



wdhs
Western District
Health Service



2024/25

Annual
Report



◉ *Jithin Nair, Jennifer Dulfo and Jubair Thazha Australian Citizens in 2024 and fun scrub nurses from the Surgical Unit.*

VISION

Creating Australia's Healthiest Rural Community

MISSION

To support our community's physical, mental and social wellbeing by:

- Providing safe, high quality and innovative services
- Building enduring partnerships
- Delivering customer service excellence.

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 acknowledges the Gunditjmara as the Traditional Owners of this land and we pay our respects to Elders past, present and emerging.

This report is also available on the WDHS website at: www.wdhs.net/publications

ABOUT THIS REPORT

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

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for Western District Health Service for the year ending 30 June 2025.

A blue ink signature of Anna Sweeney, written in a cursive style.

Anna Sweeney

Board Chairperson

Western District Health Service

24th September 2025

WDHS is a public health service established under the Health Services Act 1988 (Vic).

The responsible Ministers for the period were:

Minister for Health
Minister for Ambulance Services

The Hon. Mary-Anne Thomas
(1 July 2024 to 30 June 2025)

Minister for Health Infrastructure
The Hon. Mary-Anne Thomas
(1 July 2024 to 19 December 2024)

The Hon. Melissa Horne
(19 December 2024 to 30 June 2025)

Minister for Mental Health
Minister for Ageing

The Hon. Ingrid Stitt
(1 July 2024 to 30 June 2025)

Minister for Disability/Minister for Children
The Hon. Lizzie Blandthorn
(1 July 2024 to 30 June 2025)



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ABOUT WDHS

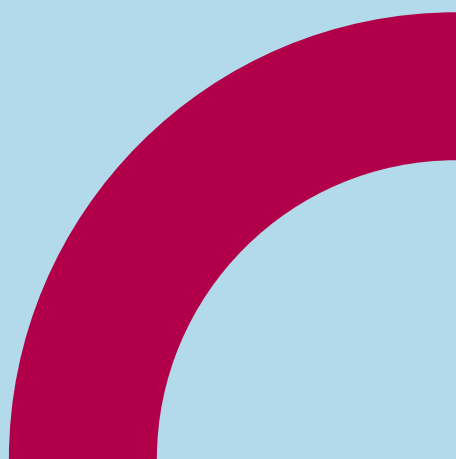
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Message From The Chairperson & Chief Executive

Anna Sweeney

Chairperson

Rowena Clift

Dual Chief Executive



Over the past 12 months, Western District Health Service (WDHS) has continued to build on its strong foundations, guided by the professionalism and dedication of our diverse and highly skilled staff. Their commitment ensures we deliver safe, high-quality care and remain responsive to the needs of our communities.

A major achievement was the completion of the Clinical Services Plan, which will guide future service planning and help ensure we continue to meet the changing health needs of our region.

During the year we also welcomed new senior medical leaders, including a Chief Medical Officer and two Surgeons, further strengthening our clinical workforce. Through strong partnerships with organisations such as Casterton Memorial Hospital (CMH), Balmoral Bush Nursing Centre, Brophy (headspace Hamilton), and South West Healthcare, we have enhanced access to mental health and wellbeing services. These collaborations, alongside our in-house mental health team, ensure more streamlined and effective care for our community.

The announcement of funding for the Penshurst Campus redevelopment marks another important step in supporting service growth into the future.

Maintaining the highest standards of quality and safety remains central to our work. The Birches successfully achieved accreditation, reflecting our commitment to continuous improvement.

Preparation is well advanced for the introduction of new Aged Care reforms, and our partnership with Safer Care Victoria has supported further innovation across our services. These efforts reinforce our focus on delivering safe, person-centred care of the highest standard.

Engagement with our community has also been a highlight. Through the National Centre for Farmer Health (NCFH), WDHS has played an active advocacy role, showcasing its work at Parliament House in Canberra and hosting a successful symposium attended by national and international experts from academia and agriculture. Locally, the establishment of Coleraine and Penshurst Community Advisory Committees has strengthened the connection between communities and the WDHS Board. Our volunteers continue to contribute generously, not only raising important funds but also supporting services such as Meals on Wheels and community transport.



📍 WDHS Board Chair, Anna Sweeney, joins Dual Chief Executive, Rowena Clift, to view the mammogram machine set to be replaced through community fundraising efforts.

In addition, the Board and senior leadership team participated in “On Country” education at Budj Bim, deepening cultural understanding and respect.

Our focus on infrastructure and technology has ensured we are well placed for the future. Significant upgrades have been undertaken at Peshurst and Coleraine, including improvements to air-handling systems and other essential works to provide safe and modern facilities for staff and patients. Information technology systems have been further strengthened, with a strong emphasis on cybersecurity and readiness for the opportunities and challenges posed by generative AI.

