballarat Orthopaedics in February. A Physiotherapy driven Musculoskeletal Clinic is planned to open in the next year, to provide optimal support for patients with bone and muscle disease.

Clinical Services

Preadmission Service

The preadmission process was streamlined to create a better patient experience by improving the screening of day procedure cases. This has reduced the requirement for multiple visits and increased Operating Theatre throughput.

New Medical Services Model

WDHS partnered with Barwon Health, South West Health Care and St Vincent's as parent hospitals to rotate Australian trained doctors in HBH as registrars, RMOs and Interns in the ED and on the wards. This model has now totally replaced the previous International Medical Graduate model.

Equipment Upgrades

Hamilton Base Hospital is in the process of replacing its anaesthetic machines with two state of the art anaesthetic workstations.

Funds from the Annual Christmas Appeal purchased much needed replacement orthopaedic equipment, including a drill and oscillating saw.

The Golf Tournament and Hospital Opportunity Shop also funded a replacement ECG machine and Accuvein for ED and ICU and 10 new day procedure chairs were also purchased.

Electronic Health Record

WDHS is making steady progress to become a paperless health service. Electronic clinical notes were further embedded and electronic observations were implemented.

The Electronic Health Record improves access to patient notes by clinicians leading to more coordinated and efficient care.

Additional funding has been received and more resources were allocated to support the roll out of the Electronic Record.

Telehealth

WDHS has telehealth links with Adult Retrieval Victoria, the Emergency Department's at University Hospital Geelong and South West Healthcare and Geelong ICU. Through these links patients can be reviewed by emergency, trauma and critical care specialists, who can advise ED and ICU staff on appropriate management or referral of patients requiring higher levels of care.

Victorian Stroke Telemedicine (VST)

The VST program links Hamilton Hospital to a network of Melbourne based neurologists, who can provide treatment advice on patients presenting to ED.

It is led by The Florey Institute of Neuroscience and Mental Health, with partners including the DHHS, Australian Government, Monash University, Ambulance Victoria and the National Stroke Foundation.

The program will provide a 24 hour clinical service to ED staff, allowing immediate access to a neurologist to assist in the assessment, diagnosis and treatment of patients presenting with acute stroke symptoms.

The Hamilton Hospital ED, together with Ambulance Victoria, hospital departments and staff, deliver evidence based best practice for all patients presenting with stroke.

Planning and staff training has been conducted, with the service commencing in August 2016.

Anaesthetic Services

Stephen Watty, a highly skilled Specialist Anaesthetist, joined WDHS on a part-time basis at the beginning of 2016. The Health Service now has the services of two Specialist and two GP Anaesthetists.

Obstetrics / Maternity Services

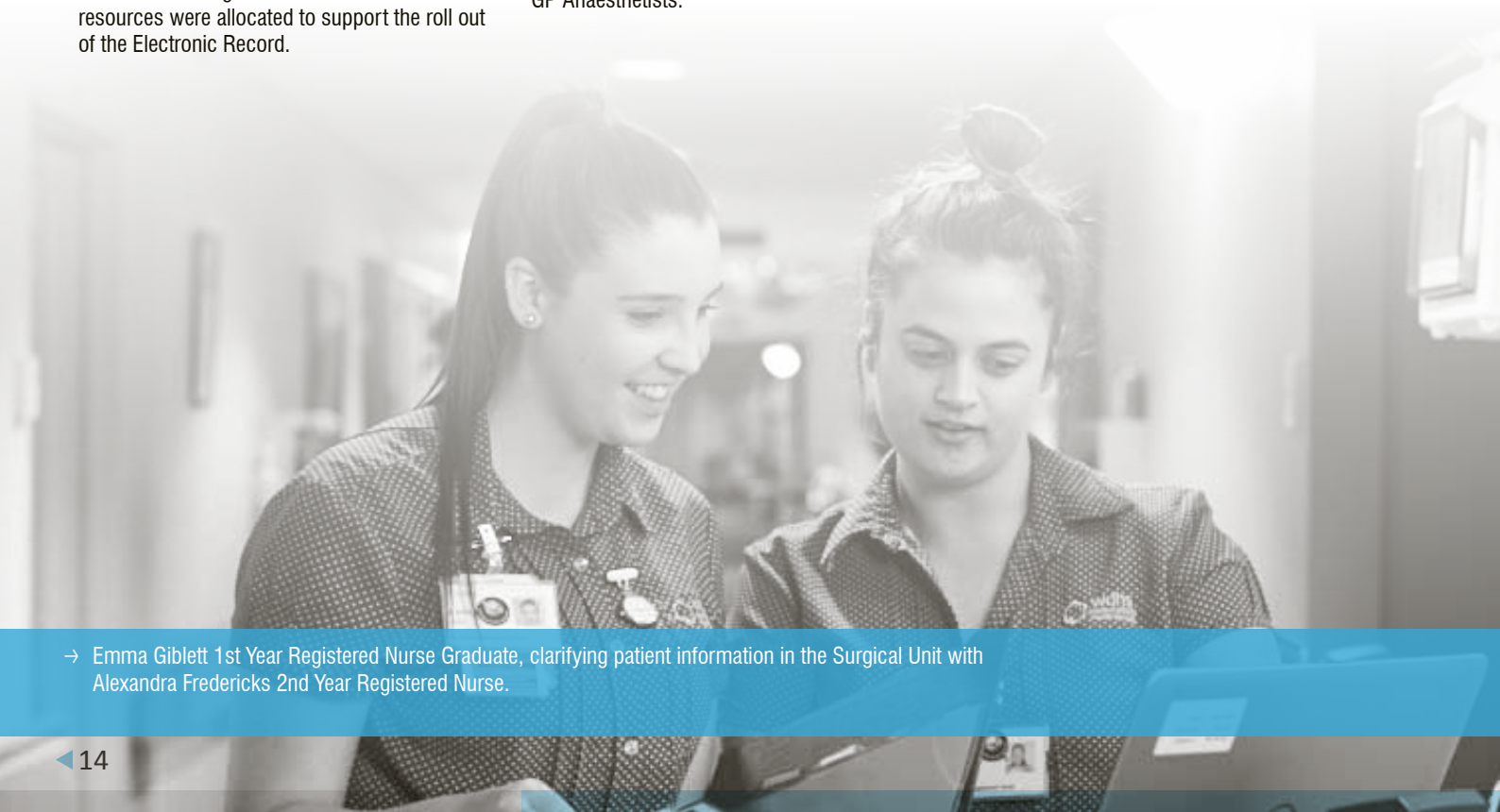
The Maternity Service at WDHS continues to provide care to nearly 200 women each year, with 193 babies born at HBH in 2015/16. The Hamilton Model of Midwifery Care has been operational for seven years, providing caseload care to women in the region, in conjunction with GP / Obstetricians from Hamilton Medical Group (Dr de Kievit, Dr Slabbert and Dr Tai).

The service works in partnership with specialist obstetricians from Greenwell Specialist Clinic and Southwest Healthcare in Warrnambool. Improving the referral pathways to these services and management of women with increased risks has been a focus this year.

Staff have continued education in areas such as neonatal resuscitation, family violence and maternity emergencies. Two nurses studying to become midwives worked with the team this year and two graduate midwives were employed in the model. WDHS also farewelled two of its longest serving midwives, who retired with a combined 60 years of midwifery experience between them.

In 2016 as part of a state-wide initiative, WDHS joined health services across the region in a Regional Maternal and Perinatal Mortality and Morbidity Review Committee.

The newly established Committee supports a consistent and coordinated regional approach, provides access to independent clinical expertise and enhances learning between maternity care clinicians to improve maternity care.



→ Emma Giblett 1st Year Registered Nurse Graduate, clarifying patient information in the Surgical Unit with Alexandra Fredericks 2nd Year Registered Nurse.

Primary & Preventative Health (PPH)

The Primary and Preventative Health (PPH) Division provides services across the acute setting, aged care, community and regional areas. The Division has a strong focus on partnering with consumers to achieve positive health outcomes.

NEW
SPECIALIST EXERCISE PHYSIOLOGIST SERVICE

30%
INCREASE IN MALNUTRITION REFERRALS TO DIETETICS

1,035
ATTENDEES AT YOUTH PROGRAMS

2,439
HOME REFERRAL CONTACTS

YOUTH BOARD DEVELOPMENT

New Services

An Exercise Physiologist joined the Physiotherapy team in 2015, to provide assessment and clinical exercise interventions for a broad range of conditions.

WDHS Physiotherapists also commenced an outreach service to Casterton Memorial Hospital three days per week.

New pain management treatment sessions in Aged Care were also delivered by Allied Health professionals under the Aged Care Funding Instrument (ACFI) system.

Service Improvements and Increased Capacity

The Primary Health Network funded a third Podiatrist for the Allied Health team in September 2015, significantly reducing waiting times for Podiatry services.

The Home Referral Service expanded, with the employment & training of three new staff members. The total Home Referral contacts for the year were 2,439, exceeding the target of 1,777.

The District Nursing team purchased eight new laptops and eight smart phones to improve clinician safety, allow for electronic note taking in clients' homes and for more efficient ordering of pharmaceuticals.

The Continence team upgraded its Uroflow machine to increase efficiency and implemented a new telephone message system for clients wanting to purchase continence aids and products.

A Respite for Carers Planned Activity Group commenced one Saturday per month in July 2015.

An additional specialist Lymphoedema and Women's Health Physio was also trained.

Nearly 300 women took advantage of an increased number of Nurse Pap Smear Clinics, including outreach clinics conducted in Balmoral and Penshurst.

Service Innovation

The Physiotherapy Department, in conjunction with the Medical Unit completed mobility aid training with a number of nursing staff. This program aims to assess and prescribe mobility aids for patients in the hospital setting on the weekends and after hours.

PPH, STAY Residential and Southern Grampians Shire Council (SGSC) worked on a successful grant application to RACV to establish Wheels 2 Work, a volunteer-based transport service to assist people with a disability to access education and employment.

The 'Baby Makes Three' program was delivered over 12 sessions by the WDHS Psychologist and Counselling team.

Allied Health staff participated in the Barwon South West Teleheath Project, improving the provision of best practice care to clients and supporting clinicians to further develop their knowledge and skills in the area of stroke rehabilitation.

An Occupational Therapy student project evaluated clients' perspectives on the use of iPads for rehabilitative education, following joint replacement surgery.

WDHS Health Promotion Dietitians and a Charles Sturt University student worked closely with the GenR8 Change movement to evaluate the Hamilton Indoor Leisure and Aquatic Centre (HILAC) Café against the Victorian Healthy Eating Advisory Service guidelines.

The community are supportive of healthy change at the facility and recommendations were made to improve the health status of the Café – to make the healthy choice the easy choice.

Improved Patient Outcomes

An Occupational Therapy 'Falls Risk for Older People' screening tool is being provided to all new Planned Activity Group (PAG) members, leading to improved falls monitoring and implementation of falls prevention strategies.

Hospital admissions were reduced by 58% and ED presentations by 48% when patients were referred to the Complex Care team.

Dietetics has seen a 30% increase in malnutrition referrals, following improvements in the detection of patients presenting with undernutrition. Australian studies have shown that the risk of malnutrition in the acute setting is likely to be 23-35% and 6-49% in the rehabilitation setting. One of the most vulnerable groups are individuals aged 65 or older. WDHS, in line with international best practice has commenced malnutrition screening for adults admitted to the hospital. To enhance the change of practice and completion of the malnutrition screens, the Nutrition and Dietetics Department has employed an Allied Health Assistant to ensure all admissions are screened and referrals to the Dietitian's are actioned according to the patients risk score. This has resulted in an increase in the number of referrals to the Dietitian and with the support of the Assistant, patients meals, snacks and fluids are altered to ensure the provision of nutrient dense options that are tailored to the needs of individuals.

Clinics

The WDHS Women's Health Nurse Practitioner has increased the number of Women's Health Clinics to seven per month, offering a range of times to improve access for all women.

The WDHS diabetes educators host a paediatric endocrinology clinic four times a year (a partnership with the Royal Children's Hospital), where children with diabetes and other endocrinological conditions can see their RCH specialist at WDHS. This clinic has seen an increase in numbers to 24 over the last 12 months, as more children and teenagers from surrounding areas take advantage of this local opportunity. The program has welcomed Delta Dogs on clinic days, providing relaxation time before appointments.

WDHS urological health services have expanded, with surgical case management, after hours and weekend support, telehealth and locum service provision to Geelong.

Education and Training

PPH hosted two successful community and staff engagement sessions, to better understand how WDHS can support LGBTI people and their families to access local health and community services. Many LGBTI people in rural areas do not access services or disclose issues of sexuality or gender identity for fear of experiencing negative reactions from health professionals and members of the community. PPH and the LGBTI community are working together to remove barriers that exist for LGBTI people, to provide equal access to services for all at WDHS.

The Physiotherapy team are completing specialist musculoskeletal / orthopaedic training to ensure their readiness to support additional orthopaedic services.

The Palliative Care Nurse and Stomal Nurse also completed specialist training.

Speech Pathology provided telehealth consults for remote swallowing assessment, articulation therapy and rehabilitation following an acquired brain injury.

Diabetes Educators facilitated a WDHS Diabetes Study Day to update nursing staff on best practice diabetes management.

Governance

The PPH Division is represented on the National Standards Committees 1,2,6,8 and 10.

Inpatient Equipment Guidelines were developed in response to consumer feedback, to support patients who might wish to use of their own equipment when admitted to hospital.

Youth Services

Freeza and Holiday Program

Over 1,000 people attended WDHS Youth Freeza and School Holiday activities in 2015/16. Dr Geoff Handbury AO generously supported the delivery of the School Holiday Program with a donation of $40,000.

WDHS received Freeza funding for a range of Freeza activities including a Skate Festival, Christmas Rock Concert and Battle of the Bands.

The Community 4 Youth Board (C4YB)

C4YB will be a new addition to youth services in the Southern Grampians Shire (SGS). C4YB is a WDHS Board Advisory Committee, that will represent the voice of young people aged between 16 and 25 who live, work, study or socialise in the SGS. The C4YB concept was generated at a Youth Forum facilitated by WDHS in June 2015. The Board will be made up of community members who are passionate about issues facing youth and delivering youth services and local young people. The aim is to increase the capacity of young people to be engaged in their community and participate in decision making. C4YB will be launched in August 2016.

Youth Awards

The Southern Grampians Youth Achievement Awards aim to recognise and celebrate young people who have demonstrated excellence in their peer group, have contributed to the community, or have been inspirational role models. The Awards also aim to encourage young people to develop a sense of responsibility for their community. WDHS, Blue Light (Hamilton Police), Glenelg & Southern Grampians LLEN, Standing Tall (supported by the Southern Grampians Youth Network) selected award winners each quarter.

→ Guest Speaker at this year's WDHS Annual General Meeting, Professor Steven Allender presents the WDHS Clinical Excellence Award to the Sub Acute Redesign Project team.

Montessori

MODEL OF CARE INTRODUCED

420K

FUNDING ANNOUNCED FOR BIRCHES REFURBISHMENT

20min rounding

FALLS RESEARCH COMMENCED

175 BEDS AVERAGING 92% OCCUPANCY FOR THE YEAR

100%

AGED CARE ACCREDITATION ACHIEVED

WDHS operates six aged care facilities in Hamilton, Penshurst and Coleraine, offering a holistic care model that supports clients to maintain their independence and special interests and offers comprehensive lifestyle programs.

Systems Improvements

Aged Care Governance

In 2015 Aged Care Governance was strengthened through the implementation of an Aged Care Governance Committee reporting to the Quality Improvement (QI) Committee. Three sub groups report to Aged Care Governance - People and Culture, Business and Innovation and Process and Technology. This ensures that quality aged care is person-centred, safe, effective, appropriate and reflects organisational quality goals. An Aged Care Strategic Plan has been developed for each sub group. A consumer representative attends the People and Culture Workgroup.

Occupancy

Maintaining maximum residential occupancy across the six aged care facilities ensures that WDHS's aged care services remain viable. Ultimately this means that the Health Service can continue to provide high quality care and services for the community.

Occupancy has been an ongoing challenge, however, with an improved focus on how it is managed right across the organisation, there has been an upward trend since December 2015. WDHS employs an Aged Care Placement Coordinator who assists with appropriate placement of residents in its aged care facilities. This role has proved vital in improving and maintaining the residential occupancy status.

Consumer Directed Care – Home Care Packages

The Grange administers 28 Home Care Packages (HCP). WDHS successfully transitioned to the Consumer Directed Care model for management of its HCP in July 2015, having developed a comprehensive service model and guidelines to support the change. The transition allows HCP recipients to assume greater control over their package, underpinned by the goals they set.

Capital Works

To ensure that residents live in safe and reliable facilities that meet relevant standards, WDHS continues to redevelop and refurbish each facility through planned capital works. Significant capital works and upgrades during the year included:

- Refurbishment of the Birches Psychogeriatric Unit
- Construction of a storage shed and carport at the Penshurst Campus
- Installation of new generators at both the Grange and Penshurst Campuses.

Initiatives and Partnerships

Shaping a Montessori Community

In partnership with Alzheimer's Australia, Victoria, WDHS adopted a Montessori Model of Care in its aged care facilities this year. Montessori philosophies are based on respect, dignity and equality. All aged care facilities at WDHS can offer every person (regardless of the level of care and support they require) an opportunity to engage in purposeful activities and make meaningful contributions to their community. In addition to having the opportunity to maintain, or even restore function. The model is evidence-based and person-centred and has been proven to improve the quality of life of the frail elderly and people living with dementia.

Dementia Care

WDHS has implemented a Dementia Game-Plan to apply best practice dementia care across the organisation. A Dementia framework is being developed and a gap analysis of the National Framework for Action on Dementia 2015 – 2019 is being conducted. A Montessori Regional Project Plan was also developed and implemented.

Dr Rosie Crone, a Geriatrician from Barwon Health has provided staff education on dementia and delirium.

Aged Care

→ Residents of the Grange enjoyed a drive by of 204 vintage cars on the RACV 2016 Fly the Flag Western Tour.

Geriatrician Telehealth Consultations

Telehealth Geriatrician consults are now available for residents and families in WDHS Aged Care facilities. The Geriatrician provides specialist dementia, delirium and continence care. The consults are delivered by Barwon Health specialists, in consultation with the client / resident's GP.

National Quality Indicator Program

WDHS has participated in the DHHS Victorian Public Sector Residential Aged Care Quality Indicator Program for many years. This program has received both national and international recognition in supporting health services to improve quality of care, as well as draw comparisons with other public sector residential aged care services. This program has now expanded to include national reporting and benchmarking and as part of the Aged Care reform process, the suite of indicators will be published on the Commonwealth's My Aged Care website and include a measure for quality of life and consumer experience, as well as current indicators collected including pressure injuries, unplanned weight loss and the use of physical restraint.

20-Minute Rounding Research Project

Falls in aged care continue to be problematic and often result in injury. Hourly 'staff rounding' of aged-care residents at high risk of falls (to observe and intervene if necessary), has been shown to be effective in reducing the incidence of falls and related injury. WDHS is embarking on a study to examine whether staff rounding on a 20-minute basis can reduce falls and minimise falls-related injury. This project is a collaboration of nursing and Allied Health clinicians in aged care at six WDHS sites.

Western Alliance Academic Health Sciences Centre (WAAHSC) is providing $30,000 to support this important research.

Quality Improvement and Risk Management

Aged Care Accreditation

Full Aged Care Accreditation compliance was achieved this year. Penshurst and Hamilton also underwent a full site audit. Facilities use this process as an opportunity to demonstrate the high quality care provided, as evidenced by successful compliance with all 44 outcomes.

Pressure Areas

The incidence of pressure areas continues to decrease at WDHS, with best practice management including risk assessment of residents and where necessary pressure area care, the use of pressure relieving equipment and mattresses and staff education. Each facility has wound care nurses under the expert guidance of wound care and infection control consultants.

Medication Management

Medication incidents are assessed through the Medication Advisory Committee, with recommendations and feedback provided to staff at all facilities.

Improvements include:

- Implementation of the Webster 7 medication system across WDHS
- New medication trolleys at Coleraine's Wannon Hostel
- Staff education
- System for checking medication charts each shift
- 'Do not disturb' aprons to help prevent distractions for staff dispensing medications
- Safety cross calendar
- External medication reviews
- Reconciliation process to validate Webster-paks.

Falls

WDHS continues to implement strategies to reduce the number of falls and fall related injuries including:

- Participation in the organisational Falls Working Party, which analyses all falls and makes recommendations
- Use of floor, bed and chair alarm mats
- Use of the Lets Eliminate All Falls (LEAF) system at the Birches, where a coloured leaf is placed on the resident's door as a reminder to staff of the clients falls risk
- Medication reviews
- In-depth case reviews conducted for all falls, with a significant Incident Severity Rating (ISR) 1 or 2
- Falls agenda items at resident / family meetings to educate and discuss self-management, to minimise the risk of falls
- Strength training and exercise programs
- Physiotherapy ,Occupational Therapy, Continence and Dietetic referrals, as required.

→ Leadership in Dementia Practice (Montessori Model) Project Officer, Angela Spillman demonstrates Montessori principles at a 2016 community information session.

GenR8 Change

210 COMMUNITY MEMBERS PARTICIPATED IN GENR8 CHANGE WORKSHOPS

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.