The year also marked the announcement of WDHS as a member of the new South West Local Health Service Network, enhancing collaboration and integration across the region.

Research and education have been revitalised with the re-establishment of the WDHS Research Committee.

This includes initiatives such as the Jess Churchill Scholarship and the DELIVER research project in partnership with Western Alliance. These programs build on our commitment to advancing knowledge, supporting staff development, and contributing to better health outcomes for the community.

Emergency management and sustainability have remained a priority, particularly as our communities experienced the significant impact of fires over the Christmas and New Year period. WDHS continues to prepare for and respond to extreme weather events while working to reduce the organisation’s climate impact. We remain mindful of the ongoing effects of drought on our farming communities and are committed to playing our part in supporting resilience and wellbeing.

Throughout the year, WDHS has remained financially sustainable, enabling us to expand services, strengthen governance, and deliver care closer to home.

These achievements have been made possible through the support of our Board of Directors, the exceptional leadership team, and our committed staff, whose dedication underpins everything we do.

Looking ahead, WDHS is well positioned to navigate a changing health landscape. With strong foundations, valued partnerships, and the trust of our community, we see an exciting future and remain committed to providing the highest standard of care for the people of our region.



◉ The Hamilton Base Hospital Theatre team celebrating International Nurses Day.



Report of
Operations ...



WDHS

*at a
Glance*



8,993

HBH Inpatient Separations



12,012

Emergency Department Presentations



2,994

Operations



17,512

Volunteer Hours



144

Babies Born



75,101

Outpatient Appointments



263

Aged Care Residents Cared For



\$552,362

Funds Raised



1,013

Staff



290

Home Care Package Clients



519

Community Support Service Clients

Year in Review Highlights

Nursing Services Hamilton Base Hospital

Maternity Services

Throughout the year, 144 babies were born at Hamilton Base Hospital, with care provided to approximately 200 women.

Maternity Outreach services were expanded, with monthly visits to Harrow and fortnightly visits to Heywood, improving access for women in surrounding communities. Stronger connections were developed with Maternal and Child Health, the Koori Maternity Service, and the Perinatal Emotional Health Program to ensure wraparound care for families. The Public Maternity Clinic continued to offer daily free antenatal and postnatal care for Medicare-eligible clients. Face-to-face antenatal classes were also reintroduced in Hamilton and Harrow, supporting parents-to-be with personalised, local education. The team supported three postgraduate midwifery students from Federation and Deakin Universities, and farewelled Dr Reid, who provided outstanding service to our community over the past eight years.

Infection Prevention & Control

The Infection Prevention and Control team delivered several key initiatives to support clinical safety and education.

◊ The new Clinical Access and Resource Unit team from left: Brigietta Herbertson, Roxanne Wenn, Michelle Ives and Michaela Hallam

Hand Hygiene Auditor training was delivered using a blended model of online modules and in-person assessment. A new "Train the Trainer" program for aseptic technique was launched, incorporating updated SOLLE-based education to enhance clinical standards. The Peripheral Intravenous Catheter (PIVC) Clinical Care Standard was implemented, supported by a series of education sessions for staff. The team continued its strong annual influenza vaccination campaign, aiming for full compliance, and maintained strict pre-employment screening processes to ensure immunity and vaccination requirements were met.

Graduate Nurse Program

In January, Hamilton Base Hospital welcomed nine Registered Nurse graduates and four Enrolled Nurse graduates to the Graduate Nurse Program.

The RNs undertook structured rotations across the medical, surgical, emergency, and perioperative units, while ENs gained valuable experience across aged care services. The program focused on building clinical confidence, supporting preceptors, and showcasing rural nursing career pathways.

Participation in career expos and regional outreach activities further strengthened efforts to attract and retain nurses in rural health settings.

Geriatric Oncology Program

Launched in July, the Geriatric Oncology Program improved care for older adults diagnosed with cancer by aligning treatment to individual goals and reducing adverse outcomes.

The introduction of the Practical Geriatric Assessment (PGA) and regular multidisciplinary team meetings supported personalised care for patients aged 70 and over, or 50 and over for Aboriginal and Torres Strait Islander people. The program, guided by medical oncologist Dr Ranjana Srivastava of Monash Health, led to improved patient satisfaction and reduced hospital admissions and emergency presentations. WDHS staff presented two abstracts on the program at the 2024 International Society of Geriatric Oncology Conference in Montreal. The initiative, supported by the Barwon South West Regional Integrated Cancer Service, has strong potential for regional expansion.





Orthopaedic Pathway Redesign

In July, a staff-led redesign of the orthopaedic post-operative pathway significantly improved the experience for patients undergoing hip and knee surgery.

Patients now transfer directly from Theatre to the Medical Unit, where rehabilitation begins the following day. This change has resulted in a smoother and more consistent care journey, fewer lost personal items, a reduction in patient complaints, and improved satisfaction. Staff also reported a clearer workflow and fewer pressures related to bed management.

Theatre & Equipment Upgrades

Significant upgrades were delivered to improve theatre operations and infection control processes.

In January, a Medivator system for endoscopy reprocessing was installed, and a new Platypus washer was introduced in the Central Sterile Supply Department (CSSD). A graduate nurse rotation through Theatre was also launched, enhancing training and workforce development.

The detailed design for a new CSSD was completed during the year, and a funding submission was lodged to support the next stage of development.

Clinical Access & Resource Unit (CARU)

The Clinical Access and Resource Unit (CARU) was established in November to streamline patient access and flow across all WDHS sites.

CARU now oversees bed management, workforce allocation, aged care placements, subacute programs including Hospital in the Home (HITH), Geriatric Evaluation and Management (GEM), Rehabilitation, and the Transition Care Program (TCP), as well as staff accommodation. The centralisation of these functions has improved communication, coordination, and overall resource utilisation.

Sleep Centre

In April, WDHS and Manse Medical celebrated 20 years of partnership at the Hamilton Sleep Centre.

As the only publicly funded Level 1 sleep lab in regional Victoria, the service continues to provide high-quality sleep diagnostics and care to people across the region.

The milestone marks two decades of helping the community achieve better sleep and better health.

Primary & Preventative Health

Diabetes Education

The Diabetes Education team participated in an innovative trial using Freestyle Libre2 Continuous Glucose Monitoring technology, in collaboration with glucose meter company Abbott.

This technology helps reduce the burden of traditional finger-prick testing and supports improved blood glucose control, empowering people with diabetes to better understand and manage their condition. The initiative also promotes healthier lifestyle choices and enhances quality of life for people living with diabetes.

In August, we celebrated 25 years of the Royal Children's Hospital Diabetes and Endocrinology Regional Clinic. This milestone highlighted the clinic's enduring impact on the lives of children and young people living with diabetes by offering high-quality specialist care close to home.



The clinic has significantly reduced the need for families to travel to Melbourne, easing the burden of missed school, travel time, and accommodation costs. The service has not only benefited the community but has also been instrumental in supporting our clinicians to deliver best practice care locally.

Pre-Habilitation Program

The Pre-Habilitation Program, which prepares individuals for joint replacement surgery, continued to grow in its second year.

Participants have reported positive feedback, noting the benefits of improved strength, mobility, and confidence leading up to surgery. The program plays a key role in improving surgical outcomes and recovery, and is an important component of our preventative health approach.

Contenance Services

The Contenance Team expanded its reach this year with the introduction of a new continence clinic at Casterton.

This development has improved access to specialist continence care for residents in the region, reducing the need for travel and helping clients manage their continence concerns with dignity and confidence.

Live4Life Program

The Southern Grampians Live4Life Program marked its fifth year of operation, continuing its mission to improve youth mental health and prevent suicide through school-based education and engagement.

WDHS remains the Lead Agency for the program across the Southern Grampians Shire.



Over the past five years, 1,702 students in Years 8, 10 and 11 have completed Teen Mental Health First Aid (MHFA) training. In addition, 194 adults have undertaken Youth MHFA training, and 156 young people have been engaged as Live4Life Crew Members. These student ambassadors play an active role in promoting mental health awareness in their schools and local communities, helping to create a more supportive and informed environment for their peers.

Patient Reported Experience Measures (PREMs)

The Patient Discharge Support Service (DSS) has partnered with the Quality team to collect real-time feedback from recently discharged patients, helping us better understand and improve the care we provide.

Since April 2023, DSS staff have been asking patients, "What could we do better?" during follow-up calls, with responses now captured electronically via Microsoft Forms.

Between May 2024 and April 2025, 390 patients responded—61% from the Medical Unit, 38% from the Surgical Unit, and a small number from Emergency. Feedback was overwhelmingly positive, with 74% offering compliments, 13% registering complaints, and 11% suggesting improvements. Common compliments praised the care, staff compassion, and overall experience. Suggestions for improvement included better discharge communication, follow-up with families, and smaller meal portions.



This initiative supports our commitment to partnering with consumers and continuously improving the quality and delivery of care.

Medical Administration & Workforce

Recruitment

This year saw several key appointments across our medical workforce, contributing to greater stability and access to high-quality care for our community.