57 ACTIONS

THE SOUTHERN GRAMPIANS COMMUNITY IS WORKING ON TO ADDRESS CHILDHOOD OBESITY

$1.4M

ADDITIONAL FUNDING FOR GREAT SOUTH COAST REGION TO ADVISE AND EVALUATE OBESITY PREVENTION WORK

30M

PIECES OF ENERGY EFFICIENCY DATA COLLECTED TO EVALUATE 'GLENELG SAVES' RESULTS

Leading Practice

SGGPCP is forging new practice in the areas of obesity prevention in Portland and Southern Grampians and building resilience to climate change.

GenR8 Change – Obesity Prevention in Southern Grampians

Building on the experience gained through SEA Change Portland, GenR8 Change commenced in October 2015, with the establishment of a strong Ambassador Group of Southern Grampians 'change makers'.

Over 200 community members joined the social movement and committed to taking collective action across 57 areas. In the first six months a range of actions were achieved, including the removal of sugary drinks from sale at WDHS (an Australian first). Three schools held additional school community workshops and a further three schools made changes to canteen menus and curriculum. A very popular 'Bike Bus' was set up in Dunkeld to support children to ride to and from school. More breastfeeding friendly cafés were established and a forum of over 40 people explored options to further improve breastfeeding experiences in the region. The Hamilton Indoor Leisure and Aquatic Centre also surveyed the community to inform future menu changes at the Café.

Building Resilience to Climate Change

The Glenelg SAVES Project involved training 25 Glenelg Shire Home and Community Care (HACC) workers to carry out home energy audits. These workers audited their own homes and 300 HACC clients' homes. The significant data collection included sourcing energy usage information for all 320 homes. It established that there were considerable improvements to client's comfort and safety using this approach.

Enhancing Networks for Resilience (EN4R) is a new project that aims to understand how formal and informal networks are used to build community resilience around the changing climate. This new work includes building a Social Network Map to use as a tool to visualise the relationships between SGGPCP members and other significant stakeholders, facilitate the identification of strong ties and links to knowledge and provide a basis to strategically work to increase knowledge flow.

SGGPCP Partners

SGGPCP acknowledges and thanks WDHS for its work as the SGGPCP auspicing body.

Balmoral Bush Nursing Centre Inc
Brophy Family & Youth Services Inc
Casterton Memorial Hospital
Dartmoor & District Bush Nursing Centre
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

Chair: Nola McFarlane

Executive Committee Members:

Ann Kirkham (GSC), Fiona Heenan (PDH), Jackie Kellie (HRH), Mary-Ann Betson (CMH), Fran Patterson (WDHS), Gay Kelly (DWECH)

NCFH staff delivered Health and Lifestyle Assessments to farmers, farm workers and thier families in the Rural Bank marquee at the Sungold Field Days.

1 PHD SUBMITTED AND RECOMMENDED FOR THE CHANCELLORS RESEARCH MEDAL

3
NEW RESEARCH PROJECTS

516
COMPREHENSIVE FARMER HEALTH ASSESSMENTS

2,547
PEOPLE ATTENDED NCFH PRESENTATIONS

121,000
UNIQUE USERS ON WWW.FARMERHEALTH.ORG.AU

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.

Service Delivery

In July the NCFH received four years funding from the Victorian government and four new staff and four casual research assistants joined the Centre in 2015/16. An exciting new partnership also developed with Rural Bank, creating an opportunity for both organisations to invest in the health, wellbeing and safety of the most valuable asset in farming enterprises — farm men and women!

The provision of free comprehensive farmer health and lifestyle checks at agricultural field days in Victoria, South Australia and Tasmania has provided farm men, women and agricultural workers with access to health professionals trained in agricultural health and medicine, while attending their favourite agricultural events.

Over 350 farmers have taken the opportunity to invest in their health and over 70% were recommended for further follow up.

The Sustainable Farm Families (SFF) program recommenced with a Train the Trainer program in December and SFF workshops were conducted in Spalding and Yorke Peninsula, South Australia and Hopetoun Victoria.

Achievements and Highlights

- SFF was recognised as an example of best practice by the Victorian Mental Wellbeing Collaboration
- Expansion of AgriSafe™ clinics to Lake Bolac Bush Nursing Centre, PDHS and CDHS
- Additional funding for SFF in Alberta, Canada with over 200 farmers participating.

Research and Innovation

Successes this year included the commencement of three new research grants. The research areas covered farmer pesticide exposure, major trauma from farm injury, mental health and wellbeing and suicide.

Achievements and Highlights

- PhD candidate Alison Kennedy was recommended for the University of New England Chancellors Research Medal
- Shepherd Foundation grant for In Field Personalised Cholinesterase Assessment Project (PCAP) Research commenced
- *beyondblue* grant for The Ripple Effect received.

Reputation and Reach

The NCFH has a goal to extend its reach to farming communities locally, nationally and globally and it aims to achieve this through farmerhealth.org.au and its growing number of unique users (over 121,000). In August 2015 NCFH received the Health On the Net Foundation HONcode reaccreditation for quality health information on the internet.

Achievements and Highlights

- Reaccreditation with HONCode in August 2015
- Three peer reviewed articles published, one in print
- Stewards of the Soil photo competition exhibited at Federation Square, 1 Spring Street and Deakin University School of Medicine.

Education and Training

In February we welcomed Occupational Physician Gert Van de Laan, President of the Rural Health Scientific Committee of the International Congress of Occupational Health (ICOH), to observe the delivery of our Graduate Certificate in Agricultural Health and Medicine.

This year 24 students from four states and two international students studied the course. Other training of over 200 health and rural professionals has occurred through the Look Over the Farm Gate program and Rural Bank staff training.

Future Direction

The next 12 months sees the launch of the Ripple Effect website, ongoing research into farmer pesticide exposures, farmer health selective placements with final year students from Deakin University, the offering of PhD scholarships and continued extensive service delivery to farm men and women.

Career opportunities for the next generation of healthcare professionals were on show at the Careers in Health Day

Our People in the Workplace

LARGEST NUMBER OF APPLICANTS FOR RN GRAD PROGRAM IN 20 YEARS

RN & EN

GRADUATE OF THE YEAR AWARD INTRODUCED

4X

4 EXTRA RN GRAD AGED CARE POSITIONS OFFERED

NEW STAFF

WELLBEING PROGRAM

INTRODUCED

LARGEST EMPLOYER IN THE SOUTHERN GRAMPIANS

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. The HR team focus on best practice, streamlining policies and procedures, strategic workforce planning, training, health and wellbeing, research and building a positive well-equipped workforce.

Recruitment

WDHS Human Resources (HR) implemented a range of strategies to attract candidates to the region in 2015/16. The team also investigated the use of e-recruitment systems to provide better and more efficient recruitment practices and explored opportunities for sub-regional collaboration to enhance recruitment capability.

The implementation of the WDHS Aboriginal Employment Plan was a focus and work commenced on updating the Plan for 2016-19, to further develop a supportive environment for Aboriginal and Torres Strait Islander people.

Workforce planning

Online Retirement Survey

In May 2016 WDHS conducted its third Retirement Intentions Survey, with the response rate more than doubling that of previous years. The survey results provide a clearer picture of how long staff intend to remain employed in the organisation before retirement and importantly assist in developing meaningful strategies to support staff transitioning to retirement and succession planning.

People Matter Survey

During May, WDHS participated in the 2016 state-wide People Matter Survey, conducted by the Victorian Public Sector Commission. The survey measures workplace culture, establishing how engaged and satisfied staff are in the workplace, staff commitment, perceptions about diversity, wellbeing, sexual harassment and how well change is managed in the organisation. Survey results highlight staff perspectives on the application of public sector values and employment values and principles in the organisation.

Employee of the Month Program

Staff from a range of areas were recognised with awards for excellence in supporting WDHS core values through the Employee of the Month Program. The program is sponsored by local retailer, Darriwill Farm.

2015/16 Employees of the Month:

July
Lorraine Northcott, Bed Manager, Health Information

August
Melanie Russell, Aboriginal Employment Project Officer

September
Eleni (Helen) Guy, Patient Service Assistant, The Birches

October
Fay Picken, Personal Care Worker, Coleraine

November
Lesley Povey, Hotel Services Facilitator

December
Ann Curran, PPH Business Systems and Data Manager

January
Denise Beaton, Nurse Unit Manager, Coleraine

February
Sally Kinghorn, Learning and Development Administrator

March
Alison Wooldridge, Community Health Nurse, Merino

April
Lena McCormack, Trak Project Officer

May
Sheeja Santhinilayam, Associate Nurse Unit Manager, The Birches

June
Amber Fitzpatrick, Salary Packaging and Accounts Payable Officer

Statutory Compliance

During 2015/16, WDHS made no mandatory reports to the Australian Health Practitioner Regulation Authority (AHPRA) regarding health professionals.

There were also no reports under the Protected Disclosure Act.

Code of Conduct

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

Industrial Relations

No work hours were lost at WDHS as a result of industrial action during 2015/16.

Workforce Data

Employees have been correctly classified in workforce data provided for the 2015/16 year.

Learning and Development

Learning and Development (L&D) provides training to meet the needs of staff, ensuring they deliver the highest quality service and care to the community. Programs include clinical training for students and health professionals and a range of non-clinical courses to support professional development for all staff.

Best Practice Clinical Learning Environment (BPCLE)

In 2015 WDHS received DHHS funding for a project officer to continue the implementation of Best Practice Clinical Learning Environment principles. These principles are now fully embedded in the everyday practice of Health Service staff. The L&D team continually seek feedback from students and learners about their experience, to ensure these principles are being upheld across the organisation.

Clinical Education and Training

Undergraduates

WDHS has had another busy and positive year with Undergraduate Student Clinical Placements. This year saw an increase in the number of students gaining a quality placement at one or more WDHS campuses:

- 169 Nursing students
- 17 Medicine students
- 17 Allied Health students.

The students were studying with 14 different education providers across Australia. Six local secondary school students also completed VET/VCAL placements at WDHS. Feedback from students confirms that WDHS provides a positive placement experience and is a future workplace of interest.

Graduate and Second Year Nursing Programs

WDHS continues to enjoy the fresh and innovative ideas newly registered nurses bring to the Registered Nurse (RN) and Enrolled Nurse (EN) Graduate Programs. Both programs are designed to meet the changing needs of graduate nurses and the local community, through a positive, best practice learning environment.

In February 2016 ten RN Graduates completed the 12 month program and fourteen newly employed graduates commenced (ten Acute stream and four Aged Care). Seven participants embarked on the Enrolled Nurse Program in February and a further three joined the program over the following months.

Ashlee Marley (RN) and Carolyn Tonissen (EN) were recognised by Unit Managers and colleagues for their outstanding achievements during 2015 receiving 'Most Outstanding Graduate' awards.

Our collaborative partnership continues with Portland District Health and Moyne Health Service, with three graduate nurses rotating through the three organisations, as part of the Victorian South West Collaborative Graduate Nurse Program.

This year eleven enrolled and registered nurses continue along their career journey in the 2nd Year Program.

Workforce Profile 2016*	June Current Month FTE		June YTD FTE	
Labour Category	2015	2016	2015	2016
Nursing	234.50	234.59	233.47	232.75
Administration and Clerical	79.53	83.60	85.39	83.48
Medical Support	30.57	25.01	25.80	28.06
Hotel and Allied Services	125.03	127.15	131.81	126.96
Medical Officers	1.05	1.16	1.21	1.13
Hospital Medical Officers	9.82	17.38	13.41	13.25
Ancillary Staff (Allied Health)	48.07	52.78	42.66	48.48
Total	528.57	541.67	533.75	534.11

*2015 Comparative data changed to reflect new methodology of excluding applicable overtime.

10 Year Service Badges

Nyrie Adams
Susan Anson
Steven Bennett
Emma Coulthard
Jane Hartwich
Brian Kavanagh
Natasha Macdonald
Susan Macgugan
Patricia Matthews
Cassandra Milton
Yvette Morton
Jodie Nelson
Jennifer O'Brien
Rhianna Paton
Kylie Pearce
Jennifer Reeves
Janine Rhook
Anne-Marree Simonds
Judith Steadman
Rebecca Stewart
Ruth Thomson
Narelle Turnbull

15 Year Service Badges

Katherine Boyd
Kathryn Coote
Jennifer Dunstan
Judith Forsyth
Wendy Herring
Maureen Irving
Amanda Jubb
Joy Lambourn
Fiona Liddle
Pauline McLean
Judith McLeod
Lorraine McRae
Glennis Mellington
Coryn Meyers
Gary Meyers
Mark Newell
Lynette Peach
Laurice Picken
Valerie Rigby
Andre Steele
Sally Stratmann
Robyn Wilken
Michelle Woolley
Rowena Wylie

20 Year Service Badges

Angela Brown
Bobbie Clapham
Ricky Dennert
Margaret Grinham
Helen Holcombe
Catherine Jackson
Cherie Kennett
Heather McKenry
Leanne McLaren
Megan McLeish
Pamela Menzel
Sarah Roberts
Lee Ross
Julianne Thomson

25 Year Service Badges

Kerryn Feely
Julie Picken
Eileen Robertson
Michelle Rook
Jeanette Ryan
Jane Sharp
David Young

30 Year Service Badges

Ronda Baker
Mark Baker
Robyn Beaton
Deborah Egan
Paula Foley
Christine McGennisken
Bronwyn Roberts
Kathryn Ross
Kim Sheehan
Richard Trigger

35 Year Service Badges

Fiona Cogger
Leanne Deutscher
Sally Kinghorn
Margaret Mahoney
Wayne Mahoney
Jennifer O'Donnell
Ian Ross
Carol Scherek
Anne Sparke

40 Year Service Badges

Sally Clapham
Shirley Hayward

Graduate Diploma Programs

In 2015/16 WDHS supported two staff to complete their studies at Deakin University. One achieved a Graduate Diploma of Midwifery and continues to be employed at WDHS. Another staff member completed a Graduate Certificate in Critical Care Nursing.

Sue Hindson Professional Development Fund

WDHS is grateful to the Sue Hindson Professional Development Fund for its contribution to the education costs of staff working in either the Intensive Care Unit or Emergency Department.

Continuing Nursing and Midwifery Education

WDHS has continued to offer a variety of educational opportunities for nurses and midwives. Several sessions were delivered in the Learning and Development Centre as part of the Continuing Nursing and Midwifery Fund, which is coordinated by WDHS for the Barwon South West Region 4. A number of shorter presentations were conducted on the wards by WDHS subject matter experts. An increase in the number of WebEx presentations from other sites has allowed staff to also access these sessions for up to date information.

Non-Clinical Education and Training

In 2015/16 staff were again provided with opportunities to attend training in non-clinical subjects at WDHS. Topics included management of bullying and harassment, working in a purposeful and productive manner, communication and cultural awareness.

Twelve WDHS staff participated in a program with Vative Healthcare. On completion of this program, seven staff will have a dual qualification of Diploma of Practice Management and Diploma of Competitive Systems and Practices. Five others will have a dual qualification of Certificate IV in Administration and Certificate IV in Manufacturing and Technology.

Online Learning

In 2016, the SWARH group of health services began implementing a new learning management system. The implementation was undertaken in collaboration with 15 other sites in the Barwon South West region.

→ PDHS Food & Domestic Assistant, Liz Ewing.

Occupational Health and Safety

Health and Wellbeing Program

Wellbeing workshops delivered by Deakin University in 2015 created the groundwork for the development of a Staff Wellbeing Program.

The workshops aimed to create a shared understanding of the interrelated causes and effects of employee wellbeing. Participants generated a 'Wellness Map' and a prioritised list of ideas for potential responses to the map.

A Wellbeing Workgroup was formed and has delivered a number of wellbeing initiatives, including the Learn to Row program, Staff Olympics and Wellbeing Calendar. WDHS is committed to continuing to enhance staff health and wellbeing through the program.

Bullying and Harassment Training

In May, around 50 staff attended Workplace Safety and Sexual Harassment Training delivered by TressCox Lawyers.

EAP Promotional Video

To ensure all staff are aware of the Employee Assistance Program, a promotional video was produced to be rolled out in July 2017.

Emergo Train

Preparation commenced for an Emergo Train Exercise planned for July 21, 2016, to test WDHS Code Brown capabilities. External agencies will also attend.

OH&S Plan

A Corporate Services Division Occupational Health and Safety plan was developed and a standardised template will be rolled out to all divisions in 2016/17. This will allow for actions to be recorded on CAMMS and the evaluation of safety performance against KPIs.

OH&S Equipment Purchases:

WDHS continued its commitment to improving OH&S through its ongoing equipment procurement program. During 2015/16 WDHS invested $40,000 to make the workplace safer, purchasing the following items:

- Bariatric equipment
- Lifting cranes for work utes to reduce manual handling for Maintenance and Hotel Services staff
- Air curtain for the main kitchen rear exit airlock, to assist with insect control
- Upgrade of all District Nursing Services (DNS) phones for use of CFA Fire Ready app
- Height adjustable motorised delivery trolley
- Pronomic lifter and dollies to manoeuvre orthopaedic sets in Theatre
- Additional safety barriers for traffic control to be used across campuses.

Central Supply Model Improvements

In 2015, all Oracle sites in the Barwon South West Region adopted a centralised supply and procurement model, transitioning from four warehouses to a single, central warehouse in Warrnambool. In response, a review was conducted to identify manual handling and infection control issues. Tenders were submitted for the supply and installation of a range of storage options for the Surgical and Medical Units, Operating Suite and PDHS, to maximise space, meet infection control guidelines and reduce manual handling risks. $20,000 was allocated for this project.

Funding

WDHS received $10,000 from the DHHS to improve Code Brown Emergency Management equipment. The funding purchased colour coded trolleys to store and transport Code Brown Emergency Management kits, a six metre safety barrier for the HBH campus and two UHF hand held radios for emergency control centres to meet CFA communication requirements.

Worksafe Visits

WDHS participated in a Worksafe Emergency Management Project, with an audit conducted in April 2016 and achieved outstanding results in all areas, with two minor suggestions for improvement.

The Health Service also participated in a Worksafe Occupational Violence and Manual Handling Project with an audit commencing in June 2016 of the HBH campus, with no recommendations. Further audits are planned for CDHS and PDHS (July 2016).

There were no Worksafe notifiable incidents in 2015/16.

WorkCover Premium

The total premium for 2015/16 was $606,022. The premium rate for this period was 1.8719 %. This is an increase of 31.7% compared to the previous year.

Chemical, Biological, Radiological (CBR) Incidents

No CBR incidents occurred during the year where the exhaust mode of ED was activated.

Occupational Violence Statistics	2015/16
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	38
4. Number of occupational violence incidents reported per 100 FTE	7
5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0%

→ WDHS Painter, Ben Taylor primes Christmas Art Project cut outs for decoration by local Primary School and Kindergarten children and Aged Care residents.

Corporate Support Services

100%

FOOD SAFETY AUDIT COMPLIANCE

99%

EXTERNAL CLEANING AUDIT COMPLIANCE

213,000

MEALS PRODUCED IN THE HAMILTON BASE HOSPITAL KITCHEN

7,650

WORK REQUESTS COMPLETED BY MAINTENANCE

SUBREGIONAL AHSFMA FINANCE TEAM OF THE YEAR AWARD

Corporate Services provides non-clinical support to WDHS's operations. Several Corporate Service departments work directly in clinical areas, including the catering and environmental service teams, while others provide maintenance, business, administrative finance, payroll, human resources and information technology support.

New Initiatives

Sub Regional Corporate Services Project

In 2015 funding was allocated for a project to identify opportunities to collaborate further with other Health Services to establish a more robust corporate and financial service delivery and workforce model.

WDHS is the lead agency on this project, with Patrick Turnbull, former Director of Corporate Services, the Project Officer. The core agencies involved are WDHS, Portland District Health, Casterton Memorial Hospital, Heywood Rural Health, Balmoral Bush Nursing Centre and Dartmoor and District Bush Nursing Centre.

The project aims to develop a sustainable service and workforce model to provide Finance and Corporate Services functions across the sub region that will improve health service resilience, finance and corporate service coverage, business intelligence capability and use of resources on value add projects.

It builds on existing alliances, partnerships and shared services to formalise further improvements and will eliminate waste and duplication of resources by standardising processes, sharing expertise and systems and reducing compliance requirements to allow resources to be redirected to value add work.

The project is a time limited collaboration and is scheduled to be completed by the end of 2016.

Non-Emergency Patient Transport

Health Purchasing Victoria (HPV) facilitated a Non-Emergency Patient Transport (NEPT) tender in April 2015. Two NEPT providers were recommended in the South West Zone for health agencies to explore and potentially engage. South West Healthcare, Portland District Health and WDHS collaborated to assess each NEPT provider, with the intention of making a joint appointment.

National Patient Transport (NPT) was the selected provider for the region. The NPT proposal ensured that two vehicles would be based in Warrnambool and one in Hamilton, providing coverage for all health services in the South West region. The new service commenced in April 2016 and is expected to deliver savings of $60,000 per annum.

Electronic Car Booking System

In May 2016, WDHS implemented an electronic car booking and fleet management system to replace the existing manually intensive paper based process. The new system will improve all aspects of fleet management and assist with compliance requirements.

Fleet vehicles are used to deliver a variety of services, including District Nursing, Allied Health and Infection Control. The cars also transport staff to training sessions and meetings.

Initially implemented for the Hamilton Base Hospital's fleet of 28 vehicles, there are plans to extend use of the system to the Coleraine and Penshurst Campuses.

→ NPT Patient Transport Officer, Chris Eccles with WDHS Chief Executive, Rohan Fitzgerald, NPT Northern Region Manager, Clyde Scorgie and WDHS Director of Corporate Services, Nick Starkie

Waste Management

The Health Service's existing general waste contractor ceased business in November 2015. Following a detailed analysis of available options, WDHS decided to manage its waste services in-house. The in-house waste management service commenced in February 2016 and the new arrangement is expected to generate substantial cost savings compared to the market rate.