We welcomed Dr Sophie Ping as Chief Medical Officer, alongside the recruitment of Dr Rihab Idrissy, an Advanced Trainee in General Medicine. Our surgical services were strengthened by the appointments of General Surgeons Ned Abraham and Janine Arnold. Anaesthetic services were supported by the arrival of General Practice Anaesthetists Dr Hilary Von Maltzahn and Dr Sarah Lim. We also welcomed Dr Mark Johnson as Director of Medical Education and Workforce Wellbeing, supporting professional growth and staff support initiatives. Recruitment efforts continue to focus on strengthening our Pharmacy support team to meet increasing service demands.

Workforce Development

WDHS secured additional funding this year to expand the junior medical staff program, helping to grow and sustain the future medical workforce in our region.



Continued efforts were made to support International Medical Graduates (IMGs) in achieving General Registration through the Australian Health Practitioner Regulation Agency (AHPRA), ensuring we maintain a skilled and diverse workforce. The service also successfully contracted doctors to work in the Emergency Department, reducing reliance on locum staff and improving continuity of care for patients.

Service Improvements

A review of the Public Maternity Clinic model was undertaken to identify opportunities for enhanced service delivery and access.

Relationships with visiting Plastic Surgeons were developed to broaden the scope of surgical services available locally. Additionally, general surgical capacity was increased, helping to reduce waiting times and improve access to timely surgical care for our community.

Regional Collaboration

Collaboration with regional partners remained a strong focus in 2024-25.

WDHS strengthened its relationships with neighbouring health services within the Local Health Service Network to support improved patient flow, service delivery, and education opportunities. Partnerships with Deakin University and Flinders University were also enhanced, supporting medical student placements and building networks that encourage future employment in rural settings.

The Service continued to work closely with hospitals in Melbourne and Geelong to enhance the clinical experience of junior doctors rotating through Hamilton.



In addition, WDHS actively collaborated with the Victorian Rural Generalist Program to expand opportunities for General Practitioners to train with advanced skills in specialty areas, contributing to the sustainability of rural healthcare delivery.

Aged Care

Grange Dining Room & Café Redevelopment

The completion of the dining room and café redevelopment at The Grange has created a more modern, welcoming environment that enhances the dining experience and supports a sense of community among residents.

Dementia Support Initiatives

A new 'Walk with Purpose' pathway was introduced to encourage independence and mobility for residents living with dementia.

In addition, a monthly Memory Loss Carers' Support Group was established, offering guidance, connection, and emotional support to families and carers.

Expansion of Aged Care Beds Penshurst

To meet growing demand, Penshurst Nursing Home opened four additional beds ahead of its Stage 3 redevelopment, ensuring more residents can access local care.

Palliative Care Garden

The new Palliative Care Garden at The Birches was completed, offering a peaceful and therapeutic outdoor space for residents, families, and staff. This was made possible thanks to a donation from Mr Ken Moore.



Relocation of Community Aged Care Programs

Community Aged Care Services, including Home Care Packages and the Commonwealth Home Support Program, were relocated to McKellar House, improving integration and service coordination.

Aged Care Marketing and Brand Refresh

A major marketing project was completed, including the launch of a refreshed aged care brand, a new website, and a comprehensive Residential Aged Care Information Booklet.

These resources were officially unveiled at a well-attended community launch event.

Birches Reaccreditation

The Birches successfully met all requirements of the Aged Care Quality and Safety Commission, achieving reaccreditation and reaffirming its commitment to delivering high-quality aged care.

Unbreakable Farmer Event

Coleraine hosted the 'Unbreakable Farmer' event, a community gathering focused on mental health, resilience, and stress management, for those working in agriculture.

Stage 3 Redevelopment – Penshurst

Planning for Stage 3 of the Penshurst redevelopment was finalised, with the project moving into the tendering phase, paving the way for further upgrades to residential aged care infrastructure.



Hovermatt Donations

A generous donation from Mr Ken Moore enabled the purchase of Hovermatts at Coleraine, Penshurst, and The Grange, improving safety and comfort for residents and staff during transfers and repositioning.

Lifestyle & Dining Enhancements

A successful Lifestyle and Dining Equipment Grant supported the purchase of new items to expand leisure activities and enhance the dining experience across all aged care facilities.

Service Integration at Penshurst and Coleraine

The administrative functions of the co-located aged care facilities at Penshurst and Coleraine were combined, supporting streamlined operations and ensuring compliance with the requirement for 24/7 Registered Nurse coverage.

National Centre for Farmer Health

The National Centre for Farmer Health (NCFH) continued to advance its mission of improving the health, wellbeing, and safety of Australian farming communities through education, research, and service delivery.



Improving Access & Visibility

The NCFH relocated to a new premises at 115 Lonsdale Street, Hamilton, increasing public access to health services, training, and resources for farming communities.

The official grand opening of the new location welcomed community members, partners, and stakeholders, showcasing the Centre's commitment to local engagement and accessibility.