Achievements

Meals on Wheels Tender

WDHS was re-awarded the Southern Grampians Shire Council Meals on Wheels contract for two years, effective July 2016.

National Finance Team of the Year Award

The Finance & Supply teams of South West Healthcare, Portland District Health, Colac Area Health and WDHS were recognised with the 'National Finance Team of the Year' award at the Australian Health Services Financial Management Association (AHSFMA) National Conference. The four agencies worked together to lead the establishment of South West Supplies and Logistics, which consolidates the supply and logistics operations of the four agencies in the South West Region of Victoria. A Central Supply hub was established in Warrnambool and all agencies transitioned without any major disruptions. The cost of supply has been reduced and resources reinvested to add further value and support to clinical operations.

OH&S Generic Template

The Corporate Services Division Occupational Health & Safety (OH&S) Plan has been adopted across the Health Service as the OH&S template, to provide a safer environment for all staff.

Compliance

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

Health Purchasing Victoria Reform

Health Purchasing Victoria (HPV) developed a new policy framework effective 26 June 2014 to cover the broader internal procurement practices of health services, to ensure they align with the Victorian Government Purchasing Board's new policy framework. The HPV Board approved a twenty-four month transition period for all public hospitals and health services were mandated to comply with the health purchasing policies effective 30 June 2016. WDHS has been participating in a sub-regional collaborative to ensure compliance. In addition, an internal working group involving all major spends across the Health Service has overseen this transition since January 2016.

The five new HPV policies are:

Policy 1 - Procurement Governance

Policy 2 - Procurement Strategic Analysis

Policy 3 - Market Approach

Policy 4 - Contract Management & Asset Disposal

Policy 5 - Collective Purchasing

WDHS will be required to undertake a compliance audit during 2016/17 and provide an audit report to the HPV Chief Executive by 30 June 2017.

Health Legal System

WDHS transitioned to a new compliance reporting system - Health Legal / Riskman. This system replaced the BACES reporting system. The Corporate Services Division has overseen this transition, with legislative topics delegated to responsible officers and training facilitated.

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 conducted by RSM Bird Cameron, independent internal auditors contracted by the WDHS Board. Activities conducted by the internal auditors and the Auditor General Agent for the period of July 2015 to June 2016 requiring governance from the Audit & Compliance Committee included:

- Audit Committee Approval of WDHS 2014/15 Annual Finance Statements
- Audit Committee Approval for appropriation to reserves for 2014/15
- Audit Committee Approval for Risk Management Attestation
- Audit Committee Approval of 2015/16 Operating Budget Assumptions & Parameters
- Internal Audit Plan 2015/16
- Internal Audit – Review of 2015 Financial Management Compliance Framework
- Internal Audit – Review of Visiting Medical Officer Payments (Controls & Mechanisms)

Food Compliance

Health Service kitchens were issued with Food Premises Registrations in 2016. All WDHS kitchens achieved 100% compliance with the WDHS Food Safety Plans and were issued with certificates of compliance. To achieve compliance, each kitchen complied with 45 mandatory food safety standards.

Cleaning Compliance

The annual external cleaning audit was conducted in July 2015 and WDHS achieved a compliance score of 99%, exceeding the DHHS benchmark by 9%.

Maintenance Compliance

- A safety audit was carried out in May to assess compliance with the Bus Safety Act (BSA) 2009 (Vic) - in particular the conditions set out for Bus Operators.
- The VMIA Site Risk Audit was completed in October 2015. The report issued was an excellent outcome for WDHS, with only a small number of minor recommendations needing to be actioned.
- An asbestos five year re-audit at all campuses is required under legislation and air monitoring was completed at HBH with an updated management plan to be implemented.

Sustainable Energy – Carbon & Water Performance

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

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

The public report against the management plan was completed in December 2015 and is available on the website: www.wdhs.net

Capital Works

Significant capital works and upgrades during the year included:

- New fire ring main and sprinkler system upgrade project completed in May 2016 at a total cost of $1.2 million (a certificate of final inspection was issued 23/5/2016)
- Emergency generator upgrades were carried out at both Penshurst and the Grange, at a total cost of $191,000
- Works commenced in June 2016 to upgrade the Hamilton Medical Group air conditioning system and the Hamilton Base Hospital kitchen cooling system (both works are due for completion in September 2016)
- Resealing of the NCFH driveway.

ICT Expenditure

The total ICT expenditure incurred during 2015/16 is $3,384,455 (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)
$3,293,911	$90,544	$90,544	-

Our Community Partnerships

WDHS has for many years been remarkably well supported by its community. In appreciation, the Health Service has committed to creating events and initiatives that support healthier, happier communites.

$50K

RAISED AT MISCHIEF WITH MARNEY DINNER

PUBLIC DEFIBRILLATOR ACCESS PROJECT FUNDED

$1.4M

TOTAL DONATIONS / FUNDING RECEIVED

300

VOLUNTEERS SUPPORTED OUR WORK

1,500 WDHS FACEBOOK PAGE LIKES

WDHS has for many years received incredible support from its community and the 2015/16 year was no exception. The organisation received a total of $1.4m in bequests, grants from trusts and foundations, appeals and fundraising.

Its 300 plus big-hearted volunteers, many who help deliver programs on a weekly basis, are also testimony to the incredible dedication of others to ensuring the Health Service is well equipped to meet the healthcare needs of its community.

Giving back

In appreciation for this support, WDHS committed to delivering a range of projects and events to give back to the community this year.

International Women's Day Luncheon

In March over 120 local women and men celebrated International Women's Day at a WDHS luncheon. Guest Speaker, Avril Hogan delighted guests with her inspiring and down to earth message about creating opportunities regardless of where you live and supporting others to achieve their goals.

Lifesaving Public Defib Access

Supported by a Southern Grampians Shire grant, WDHS worked with local businesses to fund public defibrillator access in the Hamilton CBD. The defibrillators will be installed at Woolworths, Coles and the Hamilton Spectator in July '16.

Shake Off Sugar Program

WDHS is developing a web-based school fundraising tool that aims to motivate kids to make better food and lifestyle choices.

Christmas Community Arts Project

In December WDHS celebrated Christmas through art when it kicked off its Community Arts Project. Six local schools and kindergartens and several aged care facilities took up the challenge to decorate Christmas cut outs created by the WDHS Maintenance Team.

The figures were judged and put on display, adding to the Christmas cheer and atmosphere at Hamilton Base Hospital.

Wellbeing Program Support

Part of the philosophy of the Staff Wellbeing Program is to engage staff in activities that support other community organisations and businesses. To this end, over 40 people participated in the Rowing Program this year, a number who continue to be seen out on the water with the Hamilton Rowing Club. WDHS will continue to create partnerships with local businesses and groups to engage and support local enterprises and activities.

Hamilton Boomers Sponsorship

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

Fundraising

Fundraising at WDHS is conducted in accordance with the Fundraising Appeals Act 1998 and the Fundraising Institute of Australia Ethical Codes of Fundraising. It is guided by the Development Council; an eleven-member committee of community representatives, WDHS Board members and staff. Community Liaison manages the overall fundraising strategy on behalf of WDHS. In addition to fundraising events, functions and appeals the Department submits applications to philanthropic trusts and foundations.

Cancer Redevelopment

In 2015/16 funds raised at many WDHS events were directed to the cancer treatment area redevelopment at Hamilton Base Hospital. This project will greatly improve the delivery of cancer care in the region.

Funds raised at the following events will support the construction of the new treatment area:

A Night of Mischief with Marney

Over 200 guests enjoyed a night of comedy and mayhem at the Mischief with Marney dinner in August. The event raised over $50,000.

Vitality Fun Run

Over 330 participants walked or ran the 8th Hamilton Vitality Fun Run in November. The popular event raised $8,000.

Cocktails in the Courtyard

Over 150 people enjoyed a perfect summers evening mingling in the Handbury Courtyard at Hamilton Base Hospital, raising over $7,000.

Murray to Moyne Cycle Relay

The annual Murray to Moyne Cycle Relay was held in March and the Hamilton Base Bikers team of 18 riders once again took up the challenge to ride from Mildura to Port Fairy. The team raised $10,000 for Allied Health equipment purchases and $5,700 for the cancer treatment area.

Op Shop Golf Tournament

In its sixth year, the popular Op Shop Golf Tournament raised $15,000 for an electrocardiograph (ECG) machine for the HBH Emergency Department. Around 120 golfers enjoyed a stormy day on the greens at the Hamilton Golf Course and battled it out in the Ambrose Stableford competition. Since the first tee off in 2009, this popular golfing fundraiser has generated in excess of $85,000 for WDHS.

Appeals

Christmas Appeal

The Annual Christmas Appeal raised $24,000 in 2015/16. The funds purchased an orthopaedic drill and oscillating saw for the HBH Operating Theatres, to support an increase in orthopaedic procedures following the recruitment of a new visiting specialist.

WDHS Door Knock Appeal

Over 120 volunteers door knocked for the Hospital in May, one month earlier than in previous years. The door knockers visited homes in Hamilton, Penshurst, Cavendish and Dunkeld. A mail-out was also conducted in several rural areas. A total of $51,000 will be directed to the oncology redevelopment. Funds collected in Penshurst totalling $9,000 will purchase items for the Penshurst Campus.

Donors and Supporters

Many community groups and individuals gave WDHS substantial financial and in-kind support throughout the year.

Darriwill Farm continued their 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 and IGA Hamilton contributed to WDHS through the Community Benefits Scheme.

Contributions over $3,000

Coles Supermarket	$3,076
Collier Charitable Fund	$37,600
Hamilton Base Hospital Ladies Auxiliary	$5,500
Dr Geoff Handbury AO	$60,000
Hospital Opportunity Shop	$12,000
Estate of Gordon Stanley McGregor	$6,380
North Hamilton Base Hospital Auxiliary	$5,000
The Estate of Rupert Rentsch	$1,000,000
The Weston Family	$29,000

Thank You

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 2015/16 year. A list of donors contributing $100 or more is shown on page 32.

Auxiliaries and Community Groups

WDHS is very grateful for the continued support of its hard working auxiliary members.

The five auxiliary groups, Hamilton Base Hospital Opportunity Shop and Hamilton & District Aged Care Trust again contributed substantially to support the Health Service. The North Hamilton Ladies' Auxiliary purchased blood pressure monitors, lifting equipment and Kingstone chairs with their annual donation of $5,000.

The Hamilton Base Hospital Ladies' Auxiliary purchased an ICU equipment trolley, chair scales and a number of other items for the Surgical and Medical Units at a cost of $5,500.

The 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 continued to actively fundraise to support WDHS Aged Care facilities.

The Coleraine District Health Service Ladies' Auxiliary raised $944 for Coleraine Hospital. The Coleraine Homes for the Aged raised $1,500 and the Coleraine Opportunity Shop donated $900 for Coleraine District Health Service (CDHS).

After fundraising for this cause for a number of years, the Penshurst and District Ladies Auxiliary purchased a storage shed and carport at a total cost of $22,000. Throughout the year the Auxiliary donated a further $3,000 to the facility.

Opportunity Shop

The Hamilton Base Hospital Opportunity Shop opens five days a week and is staffed by up to four volunteers each day. The Op Shop donated $7,000 to purchase an Accuvein for the Medical Unit and continued its annual $5,000 major sponsorship of the Golf Tournament.

→ The Hamilton Base Bikers Murray to Moyne team and support crew prepare to set off on the 2016 ride.

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 Awards

The Palliative Care team and Hamilton Base Hospital Auxiliary and events volunteer, Roma Tully were both nominated for a Minister for Health Volunteer Award in 2016.

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

July
Bill Edge, Community Transport

August
Hermina Schaap-Russeller, Coleraine PAG

September
Des King, Community Transport

October
Elizabeth Gribbin, HBH Ward / Information / Grange

November
Allan Olive, Community Transport

December
Jenny Groves, The Birches

January
Francis 'Frank' Willey, PAG

February
Neil Sandford, WDHS Waste Management, Penshurst PAG

March
Cindy Benson, HBH Ward, Palliative Care

April
Wes Walter, Community Transport, Events

May
Rayleen Holliday, The Grange

June
Katie Benson, Penshurst, PDHS PAG

Life Governors

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

→ 2016 Life Governor recipients Dr Geoff Coggins and Mary-Ann Brown (pictured with Board President, Hugh Macdonald).

Volunteer Program Hours 2015/16

Program	Volunteers	Hours
Hamilton Community Transport	58	3,534
Hospital Opportunity Shop	17	5,703
Comforts Trolley	9	130
Hospital Door Knock Appeal	120	250
Golf Tournament	15	120
Vitality Fun Run	4	16
Hospital Harmonies Choir	4	26
The Grange	19	894
The Birches	17	672
Meal Buddies	2	225
Palliative Care	10	274
Penshurst District Health Service	7	884
HBH Ward	7	1,377
Delta Dogs	3	106
Planned Activity Group Hamilton	13	913
Community Liaison Support	2	50
Coleraine Aged Care	14	1,511
Coleraine Community Transport	38	817
Merino	18	1,222
Total Hours		18,724

Gifts Over $100

Mr & Mrs E & G Acreman
Mrs S Adams
Mr and Mrs J & J Addinsall
Mrs J Aitken
Mrs J I Alexander
Mr and Mrs D & D Alstin
Mr and Mrs M & A Archer
Mr R Astbury
Mr T Auden
Mr and Mrs K & F Barber
Mrs M Barber
Mr and Mrs J Barke
Mrs J Barnes
Mr and Mrs CJ Baulch
Bensch Family
Mr and Mrs W & C Blackwell
Anonymous
Mr and Mrs G & B Botterill
Mrs I K Boyd
Breast Cancer Support Group
Mr and Mrs K Brennan
Mr and Mrs C Brinkmann
Ms E Britten
Mr and Mrs D & C Brooks
Mr R E Brown
Mrs Alison Brumby
Mr & Mrs P and B Bunney
Mr and Mrs G S Burger
Mr S Burger
Ms A Burne
Mr and Mrs A R Burrowes
Mr and Mrs H Caldow
Mr and Mrs G & R Cameron
Mrs Louise Cameron
Ms Megan Campbell
Mr Richard Canapini
Chillmech Services
Mr & Mrs N & D Claydon
Mr and Mrs G & P Coates
Dr G & Mrs L Coggins
Mr and Mrs I Colclough
Mr and Mrs D Coldbeck
Coleraine District Health Service Ladies Auxiliary
Coleraine Opportunity Shop
Coles Supermarket
Reverend Peter Cook
Mr Brian Cordy
Miss Mary Cox and Miss Mareeta Cox
Dr L & Mrs E Cummins
Mr R J Cunningham
Mr and Mrs John Dean
Mr John Dempster
Mr & Mrs S & J Donehue
Mr and Mrs K J Doyle
Mr and Mrs Hayden Duncan
Mr J Duyvestyn
Mr & Mrs S & G Eats
Ms Margaret Egan
Elders Insurance
Mr and Mrs JMW Ellis
Mrs Louise Emsley
Equity Trustees Ltd
Equity Trustees Ltd
Mr John Ernst
Ms Anne Ferguson
Mr and Mrs Ross Fitzgerald
Mr and Mrs Peter Flinn
Mr and Mrs G Fry
Mr and Mrs Peter Fry
Mrs L Fulton
Mr and Mrs R & E Gardiner
Mr and Mrs R & J Gardner
Mr and Mrs D & H Garfoot
Misses Eleanor & Helen Gartner
Mr Jock Gash
Mr and Mrs G & R Gebert
Mr and Mrs A & R Gledhill
Mr and Mrs RJ & GV Gordon
Mr and Mrs J & M Gough
Mr Ralph Greaves
Mr and Mrs P & J Greenaway
Mr and Mrs M & J Grimwade
Mrs Amanda Gubbins
Hamilton Anglican Mothers Union
Hamilton Base Hospital Ladies Auxiliary
Hamilton P & A Society
Dr Geoff Handbury AO
Mr D J Hearn
Mrs Margaret Herd
Mr and Mrs L & M Herrmann
Mr and Mrs M & P Hill
Mrs Anne Hindson
Mr and Mrs C & S Hines
Hospital Opportunity Shop
Mr and Mrs R & K Huf
Dr Noel Hyslop
Interchurch Social Committee
Mr and Mrs R Irvine
Mr & Mrs & J Ivory
J M Ellis & Co.
Mr R Jackson
Janah Administration Pty Ltd
Mr H Jansen
Mrs J Jones
Mr and Mrs B & W Kearney
Kellys Merchandise
Mr and Mrs J & H Kelsall
Mr & Mrs D & J Kennett
Mr and Mrs W & J Kinnealy
Mr H Klein
Mrs P M Koenders
Mr and Mrs N & S Kruger
Ms D Langford
Mrs D Lanyon
Mr and Mrs H & P Leech
Mr G Leech
Mr and Mrs M & R Leeming
Mrs L Lehmann
Mrs J Lewis
Mr and Mrs PW Lewis
Mrs G Leyonhjelm
Mr N Linke
Mr and Mrs G & R Linke
Mrs G Linke
Lions Club Hamilton
Mr and Mrs L & V Lovell
Mr and Mrs H & J Macdonald
Mr and Mrs D & S MacGugan
Mr and Mrs HH & S Mackinnon
Mackkcon Homes
Mr and Mrs N & H MacLean
Mr and Mrs E & M MacLean
Mrs E A Mathews
Mrs E Mayfield
Mr W & E McDonald
Ms J McDonald
Mr and Mrs D & S McFarlane
Mr and Mrs M & S McGinnity
Mr and Mrs S & H McKenry
Mr M McKinnon
Mr P McLean
Mr A McLeod
Mrs R Mercer
Midfield Meats
Mrs M Moore
Mrs J Morice
Mr and Mrs J & AR Morgan
Mrs G Muir
Mr and Mrs J & E Nagorcka
Mr and Mrs D & J Nagorcka
Mr and Mrs J & J Nagorcka
Mr R Napier
Ms M Nolte
North Hamilton Base Hospital Ladies Auxiliary
Mr I & Z Noske
Mrs P Oliver Snell
Pigeon Ponds Sports Club
Mr K Presser
Mr R & L Purvis
Mrs H Rae
Mr M Rees
Mr and Mrs D & J Rentsch
Mr J Rentsch
Mrs G Rentsch
Mr and Mrs J & C Roads
Mr and Mrs J & S Robertson
Mr and Mrs R & A Robinson
Mr and Ms J & K Scholfield
Mr and Mrs M & R Schultz
Searle Family
Mrs L Slorach
Mrs E Smith
Mrs N Smooker
Mr and Mrs F & D Soulsby
South Kolor Partnership
Southern Grampians Livestock & Real Estate
Stanich Partnership
Mrs E Staude
Mr and Mrs R & L Stewart
Mr R Sutherland
Tarrington Women's Guild
Mrs M Taylor
Ms R Testro
Mr M Thomas
Mrs C Thomas
Mr and Mrs M & B Todd
Mr I S Troeth
Mr J Trotter
Mr P Tung
Mr A Walsh and Ms N Turner
Mr L Uebergang
Mr & Mrs N & I Van Zyl
Mrs M Walker
Rev F Walker
Mr and Mrs A & R Walkom
Mr D Walter
Mrs M J Waters
Mr and Mrs J & J Watt
Mr and Mrs P & M West
Weston Family
Mr and Mrs P & C Wettenhall
Mr and Mrs C & V Whitehead
Mr & Mrs A Willis
Mr Wilson
Mr and Mrs P & L Young
Mr J Young

Mischief with Marney Major Sponsors

ACE Radio
Dorevitch Pathology
Bendigo Radiology
ILUKA Resources Ltd
Jigsaw Farms
The Kerr Family
Woolworths Hamilton
Rococo Events
Café Catalpa
Candied Lime Catering

Fun Run Major Sponsors

Australian Bluegum Plantations
Hamilton Vitality
Ace Radio

Golf Tournament Major Sponsors

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

National Centre for Farmer Health

Western District Ball
Geelong Gentlemen's Lunch
Mellow in Yellow - Live Rural Ltd
Devondale Murray Goulburn Run 4 Farmer Health Team
Run 4 Farmer Health team members
Dairy Australia
Victorian Farmers Federation and Royal Agricultural Society Victoria
The Searle family
Bass Coast Branch - Victorian Farmers Federation
Dairy Australia Social Club
Cohuna District Hospital

Community members and clinicians may value different aspects of quality care. While the clinical focus is often on the results of the clinical care provided, consumers might consider aspects relating to timeliness, access, and communication. All agree however, that the key to delivering a quality health service, is providing skilled and competent staff, a clean, safe, welcoming environment and appropriate service.

Governance

Governance is essentially being accountable for providing good safe care and continuing to improve patient / client safety. The WDHS Board of Management has a number of committees to ensure a safe and effective workplace:

- Penshurst Advisory
- Coleraine Advisory
- Executive
- Audit and Compliance
- Consumer Advisory
- Quality Improvement Coordination
- Credentialing
- Medical Consultative.

Quality and Safety Framework

The WDHS quality and safety framework describes the structured process around safety and quality initiatives, data collection and continuous improvement, to ensure the community receives safe and high quality health services. It has at its core the four domains of quality and safety:

- Consumer participation
- Clinical effectiveness and appropriateness
- Effective workforce
- Risk management.

Consumer Participation

The involvement of consumers, carers and community members as active participants in planning, improvement processes and evaluation of services ensures that organisations are responsive to the views, opinions and needs of the communities they serve. WDHS consumer participation strategies and functions include:

- Consumer Participation Plan
- Consumer Advisory Committee (CAC)
- Consumer feedback system to inform planning and improvement activities
- Diversity Policy and Plan
- Process of open disclosure for adverse events that cause patient harm
- Publication of the annual Quality of Care Report
- Promotion of patient rights and responsibilities to the community, consumers and staff
- Suite of patient brochures and information reviewed by consumers
- Active patient involvement in planning and taking responsibility for their care through day to day activities and collaborative care planning
- Action on results of Victorian Healthcare Experience Survey.

Clinical Effectiveness and Appropriateness

Clinical effectiveness and appropriateness is ensuring the right care is provided, to the right patient, who is informed and involved in their care, at the right time, by the right clinician, with the right skills, in the right way. WDHS strategies and functions to ensure clinical effectiveness and appropriateness:

- Mechanisms in place to meet accreditation standards
- Evidence based clinical policy development and care delivery
- Clinical risk assessments performed to plan and coordinate care
- New procedures and therapies introduced in consideration of quality and safety issues.

Effective Workforce

All staff employed at WDHS are required to have the appropriate skills and knowledge required to fulfil their role and responsibilities in the organisation. WDHS strategies and functions to ensure an effective workforce include:

- Recruitment and selection policy and process
- Credentialing process for all medical officers (Credentialing and Defining the Scope of Practice Policy and Australian Health Practitioner Regulation Agency)
- Clearly defined position descriptions that communicate expectations and standards of performance
- Sound performance appraisals and performance management system
- Commitment to training, mentoring and continuing professional development
- Staff satisfaction survey (People Matter).

Risk Management

Risk management integrates the management of organisational, financial, occupational health and safety, plant, equipment and patient safety risk.

Minimising risk and improving safety of care requires a systems approach. Risk management and improvement strategies are integrated into improvement and performance monitoring functions. WDHS strategies and functions to manage risk and improve safety include:

- Committee reporting structure with Board representation
- Risk register which is regularly monitored and updated
- Legislative compliance requirements system
- Financial management strategies
- Incidents are investigated and underlying systems issues and root causes are identified
- Incident severity escalation process is in place
- PROMPT electronic system to manage policies, protocols and procedures
- Equipment maintenance schedule
- External contract reviews
- Emergency response system including Business Continuity Plan
- Internal and external audits
- Workplace safety strategies.

Accreditation

Accreditation is a recognised process that health services use to ensure they deliver safe, high quality health care to established standards for their patients / clients / residents.

Accreditation is a mandatory process for all Victorian public acute health services and all providers of residential aged care services. WDHS participates in a number of comprehensive accreditation programs including the Australian Council on Health Care Standards (ACHS) and Aged Care Standards and Accreditation Agency Ltd (ACASA). WDHS will be undergoing an accreditation review against the 10 National Safety and Quality Health Service (NSQHS) Standards in October 2016.

National Safety and Quality Health Service (NSQHS) Standards

The Australian Commission on Safety and Quality in Healthcare developed the standards which provide a nationally consistent and uniform set of measures of safety and quality for application across a wide variety of health care services. The NSQHS Standards aim to drive the implementation and use of safety and quality systems and improve the quality of health service provision in Australia.

The NSQHS Standards focus on areas that are essential to improving patient safety and quality of care:

1. Governance for safety and quality in health service organisations
2. Partnering with consumers
3. Preventing and controlling healthcare associated infections
4. Medication safety
5. Patient identification and procedure matching
6. Clinical handover
7. Blood and blood products
8. Preventing and managing pressure injuries
9. Recognising and responding to clinical deterioration in acute healthcare
10. Preventing falls and harm from falls.

Corporate Governance

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 10 committees, which meet as required and report back to the BOD.

Board of Directors

Hugh Macdonald

BBacc

Hugh has worked in the finance industry since 1982 and is currently a Relationship Manager for Rural Bank in Hamilton, while also running the family sheep farm. Hugh is a Director of The Hamilton and Alexandra College Foundation, a Trustee of The Hamilton and Alexandra College Old Collegians and a Board Member of the National Centre for Farmer Health. He is a past President of the Hamilton Racing Club and the Hamilton Junior Basketball Association. He chaired the fundraising committee for the Hamilton Indoor Leisure and Aquatic Centre, raising in excess of $750,000. Appointed to the WDHS Board in November 2006, 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, 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. He is a member of the Advisory Committee for the Hamilton District Skills Centre. Mark is also a member of the Association of Heads of the Independent Schools of Australia and the Principals' Association of the Victorian Catholic Secondary Schools. Appointed to the WDHS Board in July 2011, current term expires 30 June 2017.

Ian Whiting

Ian is Managing Director of Bassett Estate Pty Ltd and is a Director of Club Solutions Australia Pty Ltd and Charity Bid Pty Ltd. Ian is a past Chair of the Top of the Town Charity Ball 2010 and the Branxholme Progress Development Group Fundraising Committee. Ian was Deputy Chair of the South West Academy of Sport, VCFL South West Border Regional Manager and Chair of the VCFL Regional Board. He is a past President of the Hamilton Junior Football League and College Magpies Junior Football Club, a past Founding President of the Smokey River Land Management Group and past President and Captain of the Morven CFA RFB. Appointed to the WDHS Board on 1 July 2011, current term expires 30 June 2017.

Darren Barber

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

Darren is the Organisation Development Manager at Warrnambool City Council. He has over 18 years' experience in Human Resource Management and Workforce Development from both an organisation and regional demographic 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, Mitchell Park Kindergarten Committee and has also acted as a regional delegate for the VECCI Business and Employment Forum. Appointed to the Board in July 2013, 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 and various secondary teaching positions. She is currently teaching at Monivae College and runs a mixed farming enterprise north of Hamilton with her partner David. She is also a Director of DCF Marine Pty Ltd. Appointed to the WDHS Board on 1 July 2014, current term expires on 30 June 2017.

Fleur Calvert

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

Fleur is a qualified solicitor, specialising in the areas of construction and litigation. Prior to moving to Hamilton, she was a Director of the not-for-profit organisation The Benjamin Andrew Footpath Library, as well as being involved with the National Gallery of Victoria, the Starlight Foundation and the Anti-Cancer Council. Fleur also has a Post Graduate Diploma in Human Resource Management and Industrial Relations, and briefly worked in the Human Resource Management area. Since moving to Hamilton she sits on the Committee of Management for Standing Tall Hamilton, and is an active member of The Hamilton and Alexandra College community. Appointed to the WDHS Board on 1 July 2015, current term expires 30 June 2017.

Corporate Governance

Peter Besgrove

BCom, MIR

In a long corporate career, Peter held senior executive positions in a number of global organisations as a HR business partner and has managed teams of HR professionals across a number of countries with diverse social, industrial and legal environments. Peter has now relocated from Melbourne to live in Dunkeld. Peter is also currently Deputy Chair of the Grampians Tourism Board. Originally appointed to the WDHS Board on 1 July 2014, Peter has been re-appointed, with his current term to expire 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, and is a 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 on 1 July 2015, current term expires 30 June 2018.

BOARD MEMBER	BOARD MEETINGS ATTENDED	COMMITTEE MEMBERSHIP AS AT 30 JUNE 2016	COMMITTEE MEETINGS ATTENDED
Hugh Macdonald	10 of 11		
		Audit & Compliance	3 of 5
		Medical Appointments	1 of 1
		Development Council (joined April 2016)	1 of 6
		Coleraine Advisory	6 of 7
		Medical Consultative	2 of 2
Jenny Hutton	10 of 11		
		Development Council	6 of 6
		Penshurst Advisory	4 of 5
Adele Kenneally	11 of 11		
		Quality Improvement	5 of 7
		Community Advisory	5 of 6
Mark McGinnity	10 of 11		
		Medical Appointments	2 of 2
		Development Council	6 of 6
		Quality Improvement	6 of 7
Darren Barber	10 of 11		
		Community Advisory	5 of 6
		Audit and Compliance	3 of 5
Ian Whiting	11 of 11		
		Audit & Compliance	4 of 5
Fleur Calvert	11 of 11		
		Quality Improvement	5 of 7
		Development Council	3 of 6
Caroline Coggins	11 of 11		
		Development Council	5 of 6
Peter Besgrove	11 of 11		
		Audit & Compliance	5 of 5
		Medical Appointments	2 of 2

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.

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, Deputy CEO / 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 25 times during the year, providing regular reports to the BOD.

Risk Management

Risk management is an all of organisation activity and requires appropriate action to be taken to minimise or eliminate risk that could result in personal injury, damage to, or loss of assets. During the year, VMIA conducted the site risk survey (SRS) that considers the risk profile of the site. The SRS assesses the following areas: hazards, construction, essential services, risk management systems, building services and equipment and public safety. Overall the Health Service achieved a SRS rating of very good, with six recommendations. Very good is defined as a site that demonstrates effective risk management with risks appropriately controlled and few or no recommendations made. Progress with the implementation of the ten recommendations of the 2012/17 Security Continuous Improvement Plan also continued, with eight recommendations completed and the final two being developed for completion across the remaining two years of the Plan.

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 2015/16. The Committee received internal audit reports regarding compliance with taxation and credit card financial reporting directions (in accordance with the Financial Management Compliance Framework) and Visiting Medical Officer payments. It reviewed the Victorian Auditor General's Office reports and recommendations on health service's length of stay, Bullying and Harassment in the Health Sector and Planning for Efficiency and Effectiveness of Health Services Emergency Care and made recommendations on their application to WDHS. The Committee was also kept informed of the progress of the Health Purchasing Victoria procurement reform and all other legislative requirements. Five meetings were held during the year.

Medical Appointments Advisory Committee

Advises the BOD on appointments, reappointments, suspensions and terminations of visiting medical practitioners. One meeting was 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. Two 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. Seven 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, Jennifer Kinnealy (resigned 2016), Tom Nieuwveld, Wendy Williams, Anna Watson and Rick Jacobs. Five 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. Sharon Donehue (retired 2016), Megan Campbell, Leesa Iredell, Libby Macgugan, Carly Behncke and Vicki Whyte were the community representatives on the Development Council in 2015/16. Six 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, Anne Pekin, Shannon Raymond, Narelle Ness. Two Youth Board Observers also joined the Committee, Anne O'Connell and Terrie Johnson. Seven 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.

Chris Phillips (retired 2016), Sherryn Jennings (retired 2016), Bev Clark (retired 2016), Rev. Peter Cook, Tracey McDonnell, Skye Grigg, Pastor Rick Penny, Emma Nicholas and Topsy Baulch were the community representatives.

Six meetings were held during the year.

Project Control Committee

Makes recommendations on the design, management and construction of major building projects. No meetings were held during the year.

→ Members of the Development Council at the Mischief with Marney Dinner. L-R : Vicki Whyte, Libby Macgugan, Leonie Sharrock, Jen Hutton, Caroline Coggins, Megan Campbell and Sharon Donehue.

Executive Team

→ L-R from rear: Chief Executive, Rohan Fitzgerald and Executive team members, Nic van Zyl, Nicholas Starkie, Associate Professor Susan Brumby, Bronwyn Roberts, Kerryn Charman, Katherine Armstrong and Fran Patterson.

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 is also a Health Purchasing Victoria Board Member and was previously 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 (from Jan 2016)

NICHOLAS STARKIE BBus, MIPA, AFA

Nick commenced his career at WDHS in the Finance Team at Coleraine in 1994 and has more recently held the position of Manager Finance and Budget since 2006.

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.

Deputy Chief Executive Officer, Director of Corporate Services (to Jan 2016)

PATRICK TURNBULL BBus, BHA, FCPA

Patrick was employed at Hamilton Base Hospital for over 33 years. He was appointed the Hospital's Principal Accounting officer in 1987 and became Director of Corporate Services in 1993. His role included representation of WDHS and rural health services in DHHS reference groups, including the ABF Implementation Reference Group and Small Rural Health Service Funding Review External Reference Group. Patrick continues his involvement with the Health Service following his departure in January, as head of the Sub Regional Corporate Services Project.

Director of Nursing

KERRYN CHARMAN DNsg, GDip Nsg Mid, DCrit Care, GDipLeadership C Identity, GDip in Intergrated Risk Mx

Kerryn is a senior health care leader in private, public, acute, community and primary health care settings. She has experience in clinical governance and organisational risk management, health and safety, quality management and as a senior nursing clinician. She previously held the position of Quality Risk Manager at the Western Victorian Primary Health Network and has also held senior positions at St John of God Geelong. Kerryn is a Registered Nurse and Midwife and holds post graduate qualifications in Critical Care and Risk Management.

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 and developing and providing 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.

Acting Director of Primary and Preventative Health (from Nov 2015)

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

Fran has worked as an Occupational Therapist 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.

Executive Team and Organisational Chart

Director of Primary and Preventative Health (to Nov 2015)

ROSIE ROWE BNatRes, MBA, GAICD

Rosie was appointed Director of PPH in May 2009. Prior to this appointment, Rosie was the Deputy Director of Community Services from October 2008, and for five years, the Executive Officer of Southern Grampians and Glenelg Primary Care Partnership. She has held senior positions in both the public and private sectors, including in natural resources and telecommunications.

Human Resources Manager (Retired Oct 2015)

HILARY KING MBA, Grad Dip HRM, Dip Physio, BA (in progress), CAHRI

Hilary commenced work at WDHS in October 2007, with extensive experience in conflict resolution, diversity management, mentoring, coaching and management development. Hilary worked as a Physiotherapist in Australia and overseas before moving into management roles in government and heavy manufacturing.

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 29 years and has held management positions in Aged Care / ICU / Emergency and projects for the last 20 years. Bronwyn was Deputy Director of Nursing (Hamilton Base Hospital) from 2004 - 2015, before commencing her role at Coleraine.

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

KATHERINE ARMSTRONG

RN, BAppSci (Nursing), Grad Cert Bus Admin

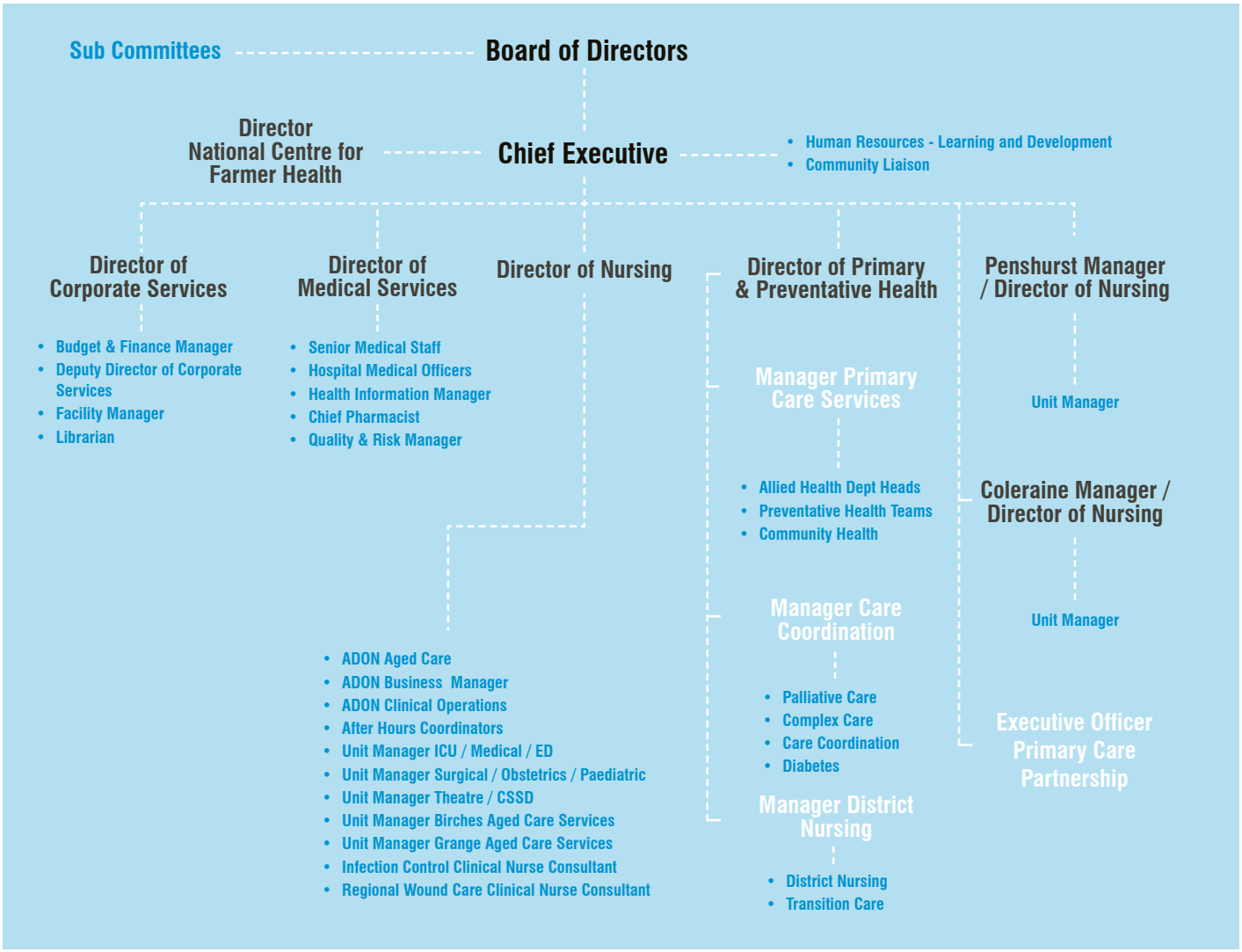
Katherine has worked at the Hamilton Campus for many years in a number of positions in Aged Care, including Nurse Unit Manager, Aged Care Quality Coordinator and Director of Nursing, Aged Care (Hamilton Campus). Katherine commenced her acting role at Penshurst in June 2015.

Director, National Centre for Farmer Health

ASSOCIATE PROFESSOR, SUSAN BRUMBY

RN, RM, DipFMgt, MHM, PhD AFCHSE, MACN, GAICD, FARL

Sue was appointed founding Director of the National Centre for Farmer Health in November 2008. She leads the implementation of key strategies to make a difference to farmer's lives, blending a theoretical and practical understanding of agriculture, health and rural communities. She 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. She is a Graduate of the Australian Institute of Company Directors, Life Fellow of the Australian Rural Leadership Program and an appointed member of the State Rural / Agricultural Advisory Council.



Chief Executive
Rohan Fitzgerald BCom

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

Director of Corporate Services
Nicholas Starkie BBus, MIPA DipTS(Bus),GradCertBusAdmin,
Patrick Turnbull BBus, BHA, FCPA

Manager Finance & Budget
Nick Templeton BCom, CPA
Nicholas Starkie BBus, MIPA, DipTS(Bus), GradCertBusAdmin, ASA

Business Support and Innovation Manager
Colin Barrie BE

Hotel Services Manager
Peter Davies BA

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

Facility Manager
Trevor Wathen Dip Frontline Mgt, MFAM

Learning and Development Manager
Dorothy McLaren BA, MA
Therese Gerber Post GradDipPsych, Cert IV T&A, BAHons (Communications), Cert.ProjectMgt

Librarian
Louise Milne ALIA

NURSING SERVICES

Director of Nursing
Kerryn Charman DNsg, GDip Nsg Mid, DCrit Care, GDipLeadership C Identity, GDip in Intergrated Risk Mx

ADON Aged Care
Katherine Armstrong BA AppSci (Nursing) & Grad Cert BusAdmin

ADON Business Manager
Lorraine Hedley RN, Bachelor of Nursing (Post Registration)

After Hours Coordinators
Leanne Deutscher RN
Linda Donaldson RN, MACN
Dianne Nagorcka RN, RM, Peri-opCert, BN
Jennifer O'Donnell RN, RPN, AdvCertMgt,
AdvCertWorkplace Practice Skills
Dianne Raymond RN
Kathy Ross RN GradDipCriticalCare
Lesley Stewart RN, Sterilisation & Infection Control Cert, Post Grad Cert Wound Management
Shamim Mahabeer RN , Grad Dip Critical Care
Sonia Shaw RN, RM - BA Nursing, Graduate Diploma of Midwifery
Vipin Joseph RN

NURSE MANAGERS

Unit Manager The Birches
Eryn Cottier RN

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

Unit Manager Medical/ICU/ED
Aisling Cunningham RN

Unit Manager Surgical/ Obstetrics/Paediatrics
Amber McDonald RN

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

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

Quality Manager
Wendy Buckland RN. BaN, Grad Dip Midwifery, Adv Dip Management
Acting Enid Smith RN, Grad Dip Qual Man Health Care, Grad Dip Rural Health
Acting Jen Membrey RN, Grad. Cert Critical Care
Gillian Jenkins RN Master of Education (Rsch), GradCertBusAdmin, MACN, Diploma Integrated Risk Management

Chief Pharmacist
Lynette Christie M Pharm, MPS, GradCertBusAdmin

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

General Practitioners
Syed Ansari MBBS, FSC
Victoria Blackwell MB, ChB, MRCGP, DRCOG, DFFP
Brian Coulson MBBS, FACRRM, Dip O&G
Craig deKievit MBBS, DRANZCOG, FACRRM
Dale Ford MBBS, FRACGP, FACRRM
Allan Mark Johnson MBBS(HON)
Robey Joyce MB, ChB (Pretoria)
Andrew McAllan MBBS, MMed (Ophth) FRACGP
Stuart Perry MBBS BMBS, FRACGP, DCH, BSc(Biomedical),JCC Anaesthesia
Greta Prozesky MB, ChB, FRACGP
Shaun Renfrey MBBS, FRACGP, Grad Dip Rural Health
Susan Robertson MBBS, DipRACOG, FRACGP, DipPallCare, Dip Obs,
Jan Slabbert MB, ChB (Free State), FRACGP, RACGP
Amy Tai MBBS DRANZCOG FACRRM DipCH
Ramin Taheri MBBS
Linda Thompson BMS, FRACGP
Leesa Walker MBBS, FRACGP
Anthony Wark MBBS, FACRRM
Loba Haque MBBS
Patricia Macgibbon MBBS Grad Dip Farm Med
Peter Wang AMC, MBBS
Yao Zhang BM
Steven Yuan MBBS, BMedSci