National Thought Leadership & Collaboration

The Farmer Health Symposium was held in Canberra, bringing together 62 attendees from across Australia to discuss current challenges and solutions in farmer health and wellbeing.

The NCFH continued to be recognised as a provider of choice for expert input on farmer health, wellbeing, and safety. Notable invitations included:

- Farmer Mental Health Roundtable (South Australia)
- Victorian Premier's Drought Taskforce
- National Farmers' Federation Mental Health Steering Committee
- Ministerial Roundtables on farmer mental health (two in Queensland) and farm safety in New South Wales.



Health Service Delivery & Community Engagement

The team delivered 266 farmer health checks at agricultural events across Victoria, South Australia, and Queensland, made possible through strong partnerships with community groups, government agencies, and industry supporters.

The NCFH played a key role in Victoria's drought response, including:

- providing on-farm training and health checks
- administering the Look Over the Farm Gate Community Grants Program
- disseminating tailored farmer-focused resources
- launching a dedicated Mental Health Support Hub on the NCFH website to improve access to mental health support services.

Education & Capacity Building

The NCFH team also delivered education and training to 282 participants through community workshops and postgraduate education, equipping health professionals and industry stakeholders with the knowledge and skills to support farmer wellbeing.

Our Story

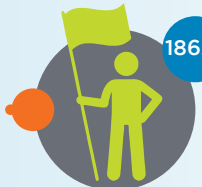
Amalgamation

Amalgamation of Hamilton Base Hospital, Southern Grampians Community Health Services and Penshurst and District War Memorial Hospital to form WDHS



1862 Establishment

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



2000 Aged Care

Aged care redevelopment at Hamilton campus, including construction of The Birches Residential Aged Care facility



Coleraine

Coleraine District Health Service joins WDHS



2008 NCFH

National Centre for Farmer Health established in partnership with Deakin University



Grange

Grange Residential Care Service redevelopment works completed, including construction of new wing



2013 Coleraine Campus & HBH Rehab

The Coleraine campus \$27 million 'one stop shop' health precinct completed and Hamilton Base Hospital Rehabilitation Wing opened



Cancer Care

Cancer & Dialysis Centre constructed to support local cancer and dialysis patients



2019 The Birches

Refurbishment of The Birches Residential Aged Care facility



Penshurst

Completion of Stage 1 of the Penshurst campus redevelopment



2023 Hamilton MRI

Magnetic Resonance Imaging (MRI) machine and pod located at Hamilton Base Hospital



Nature & Range of Services

WDHS is a leading rural and regional healthcare provider, recognised for delivering a range of quality services, Australian firsts and internationally recognised programs.

Our Region

Located in Victoria's Western District, WDHS serves the Southern Grampians Shire, with a population of 16,525 (Southern Grampians Shire Council 2024) and covering an area of 6,654 square kilometres. Hamilton is the main retail centre, supported by nine surrounding townships of Balmoral, Branxholme, Byaduk, Cavendish, Coleraine, Dunkeld, Glenthompson, Peshurst and Tarrington. WDHS also serves the communities of Merino and Digby in the Glenelg Shire.

A summary of the services provided across our campuses is shown below:

Hamilton

- Hamilton Base Hospital - a 67-bed acute hospital, with Emergency Department, operating theatres, intensive care, maternity services, cancer and dialysis and education facilities.
- The Birches Residential Aged Care - a 46-bed facility providing residential aged and palliative care, as well as support for people with dementia and special needs.
- The Grange Residential Care Service - providing 50 residential aged care beds.
- McKellar House - providing community aged care home care packages (290 across 5 Local Government Areas (LGAs)).
- Commonwealth Home Support Program - supporting 519 clients.
- Hamilton House and Frances Hewett Community Centre - delivering a broad range of allied health, primary care and community nursing services.
- National Centre for Farmer Health - established in partnership with Deakin University providing leadership to improve the health, wellbeing and safety of farmers, farm workers and their families across Australia and internationally.

Coleraine & Merino

- Thomas Hodgetts Primary Care Centre - providing medical, district nursing, allied health and community services for the Coleraine and District community.
- 10 acute beds - providing acute and sub-acute care.
- Wannon Court Hostel - providing permanent and respite aged care accommodation for 39 residents.
- Valley View Nursing Home - providing permanent and respite aged care accommodation for 12 residents.
- 25 independent living units.
- Merino Community Health Centre - delivering primary nursing and allied health services to the Merino and surrounding communities.