General Practitioner Registrar
Debra Bird MBBS Dip Child Health
Amanda Teo MBBS (Honours)
Sareetaa Vijayan MBBS

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

Senior Staff

General Surgeons
Stephen Clifforth MBBS, FRACS
Uvarasen Kumarswami Naidoo MBcHB, FCS, FRACS
Peter Tung MBBS, FRACS, FHKAM
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 MBGBS, DRANZCOG, FACRRM
Jan Slabbert MB, ChB, (Free State), FRACGP, RACGP
Peter Wang AMC, MBBS
Amy Tai MBBS DRANZCOG FACRRM DipCH

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
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

Otolaryngologists
Anne Cass MBBS, FRACS

Paediatrician
Christian Fiedler MD, (KIEL), FRACP

Pathologist
David Clift MBBS, FRCPA

Physicians
Camelia Borta MBBS, FRACP
Andrew Bowman MBChB (Zimb),LRCP(Edin),LRCS(Edin),LRCP&S(Glas),FRCP(UK),CCST(UK), FRACP
Andrew Bradbeer MBBS, FRACP
Trevor Branken MB. ChB (Birm) FCP (Sth Africa)
Geoffrey Coggins MBBS, FRACP
Wimal Weerasinghe MBBS, DCH,MD,MRCP, FCCP
Win Win Myint MBBS, M Med.Sc(Int Med), MRCP (UK), FRCP(Edin)

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, three emergency PGY3 two surgical registrar, three medical registrars
St Vincent's Hospital - two general surgical interns, two general medicine interns

Hospital Medical Officers (employed by WDHS)
Fouzia Kashem MBBS
Farideh Lashkary MBBS
Zannatun Nur MBBS
Ranga Panagoda MBBS

PRIMARY & PREVENTATIVE HEALTH

Director Primary & Preventative Health
Fran Patterson (Acting from Nov 2015) B.App Sct OT, Dip VET
Rosie Rowe (to Nov 2015) BNatRes, MBA, GAICD

Manager, Primary Care Services
Belinda Payne, GradDipBus

Manager, Care Coordination
Robyn Beaton RN
Usha Naidoo, MSc, BSocSc, RN, DipOncol, DipMgt

Manager, District Nursing
Pat O'Beirne RN, RM

Chief Dietitian
Jodie Nelson BHSc(Nutrition&Dietetics)

Chief Occupational Therapist
Sarah Baker (Acting from Nov 2015) B.AppSci (OT) Hons
Fran Patterson (to Nov 2015) BAppSci (O.T), Dip VET

Chief Physiotherapist
Tatum Pretorius BSc (Physio)

Speech Pathologist
Sue Cameron BAppSc(SpeechPath), MSPAA

Senior Social Worker
Tricia Cox B.App Sci (SW)
Rinu Thomas B.Com, MSocialWrk

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

Palliative Care Service
Susan Rees RN

PRIMARY CARE PARTNERSHIP

Executive Officer
Janette Lowe MBA, BEng

NATIONAL CENTRE FOR FARMER HEALTH

Director, National Centre for Farmer Health
Clinical Associate Professor Susan Brumby RN, RM, DipFMgt, MHM, PhD AFCHSE, MACN, GAICD, FARL

Statement of Priorities Agreement

Strategic Priorities for 2015-16. The Victorian Government's priorities and policy directions are outlined in the Victorian Health Priorities Framework (VHPF) 2012-2022. In 2015/16 WDHS contributed to the achievement of the priorities by:

Domain	Action	Deliverable	Outcomes
Patient Experience and Outcomes	o Drive improved health outcomes through a strong focus on patient-centred care in the planning, delivery and evaluation of services and the development of new models for putting patients first.	o Measure the patient experience before, during and after discharge from Hamilton Base Hospital acute services to identify improvements in patient-centred care.	A discharge planning committee was established to conduct an in-depth case study and is currently actioning the recommendations from that group. VHES data collection shows improvement in our patients discharge experience over the last 12 months.
	o Strengthen the response of health services to family violence. This includes implementing interventions, processes and systems to prevent, identify and respond appropriately to family violence at an individual and community level.	o Increase staff awareness of organisational policies to improve our responsiveness and intervention to support the prevention of family violence.	Domestic violence awareness training has been incorporated into the organisational and staff orientation program. The Take a Stand against domestic violence program will be rolled out organisationally and the Health Service has reviewed its policies.
	o Improve the health outcomes of Aboriginal and Torres Strait Islanders by increasing accessibility and cultural responsiveness of the Victorian health system.	o Implement the recommendations of the final evaluation of the Aboriginal Employment Project and develop and implement a Western District Health Service Aboriginal Health and Employment Plan.	The recommendations from the plan are completed. More staff are choosing to identify as Aboriginal, cultural safety training was delivered to staff and two positions were identified for Aboriginal people.
	o Demonstrate an organisational commitment to quality cancer services through engagement with the local Integrated Cancer Service and implementation of the Optimal Care Pathways.	o Investigate developing a regional public cancer service model in collaboration with Ballarat Regional Integrated Cancer Centre and the Andrew Love Cancer Centre (University Hospital Geelong).	BRICC cancer outreach to WDHS commenced in February 2016, in addition to the service provided by the Andrew Love Cancer Centre.
Governance, Leadership and Culture	o Demonstrate an organisational commitment to Occupational Health and Safety, including mental health and wellbeing in the workplace. Ensure accessible and affordable support services are available for employees experiencing mental ill health. Work collaboratively with the Department of Health and Human Services and professional bodies to identify and address systemic issues of mental ill health amongst the medical professions.	o The Health Service will continue to provide an employee assistance program to staff and establish an organisational staff working group to investigate ways of improving wellbeing using Deakin University's innovative community based systems approach.	Deakin University facilitated workshops were conducted with staff to identify workplace strategies to improve wellbeing. A Wellbeing Program was established to implement the strategies.
	o Monitor and publicly report incidents of occupational violence. Work collaboratively with the Department of Health and Human Services to develop systems to prevent the occurrence of occupational violence.	o Review and update the current Western District Health Service occupational violence strategy to ensure that reporting, investigation and management of Occupational Violence within Western District Health Service is in accordance with best practice.	Policies and procedures were updated organisationally to support safe practice.
	o Promote a positive workplace culture and implement strategies to prevent bullying and harassment in the workplace. Monitor trends of complaints of bullying and harassment and identify and address organisational units exhibiting poor workplace culture and morale.	o Develop and implement an updated Bullying and Harassment prevention strategy to ensure that prevention, reporting, investigation and management of complaints of workplace bullying and harassment within Western District Health Service are in accordance with best practice.	Bullying and harassment training was provided to Department Heads and policies and procedures updated.
	o Undertake an annual board assessment to identify and develop board capability to ensure all board members are well equipped to effectively discharge their responsibilities.	o The board will undertake an assessment of its capabilities using the Australian Centre for Healthcare Governance evaluator.	The Board implemented the Governance Evaluator.
Safety and Quality	o Implement effective antimicrobial stewardship practices and increase awareness of antimicrobial resistance, its implications and actions to combat it, through effective communication, education and training.	o Implement the actions from the organisation's antimicrobial stewardship plan, incorporating education and training of staff and the community.	Organisational policies and procedures were updated to reflect the plan.
	o Develop perinatal mortality and morbidity review processes in alignment with the Clinical Practice Guideline for Perinatal Mortality.	o Investigate the development of a regional perinatal mortality and morbidity review process with Victorian Maternity & Newborn Clinical Network and Department of Health and Human Services.	The Barwon South Western Regional Mortality and Morbidity Committee Meeting was established in collaboration with the Royal Women's Hospital.
	o Ensure management plans are in place to prevent, detect and contain Carbapenem Resistant Enterobacteriaceae as outlined in Hospital Circular 02/15 (issued 16 June 2015).	o Update policy and procedures to ensure management of CRE meets best practice guidelines.	Policy and procedures updated to ensure management of CRE meets best practice guidelines.
Financial Sustainability	o Work with Health Purchasing Victoria to implement procurement savings initiatives.	o Develop a process to support central supply contract managers to execute all new Health Purchasing Victoria contracts within 60 days.	All new consumable based contracts are reviewed and monitored by central supply and delegated to the clinical product advisor or procurement officer to review and implement.
	o Undertake cost benchmarking and develop partnerships with peers to improve operating efficiency.	o Participate in the Victorian Cost Data Collection benchmarking tool.	Completed.
	o Improve cash management processes to ensure that financial obligations are met as they are due.	o Maintain days available cash greater than benchmark 14 days.	Target achieved.
Access	o Implement integrated care approaches across health and community support services to improve access and responses for disadvantaged Victorians.	o Implement AgriSafe Clinics in partnership with rural and regional health services to improve farmer health across four rural sites.	AgriSafe Clinics were provided across a number of regional communities.
		o Deliver education through the NCFH to increase health professional's knowledge and skills on agricultural populations.	Delivered the Agriculture Health and Medicine unit to rural healthcare professionals.
		o Continue research activities that support effective interventions for farming populations through publications in journals and presentations.	Three farming research projects are being conducted, The Ripple Effect, Fitter Farmers and CROP to improve the health, wellbeing and safety of farmers.
	o Progress partnerships with other health services to ensure patients can access treatments as close to where they live when it is safe and effective to so, making the most efficient use of available resources across the system	o Participate in the Regional Medical Workforce Collaborative (Western District Health Service, South West Healthcare and Portland District Health) to optimise local resources to render specialist services as close to home as possible.	The Regional Medical Workforce Collaborative meets regularly to support medical workforce development.
	o Develop Telehealth service models to facilitate the delivery of high quality and equitable specialist services to patients across regional Victoria.	o Work with Barwon South West Regional Telehealth Stakeholders Committee to maintain and improve the Western District Health Service telehealth service model.	A policy and telehealth framework is in place and WDHS has monthly telehealth committee meetings. WDHS participates in the BSW Regional Telehealth Stakeholders Committee.
		o Expand the availability of specialist geriatric services using telemedicine to Western District Health Service aged care facilities to support improved resident management.	Geriatric telehealth clinics were expanded to include all six WDHS aged care facilities.

Service Performance

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

Safety and Quality Performance

Key Performance Indicator	Target	2015-16 Actual
Compliance with NSQHS Standards Accreditation	Full compliance	Full compliance
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Full compliance
Compliance with the Hand Hygiene Australia program	80%	85%
Percentage of healthcare workers immunised for influenza	75%	75.2%
Submission of infection surveillance data to VICNISS[1]	Full compliance	Achieved
Cleaning Standard Measure	**AQL target**	**Outcome**
Overall compliance with standards	Full compliance	Achieved
Very high risk (Category A)	90 points	Achieved
High risk (Category B)	90 points	Achieved
Moderate risk (Category C)	85 points	Achieved

Governance, Leadership and Culture Performance

Key Performance Indicator	Target	2015/2016 Actual
People Matter Survey – percentage of staff with a positive response to safety culture questions	80%	90%

Patient Experience and Outcomes Performance

Key Performance Indicator	Target	2015/2016 Actual
Victorian Healthcare Experience Survey – data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	Achieved
ICU central line associated blood stream infections	No outliers	Achieved
Maternity – Percentage of women with prearranged postnatal home care	100%	100%

Financial Sustainability Performance

Key Performance Indicator	Target	2015/2016 Actual
Finance		
Operating result ($m)	0.00	0.01
Trade Creditors	<60 days	62
Patient fee Debtors	<60 days	66
Public & private WIES[2] performance to target	100%	102%
Asset Management		
Asset management plan	Full compliance	Achieved
Adjusted current asset ratio	0.7	1.44
Days of available cash	14 days	75

Access Performance

Key Performance Indicator	Target	Result
Emergency Care		
Percentage of ambulance transfers within 40 minutes	90%	100%
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%	94%
Percentage of emergency patients with a length of stay less than four hours	81%	90%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	1

Funding Type	2015/2016 Activity Achieved
ACUTE ADMITTED	
WIES Public	3,787
WIES Private	1,137
WIES (PUBLIC AND PRIVATE)	**4,924**
WIES DVA	125
WIES TAC	37
WIES TOTAL	**5,086**
ACUTE NON-ADMITTED	
Rehab Public	1,507
Rehab Private	456
Rehab DVA	49
GEM Public	517
GEM Private	164
GEM DVA	70
Palliative Care Public	515
Palliative Care Private	115
Palliative Care DVA	15
Transition Care - Beddays	870
Transition Care - Homeday	958
SUB ACUTE NON-ADMITTED	
Health Independence Program	13,992
AGED CARE	
Residential Aged Care	57,556
HACC	45,021
Small Rural HACC	5,480
MENTAL HEALTH & DRUG SERVICES	
Residential Aged Care	1,098
PRIMARY HEALTH	
Community Health / Primary Care Programs	3,671
SMALL RURAL	
Small Rural Acute	722

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.

Consultancies

In 2015/16 Western District Health Service engaged 2 consultancies where the total fees payable to the consultants were less than $10,000, with a total expenditure of $10,492 (excl. GST). In 2015/16 there were 4 consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2015/16 in relation to these consultancies is $138,062 (excl. GST). For details of the consultancies greater than $10,000, refer to the table below.

Declarations of Pecuniary Interest

All necessary declarations have been completed. Refer to Note 24 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 68 FOI requests were received. No request was denied. All were granted in full.

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

Not Applicable

Infrastructure Projects

- Fire ring main and sprinkler system upgrade project was completed May 2016
- Emergency generator upgrades to both the Penshurst and Grange campus funded from LIAF completed October 2015
- Resealing Driveway National Centre for Farmer Health (NCFH) completed April 2016.

Building Compliance

- A certificate of final inspection was issued 23/5/2016 for completion of fire ring main and sprinkler system
- Automatic sliding door and fire curtain final inspection 27/6/2016.

Carers Recognition Act 2012

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

Protected Disclosure Act 2012

WDHS has in place appropriate procedures for disclosure in accordance with the Protected Disclosure Act 2012. No protected disclosures were made under the Act in 2015/16.

Additional information available on request

Consistent with FRD 22G (Section 6.19) the items listed below have been retained by Western District Health Service 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 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. The Western District Health Service has critically reviewed these controls and processes during the year.

Rohan Fitzgerald
CHIEF EXECUTIVE
30 August 2016

Attestation for compliance with the Ministerial Standing Direction 4.5.5 - Risk Management Framework and Processes

I, Rohan Fitzgerald certify that the Western District Health Service has complied with Ministerial Direction 4.5.5 Risk Management Framework and Processes. The Western District Health Service Audit Committee verifies this.

Rohan Fitzgerald
CHIEF EXECUTIVE
30 August 2016

Consultancies > $10,000

Consultant	Purpose of Consultancy	Start Date	End Date	Total Approved Project Fee (ex GST)	Expenditure 2015-16 (ex GST)	Future Expenditure (ex GST)
MIRUS Australia	ACFI Review	1/6/2015	31/5/2016	90,000	90,000	0
Michael Rhook	VCDC Costing	1/7/2015	30/6/2016	27,676	27,676	0
LifeMastery (Aust) P/L	Strategic Planning	1/2/2016	31/5/2016	10,386	10,386	0
Elizabeth Rankin	Feasibility Study - DSC	1/6/2016	30/11/2016	25,000	10,000	15,000
Total	**4**			**153,062**	**138,062**	**15,000**

Accountable Officer's Declaration

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 Standing Direction 4.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards, including Interpretations and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the Comprehensive Operating Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2016 and the financial position of Western District Health Service at 30 June 2016.

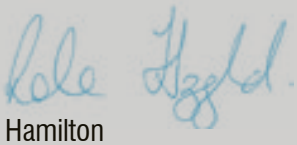
At the time of signing, we are not aware of any circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

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

Hugh Macdonald
President

Hamilton
30 August 2016

Rohan Fitzgerald
Chief Executive



Hamilton
30 August 2016

Nicholas Starkie
Chief Finance and Accounting Officer

Hamilton
30 August 2016

Disclosure Index

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

Ministerial Directions Report of Operations

Legislation	Requirement	Page Ref
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FRD 22G	Manner of establishment and the relevant Ministers	Inside front cover, 1, 73
FRD 22G	Purpose, functions, powers and duties	Inside front cover to 7
FRD 22G	Initiatives and key achievements	1-7, 13-33
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FRD 22G	Application and operation of Carers Recognition Act 2012	43
FRD 22G	Application and operation of Freedom of Information Act 1982	43
FRD 22G	Compliance with building and maintenance provisions of Building Act 1993	43
FRD 22G	Details of consultancies over $10,000	43
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FRD 22G	Major changes or factors affecting performance	2-10
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Financial Statements

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INDEPENDENT AUDITOR'S REPORT

To the Board Members, Western District Health Service

The Financial Report

I have audited the accompanying financial report for the year ended 30 June 2016 of the Western District Health Service which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board member's, accountable officer's and chief finance & accounting officer's declaration.

The Board Members' Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independent Auditor's Report (continued)

Independence

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

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of the Western District Health Service as at 30 June 2016 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

MELBOURNE
7 September 2016

Dr Peter Frost
Acting Auditor-General

Comprehensive Operating Statement For the Year Ended 30 June 2016	Note	Total 2016 $'000	Total 2015 $'000
Revenue from operating activities	2	65,756	64,525
Revenue from non-operating activities	2	1,382	1,584
Employee expenses	3	(46,183)	(44,689)
Non salary labour costs	3	(4,382)	(4,247)
Supplies and consumables	3	(7,166)	(6,416)
Other expenses	3	(9,392)	(10,156)
Net result before capital and specific items		**15**	**601**
Capital purpose income	2	4,436	2,209
Share of net result of associates and joint ventures accounted for using the Equity Method	2	(3)	(23)
Depreciation	4	(6,951)	(6,924)
Finance Costs	5	(44)	(42)
Expenditure for Capital Purpose	3	(103)	(105)
NET RESULT FOR THE YEAR		**(2,650)**	**(4,284)**
Other comprehensive income			
Items that may be reclassified subsequently to net result			
Changes to financial assets available-for-sale revaluation surplus	**20**	**(90)**	**(76)**
Total other comprehensive income		**(90)**	**(76)**
Comprehensive result		**(2,740)**	**(4,360)**

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

Balance Sheet as at 30 June 2016	Note	Total 2016 $'000	Total 2015 $'000
Current assets			
Cash and cash equivalents	6	12,659	14,398
Receivables	7	4,254	2,685
Investments and other financial assets	8	16,242	9,295
Inventories	9	153	150
Non-financial assets classified as held for sale	10	-	220
Other assets	11	1,326	1,008
Total current assets		**34,634**	**27,756**
Non-current assets			
Receivables	7	1,166	1,207
Investments and other financial assets	8	2,341	2,215
Investments accounted for using the equity method	13	93	96
Property, plant & equipment	12	131,127	136,568
Total non-current assets		**134,727**	**140,086**
TOTAL ASSETS		**169,361**	**167,842**
Current liabilities			
Payables	15	5,200	4,011
Provisions	17	9,053	8,399
Borrowings	16	358	354
Other current liabilities	19	3,631	2,368
Total current liabilities		**18,242**	**15,132**
Non-current liabilities			
Provisions	17	1,826	1,657
Borrowings	16	543	718
Other non-current liabilities	19	7,087	5,932
Total non-current liabilities		**9,456**	**8,307**
TOTAL LIABILITIES		**27,698**	**23,439**
NET ASSETS		**141,663**	**144,403**
EQUITY			
Property, plant & equipment revaluation surplus	20a	67,366	67,366
Financial asset available for sale revaluation surplus	20a	88	178
Restricted specific purpose surplus	20b	7,566	5,283
Contributed capital	20b	49,535	49,535
Accumulated surpluses/(deficits)	20c	17,108	22,041
TOTAL EQUITY	20c	**141,663**	**144,403**
Contingent assets and contingent liabilities	24		
Commitments	23		

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

Statement of Changes in Equity for the Year Ended 30 June 2016

Consolidated	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 2014		**67,366**	**254**	**4,391**	**49,535**	**27,217**	**148,763**
Net result for the year		-	-	-	-	(4,284)	(4,284)
Other comprehensive income for the year	20a	-	(76)	-	-	-	(76)
Transfer to accumulated Surplus	20c	-	-	892	-	(892)	-
Restated balance at 30 June 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	20a	-	(90)	-	-	-	(90)
Transfer to accumulated surplus	20c	-	-	2,283	-	(2,283)	-
Balance at 30 June 2016		**67,366**	**88**	**7,566**	**49,535**	**17,108**	**141,663**

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

Cash Flow Statement For the Year Ended 30 June 2016

	Note	Total 2016 $'000	Total 2015 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating grants from government		46,304	45,550
Capital grants from government		1,146	638
Patient and resident fees received		14,364	14,536
Donations and bequests received		1,426	824
GST received from/(paid to) ATO		1,340	1,255
Interest received		506	663
Dividend received		31	22
Other capital receipts		2,213	1,861
Other receipts		3,458	5,036
Total receipts		**70,788**	**70,385**
Employee expenses paid		(45,434)	(46,152)
Non salary labour costs		(4,382)	(4,247)
Payments for supplies & consumables		(9,774)	(7,965)
Finance costs		(44)	(42)
Other payments		(5,860)	(6,396)
Total payments		**(65,494)**	**(64,802)**
NET CASH FLOW FROM/(USED IN) OPERATING ACTIVITIES	21	**5,294**	**5,583**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments		(5,760)	(4,133)
Payments of non-financial assets		(1,576)	(3,313)
Proceeds from sale of non-financial assets		147	229
		(7,189)	**(7,217)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of finance leases		(394)	(347)
NET CASH FLOW FROM/(USED IN) FINANCING ACTIVITIES		**(394)**	**(347)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**(2,289)**	**(1,981)**
Cash and cash equivalents at beginning of financial year		**11,467**	**13,448**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6	**9,178**	**11,467**

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

CONTENTS

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 2016. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

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

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

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

The annual financial statements were authorised for issue by the Audit and Compliance Committee of Western District Health Service on 30/08/2016.