Peshurst

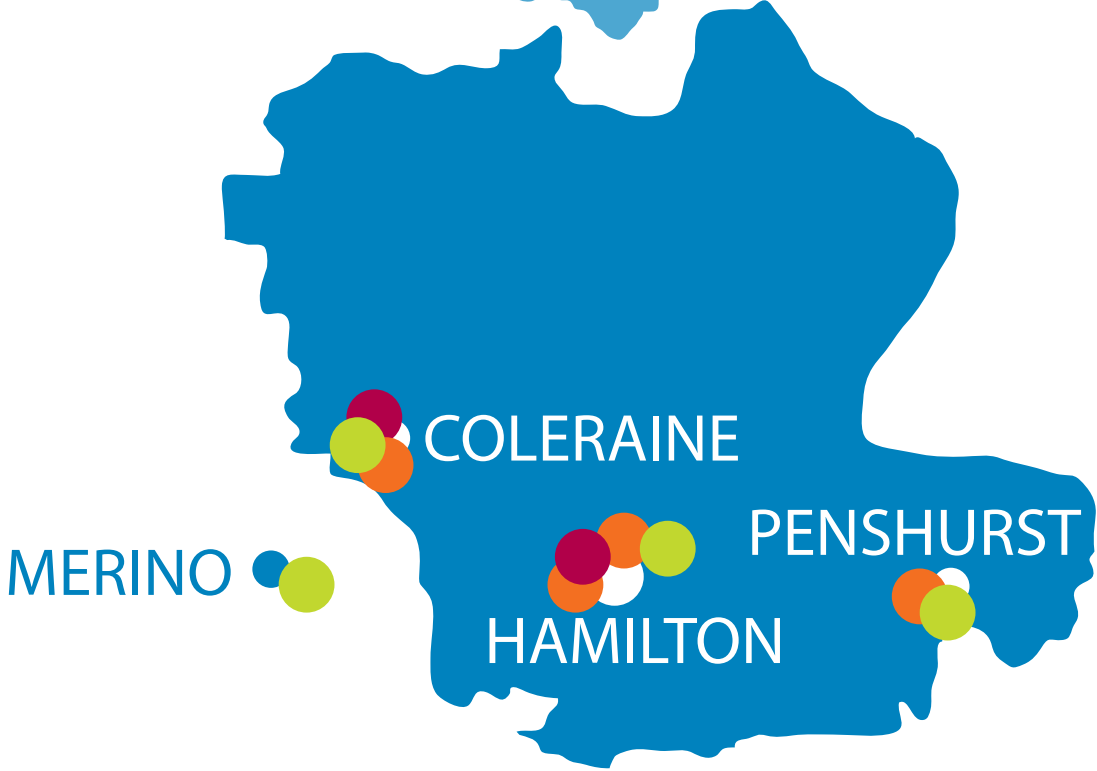
- Providing acute and community services for the Peshurst and District community.
- Kolor Lodge - providing permanent aged care and respite accommodation for up to 10 residents.
- Peshurst Nursing Home - providing aged care accommodation for 19 residents (13 until Stage 3 redevelopment is completed).
- 10 independent living units in Peshurst and Dunkeld.

SOUTHERN GRAMPIANS SHIRE

- Acute Care
- Community Care
- Aged Care



BARWON SOUTH WEST REGION



Governance Structure

BOARD OF DIRECTORS

Anna Sweeney (Chairperson)
 Andrew Bradbury (Vice Chairperson)
 Gillian Jenkins
 Stephen Bunce
 Bruach Colliton
 Tim Fraser
 Ashlyn Hiscock
 Judith McDonald
 Greg Walcott

COMMITTEES OF THE BOARD

Aged Care Governance

Board Representative: Gillian Jenkins (Chair)

Clinical Appointments Advisory

Board Representatives: Anna Sweeney (Chair),
 Tim Fraser, Judith McDonald

Coleraine District Health Service Management

Board Representative: Gillian Jenkins

Community Advisory

Board Representatives: Tim Fraser (Chair), Ashlyn Hiscock

Finance, Risk and Audit

Board Representatives: Andrew Bradbury (Chair), Bruach
 Colliton, Stephen Bunce
 Independent members - Jim Bailey, Jason Bourke

Medical Consultative

Board Representatives: Gillian Jenkins (Chair), Tim
 Fraser

National Centre for Farmer Health Advisory

Board Representative: Greg Walcott (Chair)

National Centre for Farmer Health Board of Management

Board Representative: Greg Walcott (Chair)

Penshurst District Health Service Advisory

Board Representative: Greg Walcott

Project Control Group

Board Representatives: Andrew Bradbury (Chair),
 Anna Sweeney, Bruach Colliton

Quality and Safety

Board Representatives: Ashlyn Hiscock (Chair), Gillian
 Jenkins, Judith McDonald

Remuneration

Board Representatives: Anna Sweeney (Chair), Ashlyn
 Hiscock, Andrew Bradbury

EXECUTIVE TEAM

Dual Chief Executive
 Rowena Clift

Director of Corporate Services

Nicholas Starkie
 BBus, MIPA DipTS (Bus)

Chief Medical Officer

Dr Sophie Ping
 BA, BSC hon, PhD, MBBS,
 AFRACMA, ARCPA

Director of Nursing, Hamilton Base Hospital

Lorraine Hedley
 RN, BA Nursing (Post registration),
 MACN

Director of Aged & Home Care Services Hamilton

Katherine Armstrong
 RN, BAppSci (Nursing), Grad Cert
 Bus Admin

Director of Nursing / Manager Coleraine

Director Aged Care Services Coleraine / Penshurst)

Bronwyn Roberts
 RN, ICU Cert, Grad Cert Bus Admin
 MACN

Director of Primary & Preventative Health

James 'Mac' McInnes
 BSW, DipSW, PCHSM

Director of National Centre For Farmer Health

Associate Professor
 Dr Alison Kennedy
 BBSoc (Honours), PostGradDipArts
 (Criminology), GCertHighEd, PhD



ORGANISATIONAL CHART

Western District
Health Service
Board of Directors

Chief Executive

- Community Liaison
- People and Culture
- Quality and Risk

Director of Corporate Services

- Budget & Finance
- Health Information
- Improvement & Innovation
- Maintenance & Stores
- Payroll
- Support Services

Chief Medical Officer

- Hospital Medical Officers
- Pharmacy
- Senior Medical Staff

Director of Nursing, Hamilton Base Hospital

- Cancer & Dialysis Services / Consulting Suite
- Clinical Access & Resource Unit
- Emergency Department
- Infection Prevention & Control
- Learning & Development
- Medical / Rehab / ICU
- Public Maternity Clinic
- Sleep Centre
- Surgical / Maternity
- Theatre / CSSD

Director of Aged & Home Care Services Hamilton

- Aged Care Services
- Community Support Services
- The Birches Residential Aged Care
- The Grange Residential Care Service
- Volunteer Services

Director of Nursing / Manager Coleraine; Director Aged Care Services (Coleraine / Peshurst)

- Coleraine Campus
- Merino Community Health Centre
- Peshurst Campus

Director of Primary & Preventative Health

- Aboriginal Liaison
- Allied Health
- Community Health
- Preventative Health
- Social Support Group Services
- Youth Services

Community Nursing Services:

- Complex Care
- Continence Support
- Diabetes Education
- Discharge Support Services
- District Nursing
- Men's Health
- Palliative Care
- Stomal Care
- Transition Care
- Women's Health
- Wound Care

Director of National Centre for Farmer Health



◆ A new event to recognise years of service was held in December.



*Staff, Volunteer
& Community*
Recognition



Code of Conduct

All staff must abide by the Victorian Public Sector Commission Code of Conduct and WDHS values, policies and procedures.

Workforce Data

All employees have been correctly classified in workforce data collections.

Industrial Relations

Negotiation for a new enterprise bargaining agreement for nurses was concluded and the Nurses and Midwives (Victorian Public Sector) Single Interest Employer Agreement 2024-2028 was approved at the Fair Work Commission on 8 November 2024. Significant work was subsequently undertaken by the People and Culture, Finance and Payroll teams to update payroll and other financial systems to ensure a smooth transition to the new agreement.

An employee complaint was lodged with the Victorian Equal Opportunity and Human Rights Commission in July 2024. WDHS was represented by Minter Ellison Lawyers via The Victorian Managed Insurance Authority and the matter was resolved at conciliation.

Workforce Inclusion

WDHS is continuing to implement a range of initiatives to support workforce inclusion across all clinical and non-clinical areas. This includes ongoing actions aligned with the organisation's Gender Equality Action Plan (GEAP), as well as the regular review and refinement of policies and procedures. In October 2024, WDHS received confirmation from the Gender Equality Commission that it met the requirements of the Progress Audit. Work is also progressing on reporting against the Workplace Gender Equality Indicators, along with the introduction of Gender Impact Assessments for relevant policies, procedures and projects.

Workforce Profile 2025		June Current Month FTE		June YTD FTE	
Labour Category	2025	2024	2025	2024	
Nursing	277.04	257.51	268.10	251.34	
Administration and Clerical	115.35	116.31	113.87	111.01	
Medical Support	9.79	13.80	11.67	11.64	
Hotel and Allied Services	193.49	187.80	190.00	188.12	
Medical Officers	2.89	1.54	2.30	1.21	
Hospital Medical Officers	24.02	22.02	21.66	21.53	
Ancillary Staff (Allied Health)	40.67	36.44	38.60	36.73	
Total	663.25	635.42	646.20	621.58	