(b) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2016, and the comparative information presented in these financial statements for the year ended 30 June 2015.

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

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

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

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

- non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- the fair value of assets other than land is generally based on their depreciated replacement value.

Judgements, estimates and assumptions are required to be made about the carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

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

- the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 1(j));
- superannuation expense (refer to Note 1(g));
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 1(k)); and
- equities and management investment schemes classified at level 3 of the fair value hierarchy

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

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

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

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

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

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

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

(c) Reporting entity

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

Its principle address is:

20 Foster Street, Hamilton 3300

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

Objectives and funding

Western District Health Service mission is to meet the health and wellbeing needs of our community by delivering a comprehensive range of high quality, innovative and valued health services, as well as improve the quality of life to Victorians.

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

(d) Principles of consolidation

Intersegment transactions

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

Associates and joint ventures

Associates and joint ventures are accounted for in accordance with the policy outlined in Note 1 1(j) financial assets.

Jointly Controlled Assets

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

(e) Scope & presentation of financial statements

Fund Accounting

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

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

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

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

Residential Aged Care Service

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

– The Birches and Grange Residential Care Service (located in Hamilton)

– Kolor Lodge and W J Lewis Nursing Home (located in Penshurst)

– Valley View Nursing Home and Wannon Hostel (located in Coleraine)

An apportionment of land and buildings has been made based on floor space. The results of the two operations have been segregated based on the actual revenue earned and expenditure incurred by each operation in Notes 2 and 3 to the financial statements.

Comprehensive operating statement

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

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

- capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer Note 1 (f)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.
- specific income/expense, comprises the following items, where material:

  – Non-current asset revaluation increments/ decrements

  – Diminution / impairment of investments
- impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), which have been recognised in accordance with Note 1 (i)
- depreciation and amortisation, as described in Note 1 (g)
- assets provided or received free of charge (refer to Notes 1 (f) and (g)); and
- expenditure using capital purpose income, which comprises expenditure which either falls below the asset capitalization threshold or doesn't meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

Other economic flows; are changes arising from market remeasurements. They include:

- Gains and losses from disposal of non-financial assets;
- Revaluations and impairments of non-financial physical and intangible assets;
- Remeasurement arising from defined benefit superannuation plans; and
- Fair value changes of financial instruments.

Balance Sheet

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

Statement of changes in equity

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

Cash flow statement

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

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

Rounding

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

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

Comparative Information

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

(f) Income from transactions

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

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

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

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

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

Indirect Contributions from the Department of Health

– Insurance is recognised as revenue following advice from the Department of Health 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 05/2013.

Patient and Resident Fees

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

Private Practice Fees

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

Revenue from commercial activities

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

Donations and Other Bequests

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

Dividend Revenue

Dividend revenue is recognised when the right to receive payment is established. Dividends represent the income arising from Western District Health Service's investments in financial assets.

Western District Health Service does not recognise dividends received or receivable from it associates or joint ventures as income. Instead, dividends from associates and joint ventures are adjusted directly against the carrying amount of investments using the equity method.

Interest Revenue

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

Sale of Investments

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

Fair value of assets and services received free of charge or for nominal consideration

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

Other income

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

(g) Expense recognition

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

Cost of goods sold

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

Employee expenses

Employee expenses include;

- wages and salaries;
- 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.

Defined contribution superannuation plans

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

Defined benefit superannuation plans

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

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

The name and details of the major employee superannuation funds and contributions made by the Health Service are disclosed in note 18: Superannuation.

Depreciation

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

Intangible produced assets with finite lives are depreciated as an expense from transactions on a systematic basis over the asset's useful life. Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health 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.

	2016	2015
Buildings	2 to 40 Years	2 to 40 Years
Plant & Equipment	8 to 10 Years	8 to 10 Years
Medical Equipment	8 to 10 Years	8 to 10 Years
Computers and Communication	1 to 5 Years	1 to 5 Years
Furniture and Fitting	8 to 10 Years	8 to 10 Years
Motor Vehicles	1 to 5 Years	1 to 5 Years
Intangible Assets	1 to 5 Years	1 to 5 Years

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

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

Amortisation

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

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

Intangible assets with indefinite useful lives are not amortised, but are tested for impairment annually or whenever there is an indication that the asset may be impaired. The useful lives of intangible assets that are not being amortised are reviewed each period to determine whether events and circumstances

continue to support an indefinite useful life assessment for that asset. In addition, the Health Service tests all intangible assets with indefinite useful lives for impairment by comparing the recoverable amount for each asset with its carrying amount:

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

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

Intangible assets with finite useful lives are amortised over a 10-15 year period. (2015 10-15 years)

Finance Costs

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

Finance costs include;

- interest on bank overdrafts and short term and long term borrowings (interest expense is recognised in the period in which it is incurred);
- amortisation of discounts or premiums relating to borrowings;
- amortisation of ancillary costs incurred in connection with the arrangements of borrowings; and
- finance charges in respect of finance leases recognised in accordance with AASB117 Leases.

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:

Supplies and consumables

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

Bad and doubtful debts

Refer to Note 1 (j) Impairment of financial assets.

Fair value of assets, services and resources provided free of charge or for nominal consideration

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

Borrowing costs of qualifying assets

In accordance with the paragraphs of AASB 123 Borrowing Costs applicable to not-for-profit public sector entities, the Health Services continues to recognise borrowing costs immediately as an expense, to the extent that they are directly attributable to the acquisition, construction or production of a qualifying asset.

(h) Other economic flows included in net result

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 1 (j) Revaluations of non-financial physical assets.

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

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

Net gain/(loss) on financial instruments

Net gain/(loss) on financial instruments includes:

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

Amortisation of non-produced intangible assets

Intangible non-produced assets with finite lives are amortised as an 'other economic flow' on a systematic basis over the asset's useful life. Amortisation begins when the asset is available for use that is when it is in the location and condition necessary for it to be capable of operating in the manner intended by management.

Impairment of non-financial assets

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

Revaluations of financial instrument at fair value

Refer to Note 1 (i) Financial instruments.

Share of net profits/(losses) of associates and jointly controlled entities, excluding dividends.

Refer to Note 1 (d) Basis of consolidation.

Other gains/(losses) from other comprehensive income

Other gains/(losses) include:

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

(i) Financial instruments

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

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

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments

Loans and receivables

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

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

Available-for-sale financial assets

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised in 'other comprehensive income' until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in net result for the period. Fair value is determined in the manner described in Note 22.

Financial liabilities at amortised cost

Financial instrument liabilities are initially recognised on the date they are originated. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these financial instruments are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in profit and loss over the period of the interest-bearing liability, using the effective interest rate method.

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

(j) Assets

Cash and Cash Equivalents

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

Receivables

Receivables consist of;

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

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

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

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

Investments and other financial assets

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

Investments are classified in the following categories;

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

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

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

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

Inventories

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

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

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

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

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

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

Non-financial physical assets classified as held for sale

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

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

Property, Plant and Equipment

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 12 Property, plant and equipment.

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

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

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

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

During the reporting period, Western District Health Service also holds 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.

Leasehold improvements

The cost of a leasehold improvement is capitalised as an asset and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the improvements.

Revaluations of non-current physical assets

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

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

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

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

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

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

Intangible assets

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

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

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

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

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

a) the technical feasibility of completing the intangible asset so that it will be available for use or sale;

b) an intention to complete the intangible asset and use or sell it;

c) the ability to use or sell the intangible asset;

d) the intangible asset will generate probable future economic benefits;

e) the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and

f) the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Prepayments

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

Disposal of non-financial assets

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

Impairment of non-financial assets

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

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

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

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

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

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

Investments accounted for using the equity method

An associate is an entity over which Western District Health Service exercises significant influence, but not control.

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.

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.

Derecognition of financial assets

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

- the rights to receive cash flows from the asset have expired; or
- the Health Service retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or
- the Health Service has transferred its rights to receive cash flows from the asset and either:

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

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

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

Impairment of financial assets

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

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

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

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

In order to determine an appropriate fair value as at 30 June 2016 for its portfolio of financial assets, Western District Health Service obtained a valuation based on the best available advice using an estimated valuation method provided by a reputable financial institution. This value was compared against valuation methodologies provided by the issuer as at 30 June 2015. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

Net gain/(loss) on financial instruments

Net gain/(loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through profit or loss or held-for-trading;

- impairment and reversal of impairment for financial instruments at amortised cost; and

- disposals of financial assets and derecognition of financial liabilities

Revaluations of financial instruments at fair value

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

(k) Liabilities

Payables

Payables consist of:

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

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

Borrowings

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs (refer also to note 1(l) Leases) The measurement basis subsequent to initial recognition depends on whether the Health Service has categorised its borrowings as either, financial liabilities designated at fair value through profit or loss, or financial liabilities at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowings using the effective interest method.

The classification depends on the nature and purpose of the borrowing. The Health Service determines the classification of its borrowing at initial recognition.

Provisions

Provisions are recognised when the Health Service has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

When some or all of the economic benefits required to settle a provision are expected to be received from a third party, the receivable is recognised as an asset if it is virtually certain that recovery will be received and the amount of the receivable can be measured reliably.

Employee Benefits

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

Wages and salaries, annual leave, sick leave and accrued days off

Liabilities for wages and salaries, including non-monetary benefits, annual leave accumulating sick leave are all recognised in the provision for employee benefits as 'current liabilities', because the health service does not have an unconditional right to defer settlements of these liabilities.

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

- undiscounted value – if the health service expects to wholly settle within 12 months; or
- present value – if the health service does not expect to settle within 12 months.

Long Service Leave (LSL)

Liability for LSL is recognised in the provision for employee benefits.

Unconditional LSL is disclosed in the notes to the financial statements as a current liability even where the Health Service does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months.

The components of this current LSL liability are measured at:

- undiscounted value – if the health service expects to wholly settle within 12 months; and
- present value – if the health service does not expect to settle within 12 months.

Conditional LSL is disclosed as a non-current liability. There is an unconditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service. This non-current LSL liability is measured at present value.

Any gain or loss 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 bond interest rates for which it is then recognised as an other economic flow.

Termination benefits

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

The health service recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

Employee benefit on-costs

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

Superannuation liabilities

The Health Service does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the Health Service has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due.

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.

(l) Leases

A lease is a right to use an asset for an agreed period of time in exchange for payment. Leases are classified at their inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee.

For service concession arrangements, the commencement of the lease term is deemed to be the date the asset is commissioned.

All other leases are classified as operating leases.

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.

Operating leases

Entity as lessor

Rental income from operating lease is recognised on a straight-line basis over the term of the relevant lease.

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are given to the lessee, the aggregate cost of incentives are recognised as a reduction of rental income over the lease term, on a straight-line basis unless another systematic basis is more appropriate of the time pattern over which the economic benefit of the leased asset is diminished.

Entity as lessee

Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. The leased asset is not recognised in the balance sheet.

Lease Incentives

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are received by the lessee to enter into operating leases, such incentives are recognised as a liability. The aggregate benefits of incentives are recognised as a reduction of rental expense on a straight-line basis, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset is diminished.

Leasehold Improvements

The cost of leasehold improvements are capitalised as an asset and depreciated over the remaining term of the lease or the estimated useful life of the improvements, whichever is the shorter

(m) Equity

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 assets available–for–sale revaluation surplus

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

Specific restricted purpose surplus

A specific restricted purpose surplus is established where the Health Service has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

(n) Commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer to note 23) at their nominal value and are inclusive of the goods and services tax ("GST") payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

(o) Contingent assets and contingent liabilities

Contingent assets and contingent liabilities are not recognised in the balance sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

(p) Goods and Services Tax ('GST')

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case, the GST payable is recognized as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the taxation authority is included with other receivables or payables in the balance sheet.

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

Commitments for expenditure and contingent assets and liabilities are presented on a gross basis

(q) Events after the reporting period

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

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

(r) AASs issued that are not yet effective

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2016 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30 June 2016, 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 on page 55.

The Health Service 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 Jan 2018	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. 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: o The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and Other fair value changes are presented in profit 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 Jan 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 Jan 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. 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 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends. Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. Dividends are recognised in the profit and loss only when: o the entity's right to receive payment of the dividend is established; o it is probable that the economic benefits associated with the dividend will flow to the entity; and o the amount can be measured reliably.	1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
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 Jan 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 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: o A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; o For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and o For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified in AASB 15.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	1 Jan 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 2014 4 Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 & AASB 138]	Amends AASB 116 Property, Plant and Equipment and AASB 138 Intangible Assets to: o establish the principle for the basis of depreciation and amortisation as being the expected pattern of consumption of the future economic benefits of an asset; o prohibit the use of revenue based methods to calculate the depreciation or amortisation of an asset, tangible or intangible, because revenue generally reflects the pattern of economic benefits that are generated from operating the business, rather than the consumption through the use of the asset.	1 Jan 2016	The assessment has indicated that there is no expected impact as the revenue-based method is not used for depreciation and amortisation.

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 2014 9 Amendments to Australian Accounting Standards – Equity Method in Separate Financial Statements [AASB 1, 127 & 128]	Amends AASB 127 Separate Financial Statements to allow entities to use the equity method of accounting for investments in subsidiaries, joint ventures and associates in their separate financial statements.	1 Jan 2016	The assessment indicates that there is no expected impact as the entity will continue to account for the investments in subsidiaries, joint ventures and associates using the cost method as mandated if separate financial statements are presented in accordance with FRD 113A.
AASB 2014 10 Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture [AASB 10 & AASB 128]	AASB 2014-10 amends AASB 10 Consolidated Financial Statements and AASB 128 Investments in Associates to ensure consistent treatment in dealing with the sale or contribution of assets between an investor and its associate or joint venture. The amendments require that: o a full gain or loss to be recognised by the investor when a transaction involves a business (whether it is housed in a subsidiary or not); and o a partial gain or loss to be recognised by the parent when a transaction involves assets that do not constitute a business, even if these assets are housed in a subsidiary.	1 Jan 2016	The assessment has indicated that there is limited impact, as the revisions to AASB 10 and AASB 128 are guidance in nature.
AASB 2015-1 Amendments to Australian Accounting Standards – Annual Improvements to Australian Accounting Standards 2012-2014 Cycle [AASB 1, AASB 2, AASB 3, AASB 5, AASB 7, AASB 11, AASB 110, AASB 119, AASB 121, AASB 133, AASB 134, AASB 137 & AASB 140]	Amends the methods of disposal in AASB 5 Non-current assetsheld for sale and discontinued operations. Amends AASB 7 Financial Instruments by including further guidance on servicing contracts.	1 Jan 2016	The assessment has indicated that when an asset (or disposal group) is reclassified from 'held to sale' to 'held for distribution', or vice versa, the asset does not have to be reinstated in the financial statements. Entities will be required to disclose all types of continuing involvement the entity still has when transferring a financial asset to a third party under conditions which allow it to derecognise the asset
AASB 2015 6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, AASB 124 & AASB 1049]	The Amendments extend the scope of AASB 124 Related Party Disclosures to not-for-profit public sector entities. A guidance has been included to assist the application of the Standard by not-for-profit public sector entities.	1 Jan 2016	The amending standard will result in extended disclosures on the entity's key management personnel (KMP), and the related party transactions.
AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities	The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	1 Jan 2017	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136.

(s) Category Groups

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

Admitted Patient Services (Admitted Patients) comprises all acute and subacute admitted patient services, where services are delivered in public hospitals.

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

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

Aged Care comprises a range of in home, specialist geriatric, 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.

Residential Aged Care including Mental Health (RAC incl. Mental Health) referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from DH under the mental health program. It excludes all other residential services funded under the mental health program, such as mental health-funded community care units and secure extended care units.

Other Services not reported elsewhere – (Other) comprises services not separately classified above, including: Public Health Services including laboratory testing, blood borne viruses / sexually transmitted infections clinical services, Kooris liaison officers, immunisation and screening services, drugs services including drug withdrawal, counselling and the needle and syringe program, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

Note 2: Analysis of Revenue by Source	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	-	-	4,069	4,519
Total Revenue from Operating Activities	**38,512**	**14,709**	**7,102**	**1,363**	**4,069**	**65,756**
Donations	-	-	-	-	73	73
Interest & Dividends	-	-	-	-	537	537
Other Revenue from Non-Operating Activities	-	-	-	-	772	772
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 13)	-	-	-	-	(3)	(3)
Total Revenue	**38,512**	**14,709**	**7,102**	**1,363**	**9,884**	**71,571**

Note 2: Analysis of Revenue by Source (Continued)	Admitted Patients 2015 $'000	RAC incl. Mental Health 2015 $'000	Aged Care 2015 $'000	Primary Health 2015 $'000	Other 2015 $'000	Total 2015 $'000
Government Grant	35,203	10,491	6,488	1,315	-	53,497
Indirect contributions by Department of Health and Human Services	37	17	4	2	-	60
Patient & Resident Fees	2,410	4,124	364	-	-	6,898
Commercial Activities	-	264	-	-	3,806	4,070
Total Revenue from Operating Activities	**37,650**	**14,896**	**6,856**	**1,317**	**3,806**	**64,525**
Donations	-	-	-	-	74	74
Interest & Dividends	-	-	-	-	692	692
Other Revenue from Non-Operating Activities	-	-	-	-	818	818
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**1,584**	**1,584**
Capital Purpose Income (excluding Interest)	-	-	-	-	2,209	2,209
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**2,209**	**2,209**
Share of Net Result of Associates & Joint Ventures Accounted for using the Equity Method (refer note 13)	-	-	-	-	(23)	(23)
Total Revenue	**37,650**	**14,896**	**6,856**	**1,317**	**7,576**	**68,295**

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

Note 2a: Net Gain/(Loss) on Disposal of Non-Financial Assets	Total 2016 $'000	Total 2015 $'000
Proceeds from Disposals of Non-Current Assets		
Land	104	-
Medical Equipment	8	-
Motor Vehicles	139	168
Buildings	-	60
Total Proceeds from Disposal of Non-Current Assets	251	228
Less: Written Down Value of Non-Current Assets Sold*		
Land	220	-
Medical Equipment	-	-
Motor Vehicles	67	167
Buildings	-	140
Total Written Down Value of Non-Current Assets Sold	**287**	**307**
Net gain/(loss) on Disposal of Non-Financial Assets	**(36)**	**(79)**

Note 3: Analysis of Expenses by Source	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
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**
Expenditure for Capital Purposes	-	-	-	-	103	103
Depreciation (refer note 4)	3,790	2,048	294	505	314	6,951
Finance Costs (refer note 5)	24	13	2	3	2	44
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**

Note 3: Analysis of Expenses by Source (Continued)	Admitted Patients 2015 $'000	RAC incl. Mental Health 2015 $'000	Aged Care 2015 $'000	Primary Health 2015 $'000	Other 2015 $'000	Total 2015 $'000
Employee Expenses	24,892	11,732	3,566	2,383	2,116	44,689
Non Salary Labour Costs	4,247	-	-	-	-	4,247
Supplies & Consumables	4,427	1,155	385	257	192	6,416
Other Expenses	7,532	1,220	713	305	386	10,156
Total Expenditure from Operating Activities	**41,098**	**14,107**	**4,664**	**2,945**	**2,694**	**65,508**
Expenditure for Capital Purposes	-	-	-	-	105	105
Depreciation (refer note 4)	3,775	2,040	293	503	313	6,924
Finance Costs (refer note 5)	**23**	**12**	**2**	**3**	**2**	**42**
Total other expenses	3,798	2,052	295	506	420	7,071
Total Expenses	**44,896**	**16,159**	**4,959**	**3,451**	**3,114**	**72,579**

Note 3a: Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds for Services Supported by Hospital and Community Initiatives	Expense		Revenue	
	Total 2016 $'000	Total 2015 $'000	Total 2016 $'000	Total 2015 $'000
Commercial Activities				
Private Practice and Other Patient Activities	9	59	-	-
Catering	262	377	223	326
Laundry	133	140	9	15
Cafeteria	94	92	241	267
Property Expense/Revenue	131	136	772	818
Specific Expenses	-	-	4,046	3,462
TOTAL	**629**	**804**	**5,291**	**4,888**

Note 4: Depreciation	Total 2016 $'000	Total 2015 $'000
Depreciation		
Buildings (i)	5,093	5,087
Plant & Equipment (ii)	225	221
Medical Equipment	625	664
Leased Assets	393	354
Computers and Communication	132	140
Furniture and Fittings	146	140
Motor Vehicles	337	318
Total Depreciation	**6,951**	**6,924**
Total Depreciation	**6,951**	**6,924**

(i) Of the balance in 'depreciation-buildings' $Nil [$Nil in 2015] related to assets contracted under the public private partnership (PPP) arrangements.
(ii) Of the balance in 'Depreciation - plant and equipment' $Nil [$Nil in 2015] related to assets contracted under the PPP arrangements.

Note 5: Finance Costs	Total 2016 $'000	Total 2015 $'000
Finance Charges on Finance Leases (i)	44	42
Total Finance Costs	**44**	**42**

(i) Of the balance in 'interest on finance lease', $44,000 [$42,000 in 2015] related to assets contracted under the SWARH arrangements.

Note 6: Cash and Cash Equivalents	Total 2016 $'000	Total 2015 $'000
Cash on hand	23	23
Cash at bank	12,636	9,875
Deposits at call	-	4,500
Total Cash and Cash Equivalents	**12,659**	**14,398**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	9,178	11,467
Cash for Monies Held in Trust		
- Cash at Bank	3,481	2,931
Total Cash and Cash Equivalents	**12,659**	**14,398**

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 7: Receivables	Total 2016 $'000	Total 2015 $'000
CURRENT Contractual		
Trade Debtors	2,328	810
Patient Fees	1,234	1,226
Accrued Revenue - Other	546	490
Less Allowance for Doubtful Debts		
Trade Debtors	(16)	(8)
Patient Fees	(68)	(58)
	4,024	**2,460**
Statutory		
GST Receivable	230	225
	230	**225**
TOTAL CURRENT RECEIVABLES	**4,254**	**2,685**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health / Department of Health and Human Services	1,166	1,207
TOTAL NON-CURRENT RECEIVABLES	**1,166**	**1,207**
TOTAL RECEIVABLES	**5,420**	**3,892**

Note 7(a): Movement in the Allowance for doubtful debts	Total 2016 $'000	Total 2015 $'000
Balance at beginning of year	66	218
Amounts written off during the year	(22)	(178)
Increase/(decrease) in allowance recognised in net result	40	26
Balance at end of year	**84**	**66**

(b) Ageing analysis of receivables
Please refer to note 22(c) for the ageing analysis of contractual receivables

(c) Nature and extent of risk arising from receivables
Please refer to note 22(c) for the nature and extent of credit risk arising from contractual receivables

Note 8: Investments and other Financial Assets	Specific Purpose Fund		Capital Fund		Total	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000
CURRENT						
Loans and receivables						
Term Deposit						
Others > 3 months *	16,242	9,295	-	-	16,242	9,295
Total Current	16,242	9,295	-	-	16,242	9,295
NON CURRENT						
Loans and receivables						
Term Deposit						
Others > 3 months	-	-	653	414	653	414
Available for sale						
Equities and Managed Investment Schemes						
Australian Listed Equity Securities	1,688	1,801	-	-	1,688	1,801
Total Non Current	1,688	1,801	653	414	2,341	2,215
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**17,930**	**11,096**	**653**	**414**	**18,583**	**11,510**
Represented by: Health Service Investments	11,160	5,727	653	414	11,813	6,141
Monies Held in Trust	6,770	5,369			6,770	5,369
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**17,930**	**11,096**	**653**	**414**	**18,583**	**11,510**

(i) Term deposits under 'investments and other financial assets' class include only term deposits with maturity greater than 90 days.

(a) Ageing analysis of investments and other financial assets
Please refer to note 22(c) 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 22(c) for the nature and extent of credit risk arising from investments and other financial assets

Note 9: Inventories	Total 2016 $'000	Total 2015 $'000
Pharmaceuticals		
At cost	133	135
Engineering Stores		
At Cost	11	10
Administration Stores		
At Cost	9	5
TOTAL INVENTORIES	**153**	**150**

Note 10: Non-Financial Physical Assets Classified as Held for Sale (A) Non-financial physical assets including disposal group assets classified as held for sale	Total 2016 $'000	Total 2015 $'000
Freehold Land (i)	-	220
TOTAL NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE	-	**220**

(i) The Health Service had land for sale at the commencement of 2015-2016 which was contracted for sale in May 2016. The land was previously vacant land used as a storage site.

(B) Fair value measurement of non-financial physical assets held for sale	Carrying amount 2016 $'000	Fair value measurement at end of reporting period using:		
		Level 1 (1)	Level 2 (1)	Level 3 (1)
Freehold Land held for sale (ii)	-	-	-	-
TOTAL NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE	-	-	-	-

(1) Classified in accordance with the fair value hierarchy (Note 1)
(ii) Freehold land held for sale is carried at fair value less costs to disposal.

(B) Fair value measurement of non-financial physical assets held for sale	Carrying amount 2015 $'000	Fair value measurement at end of reporting period using:		
		Level 1 (1)	Level 2 (1)	Level 3 (1)
Freehold Land held for sale (ii)	220	-	220	-
TOTAL NON-FINANCIAL PHYSICAL ASSETS CLASSIFIED AS HELD FOR SALE	**220**	-	**220**	-

(1) Classified in accordance with the fair value hierarchy (Note 1)
(ii) Freehold land held for sale is carried at fair value less costs to disposal.
Refer to note 14 for the valuation technique applied to non-specialised land

Note 11: Other Assets	Total 2016 $'000	Total 2015 $'000
CURRENT Prepayments	1,289	1,008
Other	37	-
TOTAL CURRENT OTHER ASSETS	**1,326**	**1,008**
TOTAL OTHER ASSETS	**1,326**	**1,008**

Note 12: Property, plant & equipment (a) Gross carrying amount and accumulated depreciation	Total 2016 $'000	Total 2015 $'000
Land		
Land at Fair Value	4,837	4,837
Less Impairment	-	-
Total Land	**4,837**	**4,837**
Buildings		
Buildings Under Construction at cost	53	1,143
Buildings at Fair Value	124,805	124,748
Less Acc'd Depreciation	10,081	5,039
Leasehold Improvements at cost	1,897	1,886
Less Acc'd Depreciation	99	49
Total Buildings	**116,575**	**122,689**
Plant and Equipment		
Plant and Equipment at Fair Value	6,167	4,776
Less Acc'd Depreciation	2,229	2,070
Total Plant and Equipment	**3,938**	**2,706**
Medical Equipment		
Medical Equipment at Fair Value	8,213	8,418
Less Acc'd Depreciation	5,112	4,999
Total Medical Equipment	**3,101**	**3,419**
Computers and Communication		
Computers and Communication at Fair Value	1,174	1,145
Less Acc'd Depreciation	900	762
Total Computers and Communication	**274**	**383**
Furniture and Fittings		
Furniture and Fittings at Fair Value	1,292	1,350
Less Acc'd Depreciation	828	787
Total Furniture and Fittings	**464**	**563**
Motor Vehicles		
Motor Vehicles at Fair Value	2,006	1,877
Less Acc'd Depreciation	971	978
Total Motor Vehicles	**1,035**	**899**
Leased Assets		
Computers and Communication	1,648	1,426
Less Acc'd Depreciation	745	354
Total Leased Assets	**903**	**1,072**
TOTAL	**131,127**	**136,568**

Note 12: Property, plant & equipment (continued) (b) Reconciliations of the carrying amounts of each class of asset	Land (i) $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Computers & Communication $'000	Furniture & Fittings $'000	Motor Vehicles $'000	SWARH JV $'000	Leased Assets $'000	Assets Under Construction $'000	Total $'000
Balance at 1 July 2014	**4,742**	**126,465**	**2,835**	**3,587**	**458**	**543**	**989**	**37**		**1,258**	**140,914**
Additions	95	53	92	515	32	160	374	-	-	-	1,321
Disposals	-	-	-	(19)	(4)	-	(146)	-	-	-	(169)
Net Transfers between Classes	-	115	-		-	-	-	-	-	(115)	-
Net Additions through Restructuring	-	-	-	-	-	-	-	-	1,426	-	1,426
Depreciation (note 4)	-	(5,087)	(221)	(664)	(134)	(140)	(318)	(6)	(354)	-	(6,924)
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)	-	(5,093)	(225)	(625)	(126)	(146)	(337)	(6)	(393)	-	(6,951)
Balance at 30 June 2016	**4,837**	**116,522**	**3,938**	**3,101**	**246**	**464**	**1,035**	**28**	**903**	**53**	**131,127**

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 12: Property, plant & equipment (c) Fair value measurement hierarchy for assets	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				
Plant, Equipment and Vehicles at Fair Value	3,938	-	-	3,938
Total Plant and Equipment at Fair Value	**3,938**	**-**	**-**	**3,938**
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**
Motor Vehicles at Fair Value (ii)				
Motor Vehicles at Fair Value	1,035	-	-	1,035
Total Motor Vehicles at Fair Value	**1,035**	**-**	**-**	**1,035**
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 12: Property, plant & equipment (c) Fair value measurement hierarchy for assets as at 30 June 2015	Carrying amount as at 30 June 2015 $'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				
Non-specialised Buildings	1,143	-	-	1,143
Specialised Buildings	654	-	654	-
Heritage Assets	120,516	-	-	120,516
Assets Under Construction	376	-	-	376
Total of Building at Fair Value	**122,689**	**-**	**654**	**122,035**
Plant and Equipment at Fair Value				
Plant, Equipment and Vehicles at Fair Value	2,706	-	-	2,706
Total Plant and Equipment at Fair Value	**2,706**	**-**	**-**	**2,706**
Medical Equipment at Fair Value				
Medical Equipment at Fair Value	3,419	-	-	3,419
Total Medical Equipment at Fair Value	**3,419**	**-**	**-**	**3,419**
Computers and Communication at Fair Value				
Computers and Communication at Fair Value	383	-	-	383
Total Computers and Communication at Fair Value	**383**	**-**	**-**	**383**
Furniture and Fittings at Fair Value				
Furniture and Fittings at Fair Value	563	-	-	563
Total Furniture and Fittings at Fair Value	**563**	**-**	**-**	**563**
Motor Vehicles at Fair Value (ii)				
Motor Vehicles at Fair Value	899	-	-	899
Total Motor Vehicles at Fair Value	**899**	**-**	**-**	**899**
Leased Assets				
Leased Assets at Fair Value	1,072	-	-	1,072
Total Leased Assets at Fair Value	**1,072**	**-**	**-**	**1,072**
TOTAL	**136,568**	**-**	**1,272**	**135,296**

(i) Classified in accordance with the fair value hierarchy, see Note 1. (ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value. There have been no transfers between levels during the period.

Note 12: Property, plant & equipment (continued) (d) Reconciliation of Level 3 fair value 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**

Unrealised gains/(losses) on non-financial assets (i)

Note 12: Property, plant & equipment (continued) (d) Reconciliation of Level 3 fair value (i) 30 June 2015	Land $'000	Buildings $'000	Plant and equipment $'000	Medical equipment $'000	Computers & Communications $'000	Furniture and Fittings $'000	Motor Vehicles $'000	Leased Assets $'000
Opening Balance	**4,219**	**127,184**	**2,835**	**3,587**	**495**	**543**	**989**	**-**
Purchases (sales)	-	(66)	92	496	28	160	228	-
Transfers in (out) of Level 3	-	-	-	-	-	-	-	1,426
Gains or losses recognised in net result								
- Depreciation	-	(5,083)	(221)	(664)	(140)	(140)	(318)	(354)
Subtotal	**4,219**	**122,035**	**2,706**	**3,419**	**383**	**563**	**899**	**1,072**
Closing Balance	**4,219**	**122,035**	**2,706**	**3,419**	**383**	**563**	**899**	**1,072**

Note 12: Property, plant & equipment (continued) (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

Note 13: Investments Accounted for Using the Equity Method			Ownership Interest		Fair Value	
Name of Entity	**Principal Activity**	**Country of Incorporation**	**2016 %**	**2015 %**	**2016 %**	**2015 %**
Jointly Controlled Entities						
Southern Grampians/Glenelg Shire PCP	Primary Health	Australia	45	45	93	96

Note 13.1: Investments Accounted for Using the Equity Method (Continued) Summarised financial information in respect of the agency's material associate and joint venture is set 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	2016 $'000	2015 $'000
Summarised balance sheet:		
Current Assets		
Cash and Cash Equivalents	479	592
Non-Current Assets		
Total Assets	**479**	**592**
Current Liabilities		
Other Liabilities	131	259
Staff Provisions	75	86
Non-Current Liabilities		
Staff Provisions	66	33
Total Liabilities	272	378
Net Assets	**207**	**214**
Equity		
Contributed Capital	433	433
Accumulated Surplus	(226)	(219)
Total Equity	207	214
Share of Associates Net Assets	93	96
Summarised operating statement		
Total income from transaction	740	667
Net result from continuing operation	**(3)**	**(23)**
Net Result	(3)	(23)
Other economic flows - other comprehensive income	-	-
Total comprehensive income	**(3)**	**(23)**
Share of Jointly Controlled Entities' Net Result After Income Tax	**(3)**	**(23)**
Share of Jointly Controlled Entities' Other Comprehensive Income	**-**	**-**
Dividends received from Associates	**-**	**-**

Movements in carrying amount of interests in the associate	2016 $'000	2015 $'000
Carrying amount at the beginning of the year	**96**	**119**
Share of associate's net result after tax	**(3)**	**(23)**
Carrying amount at the end of the year	**93**	**96**

Dividends Received from Associates and Joint Ventures
During the 2016 financial year, Western District Health Service received dividends of $0 (2014/2015: $0) from its associates and dividends of $0 (2014/2015: $0) from its joint ventures.

Note 14: Intangible Assets	Total 2016 $'000	Total 2015 $'000
Computer Software	46	46
Less Acc'd Amortisation	46	46
Total Intangible Assets	**-**	**-**

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

	Computer Software $'000	Total $'000
Balance at 1 July 2014	**-**	**-**
Amortisation (note 4)(i)	**-**	**-**
Balance at 1 July 2015	**-**	**-**
Amortisation (note 4)(i)	**-**	**-**
Balance at 30 June 2016	**-**	**-**

Note 15: Payables	Total 2016 $'000	Total 2015 $'000
CURRENT Contractual		
Trade Creditors	4,242	2,586
Accrued Expenses	816	946
Other	2	38
	5,060	**3,570**
Statutory		
GST Payable	27	45
Department of Health and Human Services	113	396
	140	**441**
TOTAL CURRENT	**5,200**	**4,011**

(a) Maturity analysis of payables
Please refer to Note 22c for the ageing analysis of contractual payables
(b) Nature and extent of risk arising from payables
Please refer to note 22c for the nature and extent of risks arising from contractual payables

Note 16: Borrowings	Total 2016 $'000	Total 2015 $'000
CURRENT		
Australian Dollar Borrowings		
– Finance Lease Liability (i) (refer Note 18a)	358	354
Total Australian Dollars Borrowings	**358**	**354**
TOTAL CURRENT	**358**	**354**
NON CURRENT		
Australian Dollar Borrowings		
– Finance Lease Liability (refer Note 18a)	543	718
Total Australian Dollars Borrowings	**543**	**718**
Total Non-Current	**543**	**718**
Total Borrowings	**901**	**1,072**

(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.

	$'000	$'000
Amount of finance costs recognised as expenses	44	42

Amount of investment revenue earned on borrowed funds that has been deducted from the finance costs incurred Nil.
(a) Maturity analysis of borrowings
Please refer to note 22(c) for the ageing analysis of borrowings.
(b) Nature and extent of risk arising from borrowings
Please refer to note 22(c) 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 16.a: Borrowings (a) Finance lease liabilities	Minimum future lease payments (i)		Present value of minimum future lease payments	
	2016	2015	2016	2015
Other finance lease liabilities payable (ii)				
Not longer than one year	358	354	358	354
Longer than one year but not longer than five years	543	718	543	718
Longer than five years	-	-	-	-
Minimum future lease payments	**901**	**1072**	**901**	**1072**
Less future finance charges	44	88	44	88
Present value of minimum lease payments	**857**	**984**	**857**	**984**
Included in the financial statements as:				
Current borrowings lease liabilities (Note 16)	358	354	358	354
Non-current borrowing lease liabilities (Note 16)	543	718	543	718
	901	**1072**	**901**	**1072**

(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 23

The weighted average interest rate implicit in leases is 4.90% (2015 - 4.97%)

Note 17: Provisions	Total 2016 $'000	Total 2015 $'000
Current Provisions		
Employee Benefits (i)		
Annual leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	2,716	2,687
- Unconditional and expected to be settled wholly after 12 months (iii)	-	-
Long service leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	800	582
- Unconditional and expected to be settled wholly after 12 months (iii)	3,356	3,674
Accrued Days Off	-	-
- Unconditional and expected to be settled wholly within 12 months (ii)	80	62
Accrued Wages and Salaries		
- Unconditional and expected to be settled wholly within 12 months (ii)	857	199
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled wholly within 12 months (ii)	871	786
- Unconditional and expected to be settled wholly after 12 months (iii)	373	409
Total Current Provisions	**9,053**	**8,399**
Non-Current Provisions		
Employee Benefits (i)	1,644	1,497
Provisions related to Employee Benefit On-Costs	182	160
Total Non-Current Provisions	**1,826**	**1,657**
Total Provisions	**10,879**	**10,056**

(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional Long Service Leave Entitlement	4,617	4,723
Annual Leave Entitlements	3,499	3,415
Accrued Wages and Salaries	857	199
Accrued Days Off	80	62
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (ii)	1,826	1,657
Total Employee Benefits and Related On-Costs	**10,879**	**10,056**

(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 17: Provisions (continued)	Total 2016 $'000	Total 2015 $'000
(b) Movements in provisions		
Movement in Long Service Leave:		
Balance at start of year	**6,278**	**6,197**
Provision made during the year		
- Revaluations	93	139
- Expense recognising Employee Service	872	524
Settlement made during the year	(800)	(582)
Balance at end of year	**6,443**	**6,278**

Note 18: Superannuation	Paid contribution for the year		Contribution outstanding at	
	Total 2016 $'000	Total 2015 $'000	Total 2016 $'000	Total 2015 $'000
(i) Defined benefit plans:				
First State Super (Health Super)	172	195	11	19
Defined contribution plans:				
First State Super (Health Super)	2296	2671	213	283
HESTA	689	522	63	54
Other	78	56	6	6
Total	**3235**	**3444**	**293**	**362**

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

Note 19: Other Liabilities	Total 2016 $'000	Total 2015 $'000
CURRENT		
Monies Held in Trust		
- Patient Monies Held in Trust	444	488
- Accommodation Bonds (Refundable Entrance Fees)	2,720	1,880
Income Received in Advance	467	-
Total Current	**3,631**	**2,368**
NON CURRENT		
Monies Held in Trust		
- Accommodation Bonds (Refundable Entrance Fees)	7,087	5,932
Total Non-Current	**7,087**	**5,932**
Total Other Liabilities (List major items within each category)	**10,718**	**8,300**
Total Monies Held in Trust Represented by the following assets:		
Cash Assets (refer to Note 6)	3,481	2,931
Investments (refer to Note 8)	6,770	5,369
TOTAL	**10,251**	**8,300**

Note 20: Equity	Total 2016 $'000	Total 2015 $'000
(a) Surpluses. Property, Plant & Equipment Revaluation Surplus [1]		
Balance at the beginning of the reporting period	67,366	67,366
Revaluation Increment/(Decrements)		
- Land	-	-
- Buildings	-	-
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 [2]		
Balance at the beginning of the reporting period	178	254
Valuation gain/(loss) recognised	(51)	(14)
Cumulative (gain)/loss transferred to Operating Statement on Sale of Financial Assets	(32)	(62)
Cumulative (gain)/loss transferred to Operating Statement on Impairment of Financial Assets	(7)	-
Balance at end of the reporting period	**88**	**178**

(1) The property, plant & equipment asset revaluation surplus arises on the revaluation of property, plant & equipment.
(2) The financial assets available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold, that portion of the reserve which relates to the financial asset, and is effectively realised, is recognised in the net result. Where a revalued financial asset is impaired that portion of the reserve which relates to that financial asset is recognised in net result.

Note 20: Equity (continued)	Total 2016 $'000	Total 2015 $'000
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	5,283	4,391
Transfer to and from Restricted Specific Purpose Surplus	2,283	892
Balance at the end of the reporting period	**7,566**	**5,283**
Total Surpluses	**75,020**	**72,827**
(b) Contributed Capital		
Balance at the beginning of the reporting period	49,535	49,535
Balance at the end of the reporting period	**49,535**	**49,535**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	22,041	27,217
Net Result for the Year	(2,650)	(4,284)
Transfers to and from Surplus (Identify the transfers from each of the above reserves)	(2,283)	(892)
Balance at the end of the reporting period	17,108	22,041
Total Equity at end of financial year	**141,663**	**144,403**

Note 21: Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities	Total 2016 $'000	Total 2015 $'000
Net result for the period	(2,650)	(4,284)
Non-cash movements:		
Depreciation and amortisation	6,951	6,924
Provision for doubtful debts	48	63
Movements included in investing and financing activities		
Net (gain)/loss from disposal of non financial physical assets	36	79
Net (gain)/loss from disposal of financial assets	-	14
Movements in assets and liabilities:		
Change in operating assets and liabilities		
(Increase)/decrease in receivables	(1,575)	(244)
(Increase)/decrease in other assets	72	20
(Increase)/decrease in prepayments	(289)	(44)
Increase/(decrease) in payables	1,243	2,373
Increase/(decrease) in provisions	823	(804)
Increase/(decrease) in other liabilities	861	1,363
Lease payments reclassified as finance lease	(223)	-
Change in inventories	(3)	123
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**5,294**	**5,583**

Note 22 Financial Instruments

(a) Financial risk management objectives and policies

Western District Heath 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
- debt securities

Details of the significant accounting policies and methods adopted, including the criteria for recognition, the basis of measurement and the basis on which income and expenses are recognised, with respect to each class of financial asset, financial liability and equity instrument are disclosed in note 1 to the financial statements.

The Health Service's main financial risks include credit risk, liquidity risk, interest rate risk, foreign currency risk and equity price risk (amend as appropriate). 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.

Note 22: Financial Instruments				
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	12,659	-	-	12,659
Receivables				
- Trade Debtors	2,328	-	-	2,328
- Other Receivables	1,780	-	-	1,780
Other Financial Assets				
- Term Deposit	16,895	-	-	16,895
- Shares in Other Entities	-	1,688	-	1,688
Total Financial Assets (i)	**33,662**	**1,688**	**-**	**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 (ii)	**-**	**-**	**16,679**	**16,679**

2015	**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	14,398	-	-	14,398
Receivables				
- Trade Debtors	810	-	-	810
- Other Receivables	1,716	-	-	1,716
Other Financial Assets				
- Term Deposit	9,709	-	-	9,709
- Shares in Other Entities	-	1,801	-	1,801
Total Financial Assets (i)	**26,633**	**1,801**	**-**	**28,434**
Financial Liabilities				
Payables	-	-	3,570	3,570
Borrowings	-	-	1,072	1,072
Other Financial Liabilities	-	-	-	-
- Accommodation bonds	-	-	7,812	7,812
- Other	-	-	488	488
Total Financial Liabilities (ii)	**-**	**-**	**12,942**	**12,942**

(i) The total amount of financial assets disclosed here excludes statutory receivables
(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payable)

Note 22: Financial Instruments - (b) Net holding gain/(loss) on financial instruments by category				
2016	**Net holding gain/(loss) $'000**	**Total interest income / (expense) $'000**	**Impairment loss $'000**	**Total $'000**
Financial Assets				
Loans and Receivables (i)	-	537	-	537
Available for Sale (i)	(84)		(6)	(90)
Total Financial Assets	**(84)**	**537**	**(6)**	**447**

2015	**Net holding gain/(loss) $'000**	**Total interest income / (expense) $'000**	**Impairment loss $'000**	**Total $'000**
Financial Assets				
Loans and Receivables (i)	-	692	-	692
Available for Sale (i)	(62)	-	(14)	(76)
Total Financial Assets	**(62)**	**692**	**(14)**	**616**

(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.

(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.

Note 22: Financial Instruments (continued) - Credit quality of contractual financial assets that are neither past due nor impaired					
2016	**"Financial institutions (min BBB credit rating) $'000**	**"Government agencies (AA credit rating) $'000**	**"Government agencies (BBB credit rating) $'000**	**"Other (min BBB credit rating) $'000**	**Total $'000**
Financial Assets					
Cash and Cash Equivalents	12,659	-	-	-	12,659
Loans and Receivables					
- Trade Debtors	-	-	-	2,328	2,328
- Other Receivables (i)	-	-	-	1,780	1,780
- Term Deposit	2,144	14,751	-	-	16,895
Available for sale					-
- Shares in Other Entities	1,688	-	-	-	1,688
Total Financial Assets	**16,491**	**14,751**	**-**	**4,108**	**35,350**

2015	**"Financial institutions (min BBB credit rating) $'000**	**"Government agencies (AA credit rating) $'000**	**"Government agencies (BBB credit rating) $'000**	**"Other (min BBB credit rating) $'000**	**Total $'000**
Financial Assets					
Cash and Cash Equivalents	14,398	-	-	-	14,398
Loans and Receivables					
- Trade Debtors	-	-	-	810	810
- Other Receivables	-	-	-	1,716	1,716
- Term Deposit	7,709	2,000	-	-	9,709
Available for sale					
- Shares in Other Entities	1,801	-	-	-	1,801
Total Financial Assets	**23,908**	**2,000**	**-**	**2,526**	**28,434**

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

Note 22: Financial Instruments (continued) (c) Credit Risk (continued)
Ageing analysis of Financial Assets as at 30 June

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	1-5 Years $'000	
Financial Assets							
Cash and Cash Equivalents	12,659	12,659	-	-	-	-	-
Loans and Receivables							
- Trade Debtors	2,328	1,911	220	47	134	-	16
- Other Receivables	1,780	-	1,418	38	256	-	68
- Term Deposit	16,895	16,895	-	-	-	-	-
Available for sale							
- Shares in Other Entities	1,688	1,688	-	-	-	-	-
Total Financial Assets	**35,350**	**33,153**	**1,638**	**85**	**390**	**-**	**84**

2015	Total Carrying Amount $'000	Not Past Due and Not Impaired $'000	Past Due But Not Impaired				Impaired Financial Assets $'000
			Less than 1 Month $'000	1-3 Months $'000	3 months - 1 Year $'000	1-5 Years $'000	
Financial Assets							
Cash and Cash Equivalents	14,398	14,398	-	-	-	-	-
Loans and Receivables							
- Trade Debtors	810	512	248	14	28	-	8
- Other Receivables	1,716	-	1,345	39	274	-	59
- Term Deposit	9,709	9,709	-	-	-	-	-
Available for sale							
- Shares in Other Entities	1,801	1,801	-	-	-	-	-
Total Financial Assets	**28,434**	**26,420**	**1,593**	**53**	**302**	**-**	**67**

There are no material financial assets which are individually determined to be impaired. Currently Western District Health Service does not hold any collateral as security nor credit enhancements relating to any of its financial assets.
There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired, and they are stated at the carrying amounts as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired.

(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 service operates under the Government's fair payments policy of setting financial obligation within 30 days and in the event of a dispute, making payments within 30 days from the date of resolution. The Health Service's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet. The Health Service manages its liquidity risk as follows:
Term deposits, investments and cash held at financial institutions are managed with variable maturity dates and take into consideration cashflow requirements of the health service from month to month. Trade creditors are paid in accordance with their trading terms; and accommodation bonds are refunded when the resident departs the aged care facility. The following table discloses the contractual maturity analysis for Western District Health Service'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

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**

2015	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
At amortised cost						
Payables	3,570	3,570	3,570	-	-	-
Borrowings	1,072	1,072	-	-	354	718
Other Financial Liabilities (i)						
- Accommodation Bonds	7,812	7,812	-	-	1,880	5,932
- Other	488	488		401	87	-
Total Financial Liabilities	**12,942**	**12,942**	**3,570**	**401**	**2,321**	**6,650**

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

Note 22: Financial Instruments (continued)

(e) Market risk

Western District Health Service's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraph below.

Currency risk

Western District Health Service is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

Interest rate risk

Exposure to interest rate risk might arise primarily through the 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.

Other price risk

Western District Health Service is exposed to normal price fluctuations from time to time through market forces. Where adequate notice is provided to suppliers, additional purchases are made for long term goods

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

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	12,659	-	-	-
Loans and Receivables (i)					
- Trade Debtors		2,328	-	-	2,328
- Other Receivables		1,780	-	-	1,780
- Term Deposit	2.87	16,895	-	-	-
Available for sale					
- Shares in Other Entities		1,688	-	-	1,688
		35,350	**-**	**-**	**5,796**
Financial Liabilities					
At amortised cost					
Payables(i)		5,060	-	-	-
Borrowings		901	-	-	-
Other Financial Liabilities					
- Accommodation Bonds	2.87	9,807	-	-	-
- Other		911	-	-	-
		16,679	**-**	**-**	**-**

2015	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	2.15	14,398	-	14,398	-
Loans and Receivables (i)					
- Trade Debtors		810	-	-	810
- Other Receivables		1,716	-	-	1,716
- Term Deposit	*3.10*	*9,709*	-	*9,709*	-
Available for sale					
- Shares in Other Entities		1,801	-	-	1,801
		28,434	**-**	**24,107**	**4,327**
At amortised cost					
Payables(i)		3,570	-	-	3,570
Borrowings		1,072		-	-
Other Financial Liabilities					
- Accommodation Bonds	3.10	7,812	-	7,812	-
- Other		488	-	-	488
		12,942	**-**	**7,812**	**4,058**

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

Note 22: Financial Instruments (cont)

(e) Market risk (continued)

Sensitivity disclosure analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, Western District Health Service believes the following movements are 'reasonably possible' over the next 12 months (Base rates are sourced from the Reserve Bank of Australia):

- A shift of 100 basis points up and down in market interest rates (AUD) from year-end rates of 2.90%;

- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%

- A movement of 15% up and down (2015: 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.

2016	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-Y%		+X%		-Z%		+Z%	
		Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
Financial Assets									
Cash and Cash Equivalents(i)	12,659	(127)	(127)	127	127	-	-	-	-
Loans and Receivables (i)									
- Trade Debtors	2,328	-	-	-	-	-	-	-	-
- Other Receivables	1,780	-	-	-	-	-	-	-	-
- Term Deposit	16,895	(169)	(169)	169	169	-	-	-	-
Available for sale									
- Shares in Other Entities	1,688	-	-	-	-	-	-	-	-
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**	**-**	**-**	**-**	**-**

2015	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-Y%		+X%		-Z%		+Z%	
		Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
Financial Assets									
Cash and Cash Equivalents(i)	14,398	(144)	(144)	144	144	-	-	-	-
Loans and Receivables (i)									
- Trade Debtors	810	-	-	-	-	-	-	-	-
- Other Receivables	1,716	-	-	-	-	-	-	-	-
- Term Deposit	9,709	(97)	(97)	97	97	-	-	-	-
Available for sale									
- Shares in Other Entities	1,801	-	-	-	-	-	-	-	-
Financial Liabilities									
At amortised cost									
Payables	3,570	-	-	-	-	-	-	-	-
Borrowings	1,072	11	11	(11)	(11)	-	-	-	-
Other Financial Liabilities(ii)									
- Accommodation Bonds	7,812	-	-	-	-	-	-	-	-
- Other	**488**	-	-	-	-	-	-	-	-
		(230)	**(230)**	**230**	**230**	**-**	**-**	**-**	**-**

Note 22: 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 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	Total Carrying Amount 2016 $'000	Fair value 2016 $'000	Total Carrying Amount 2015 $'000	Fair value 2015 $'000
Financial Assets				
Cash and Cash Equivalents	12,659	12,659	14,398	14,398
Loans and Receivables (i)				
- Trade Debtors	2,328	2,328	810	810
- Other Receivables	1,780	1,780	1,717	1,717
- Term Deposit	16,895	16,895	9,709	9,709
Available for sale				
- Shares in Other Entities	1,688	1,688	1,801	1,801
Total Financial Assets	**35,350**	**35,350**	**28,435**	**28,435**
Financial Liabilities				
At amortised cost				
Payables	5,060	5,060	3,570	3,570
Borrowings	901	901	1,072	1,072
Other Financial Liabilities(i)				
- Accommodation Bonds	9,807	9,807	7,812	7,812
- Other	911	911	488	488
Total Financial Liabilities	**16,679**	**16,679**	**12,942**	**12,942**

(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 2016	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				
Available for sale securities				
- Equities and managed funds	1,688	-	1,688	-
Total Financial Assets	**1,688**	**-**	**1,688**	**-**
2015				
Financial assets at fair value through profit or loss				
Available for sale securities				
- Equities and managed funds	1,801		1,801	-
Total Financial Assets	**1,801**	**-**	**1,801**	**-**

** [The fair value hierarchy disclosures shall be disclosed by class of financial instrument where class is the lowest level disclosed in the financial statements or notes and is distinct from a category of financial instruments as specified in AASB 139 paragraph 9.]

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.

Note 23: Commitments a) Commitments other than public private partnerships	Total 2016 $'000	Total 2015 $'000
Capital expenditure commitments		
Payable:		
Land and buildings	38	114
Plant and equipment	-	-
Intangible assets	-	-
Other (List)	-	-
Total capital expenditure commitments	**38**	**114**
Land and buildings		
Not later than one year	38	114
Later than 1 year and not later than 5 years	-	-
Later than 5 years	-	-
Total	**38**	**114**
Total lease commitments	**-**	**-**
Total Commitments (inclusive of GST) other than public private partnerships	**38**	**114**

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

Note 24: Contingent Assets and Contingent Liabilities

As at balance date, the Board of Directors is unaware of the existence of any financial obligatio that may have a material effect on the Balance Sheet as a result of any future even which may or may not happen. (2015-Nil)

Note 25: Operating Segments	Hospital		RAC		Linen Service		Primary Care		Eliminations		Total	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000
REVENUE												
External Segment Revenue	53,041	50,476	16,624	15,807	9	26	1,363	1,317	-	-	71,037	67,626
Intersegment Revenue	1,034	1,036	-	-	65	60	-	-	(1,099)	(1,096)	-	-
Unallocated Revenues	-	-	-	-	-	-	-	-	-		-	-
Total Revenue	**54,075**	**51,512**	**16,624**	**15,807**	**74**	**86**	**1,363**	**1,317**	**(1,099)**	**(1,096)**	**71,037**	**67,626**
EXPENSES												
External Segment Expenses	(53,739)	(52,962)	(16,827)	(16,091)	(67)	(92)	(3,588)	(3,434)	-	-	(74,221)	(72,579)
Intersegment Expenses	(1,034)	(1,036)	-	-	(65)	(60)	-	-	1,099	1,096	-	-
Unallocated Expense	-	-	-	-	-	-	-	-	-	-	-	-
Total Expenses	**(54,773)**	**(53,998)**	**(16,827)**	**(16,091)**	**(132)**	**(152)**	**(3,588)**	**(3,434)**	**1,099**	**1,096**	**(74,221)**	**(72,579)**
Net Result from ordinary activities	**(698)**	**(2,486)**	**(203)**	**(284)**	**(58)**	**(66)**	**(2,225)**	**(2,117)**	**-**	**-**	**(3,184)**	**(4,953)**
Interest Income	537	692	-	-	-	-	-	-	-	-	537	692
Share of Net Result of Associates & Joint Ventures using Equity Method	-	-	-	-	-	-	(3)	(23)	-	-	(3)	(23)
Net Result for Year	**(161)**	**(1,794)**	**(203)**	**(284)**	**(58)**	**(66)**	**(2,228)**	**(2,140)**	**-**	**-**	**(2,650)**	**(4,284)**
OTHER INFORMATION												
Unallocated Assets	114,758	114,142	42,871	41,467	631	671	11,101	11,562	-	-	169,361	167,842
Total Assets	**114,758**	**114,142**	**42,871**	**41,467**	**631**	**671**	**11,101**	**11,562**	**-**	**-**	**169,361**	**167,842**
Unallocated Liabilities	15,020	12,947	12,221	10,066	31	35	426	391	-	-	27,698	23,439
Total Liabilities	**15,020**	**12,947**	**12,221**	**10,066**	**31**	**35**	**426**	**391**	**-**	**-**	**27,698**	**23,439**
Investments in Associates and Joint Venture Partnership	-	-	-	-	-	-	93	96	-	-	93	96
Acquisition of Property, Plant and Equipment and Intangible Assets	1,302	933	252	382	-	-	3	6	-	-	1,557	1,321
Depreciation & Amortisation Expense	4,358	4,342	2,048	2,040	40	39	505	503	-	-	6,951	6,924
Non Cash Expenses other than Depreciation	40	38	18	17	-	-	6	5	-	-	64	60
Impairment of Inventories	-	-	-	-	-	-	-	-	-	-	-	-

Note 25: Operating segments (continued)

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

Business Segments	Services
Hospitals	Acute bed based services, accident and emergency, diagnostic, outpatient services.
Residential Aged Care Services (RACS)	Aged Care Residential Services
Linen Service	Linen services
Primary Care Service	Primary care and community-based services.

The basis of inter-segement 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 26: Jointly Controlled Operations and Assets

Name of Entity	Principal Activity	Ownership Interest	
		2016 %	2015 %
South West Alliance of Rural Health	Information Technology	12.80	12.93

Portland 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:

	2016 $'000	2015 $'000
South West Alliance of Rural Health		
Current Assets		
Cash at Bank	267	261
Receivables	1,911	248
Inventories	9	4
Other Current Assets	37	-
Total Current Assets	**2,224**	**513**
Non Current Assets		
Property, Plant and Equipment	29	32
Leased Assets	901	1,072
Total Non Current Assets	**930**	**1,104**
Total Assets	**3,154**	**1,617**
Current Liabilities		
Payables	1,909	216
Leased Liabilities	358	354
Employee Benefits	230	210
Total Current Liabilities	2,497	780
Non Current Liabilities		
Employee Benefits	45	52
Leased Liabilities	543	718
Total Non Current Liabilities	588	770
Total Liabilities	3,085	1,550

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

	2016 $'000	2015 $'000
South West Alliance of Rural Health		
Revenues		
Revenue From Operations	2,873	2,667
Total Revenue	**2,873**	**2,667**
Expenses		
Employee Expenses	783	751
Maintenance Contract & IT Support	1,561	1,211
Software Licence Costs		2
Other Expenses from Ordinary Activities	85	300
Total Expenses	**2,429**	**2,264**
Net Result Before Capital & Specific Items	**444**	**403**
Finance Costs	44	42
Depreciation	399	360
Net Result	**1**	**1**

Note 27a: Responsible Persons Disclosures	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	1/7/2015 - 30/6/2016
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	1/7/2015 - 30/6/2016
Governing Boards	
Mr D Barber	1/7/2015 - 30/6/2016
Mr P Besgrove	1/7/2015 - 30/6/2016
Ms F Calvert	1/7/2015 - 30/6/2016
Ms C Coggins	1/7/2015 - 30/6/2016
Ms J Hutton	1/7/2015 - 30/6/2016
Ms A Kenneally	1/7/2015 - 30/6/2016
Mr H Macdonald	1/7/2015 - 30/6/2016
Mr M McGinnity	1/7/2015 - 30/6/2016
Mr I Whiting	1/7/2015 - 30/6/2016
Accountable Officers	
Mr. R. Fitzgerald	1/7/2015 - 30/6/2016

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.

Note 27 (a) Responsible Persons Disclosure continued:

Remuneration of Responsible Persons	Total	
The number of Responsible Persons are shown in their relevant income bands;	2016	2015
Income Band	No.	No.
$0 - $9,999	9	8
$10,000 - $19,999	-	-
$20,000 - $29,999	-	-
$220,000 - $229,999	-	1
$250,000 - $259,999	-	1
$270,000 - $279,999	1	
Total Numbers	10	10
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$278,724**	**$476,099**
Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet. For information regarding related party transactions of ministers, the register of members' interests is publicly available from: www.parliament.vic.gov.au/publications/register of interests.		
Other Transactions of Responsible Persons and their Related Parties.		

Note 27b: Executive Officer Disclosures	TOTAL			
	Total Remuneration		Base Remuneration	
	2016 No.	2015 No.	2016 No.	2015 No.
$70,000 - $79,999	1	-	1	
$80,000 - $89,999	1		1	
$90,000 - $99,999	1		1	
$100,000 - $109,999	1		1	
$130,000 - $139,999	1		1	
$140,000 – $149,999	-	2	-	2
$150,000 – $159,999	1	-	1	-
$170,000 – $179,999	-	2	-	2
$230,000 – $239,999	1	1	1	1
Total	7	5	7	5
Total annualised employee equivalents (AEE) (i)				
Total Remuneration	**$878,130**	**$872,126**	**$878,130**	**$872,126**

(i) Annualised employee equivalent is based on paid working hours of 38 ordinary hours per week over the 52 weeks for a reporting period.

Note 29. Remuneration of auditors	2016 $'000	2015 $'000
Victorian Auditor-General's Office		
Audit or review of financial statement	34	32
Total Paid and Payable	**34**	**32**

Note 30: Alternate Presentation of Comprehensive operating statement	2016 $'000	2015 $'000
Interest	506	670
Dividends and income tax equivalent and rate equivalent revenue	31	22
Sales of goods and services	8,718	9,263
Grants	57,096	54,526
Other Income	5,223	3,837
Total revenue	**71,574**	**68,318**
Employee expenses	46,183	44,689
Depreciation	6,951	6,924
Interest expense	44	42
Other operating expenses	21,043	20,924
Total expenses	**74,221**	**72,579**
Net result from transactions - Net operating balance	**(2,647)**	**(4,261)**
Share of net profit/(loss) from associates/ joint venture entities excluding dividends	(3)	(23)
Total other economic flows included in net result	**(3)**	(23)
Items that may be reclassifed subsequently to net result		
Changes to financial assets available-for-sale revaluation surplus	(90)	(76)
Total other economic flows included in net result	**(90)**	**(76)**
Net result	**(2,740)**	**(4,360)**

Note 27b: Executive Officer Disclosures

Executive Officers' Remuneration

The numbers of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the first two columns in the table below in their relevant income bands.

The base remuneration of executive officers is shown in the third and fourth columns. Base remuneration is exclusive of bonus payments, long-service leave payments, redundancy payments and retirement benefits.

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

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

Note 28: Events Occurring after the Balance Sheet Date

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

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

ARA
Australasian Reporting Awards

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

BSWRICS
Barwon South West Regional Integrated Cancer Services

CDHS
Coleraine District Health Service

CE
Chief Executive

C&FN
Consumer and Friends Network

COAG
Council of Australian Governments

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

GSC Medicare Local
Great South Coast Medicare Local

GS
Glenelg Shire

HACC
Home and Community Care

HARP
Hospital Admission Risk Program

HBH
Hamilton Base Hospital

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 Medical Research Council

NSQHS Standards
National Safety and Quality Health Service Standards

OH&S
Occupational Health and Safety

OT
Occupational Therapy

PAG
Planned Activity Group

PCP
Primary Care Partnership

PDHS
Penshurst & District Health Service

P&PH
Primary & Preventative Health

QI
Quality Improvement

QOC
Quality of Care Report

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

Standard
A statement of a level of performance to be achieved

SWARH
South West Alliance of Rural Health

TRAK
Hospital patient-based information system

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.

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