Occupational Health & Safety Statistics	2024/25	2023/24	2022/23
Number of reported hazards / incidents for the year per 100 FTE	43	51	27.50
Number of 'lost time' standard WorkCover claims for the year per 100 FTE	0.155	0.15	0.47
Average cost per WorkCover claim for the year	\$52,407	\$40,264	\$10,022

Occupational Violence Statistics	2024/25	2023/24
WorkCover accepted claims with an occupational violence cause per 100 FTE	Nil	Nil
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	Nil	Nil
Number of occupational violence incidents reported	336	209
Number of occupational violence incidents reported per 100 FTE	51	32
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	15.17%	15%

Recognising Excellence & Service

Employees of the Month

JULY

Payroll Team
Finance Department

AUGUST

Dale Harris - Management Accountant
Daniel Dainty - Systems Accountant
Finance Department

SEPTEMBER

Rod Nolte - Senior Trades Assistant
Maintenance Coleraine

OCTOBER

Fay Picken - Healthcare Worker
Coleraine

NOVEMBER

Mun Nazmunnahar - Personal Services
Assistant
Hotel Services

DECEMBER

Brigietta Herbertson - Bed Coordinator
Health Information

JANUARY

Courtney Rowe - Registered Nurse
Medical Unit

FEBRUARY

Alison Criddle - Clinical Coder
Health Information
Environmental Services Team
Hotel Services

MARCH

Nyrie Adams - Nurse Unit Manger
Theatre

APRIL

Billie Preece - Occupational Therapist
Occupational Therapy

MAY

Jane Murray - Team Leader
Volunteer Services

JUNE

Paul Annett - Personal Services Assistant
The Birches

Life Governors

Aarons, B, OAM

Barber, D

Beggs, HN

Boyle, J

Broers, M

Brown, MA

Brumby, A

Brumby, S

Bunge, B

Clifforth, S

Coggins, G

Dean, J

de Kievit, C

Deutscher, L

Duff, S

Eales, M

Edmonds, J

Fitzgerald, R

Fleming, JD

Fletcher, J

Fraser, T

Gardiner, PD

Grant, M

Gubbins, J

Gumley, F, PSM

Gurry, AJ

Heazlewood, P

Holmes, ES

Hutton, J

Hutton, T

Kearney, J

Kelsh, J

Kruger, N

Langley, C

Lawson, V

Lovett, C

Lyon, E

Macdonald, H

McAllister, C

McLean, M

Milton, S

Morrison, HM

Murray, EM

Northcott, J

O'Beirne, P

Rentsch, T

Robertson, M

Runciman, P

Scaife, R

Scullion, E

Templeton, H

Tully, R

Turnbull, P

Turner, J

Walker, O

Wallis, V

Walter, R, AM

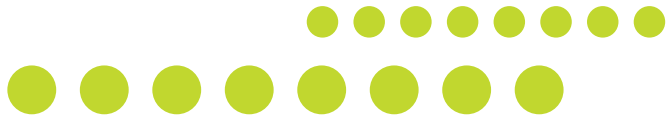
Wettenhall, HM

Wettenhall, M

Whiting, I

Wombwell, T

Staff Service Milestones



From left: Robyn Beaton, Kathryn Ross, Russell Armstrong and Madonna Spong



- o Sophie Annett
- o Joanna Austin
- o Joanne Brown
- o Ashley Criddle
- o Leanne Dennert
- o Tessa Hutchins
- o Belinda McCredan
- o Tanya Millard
- o Beverley Olle
- o Jason Parfrey
- o Melissa Pye
- o Julie Riches
- o Lynna Sheahan
- o Leanne Sherren



- o Chloe Ahearn
- o Amy Flavell
- o Teresa Holmes
- o Paula Hoy
- o Shamim Mahabeer
- o Jacqueline McCabe
- o Michelle McErvale
- o Robyn Smith
- o Susan Summers
- o Benjamin Taylor
- o Bianca Todd



- o Sharon Gorrie
- o Yvette Morton
- o Erin Rhook
- o Casey Trotter
- o Rachel Verschuren



- o Margi-Ann Bilson
- o Leesa Ladd
- o Benjamin Kele
- o Belinda Kennedy
- o Lynette Peach
- o Raewyn Powlton
- o Jane Rentsch
- o Nicholas Starkie
- o André Steele



- Rosalie Broadfoot
- Catherine Jackson



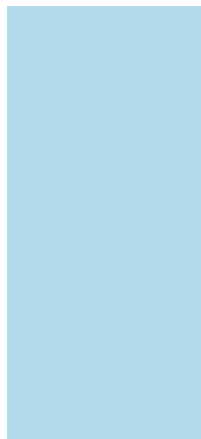
- Russell Armstrong



- Robyn Beaton
- Kathryn Ross



- Madonna Spong





Volunteer Week recognition for 15 years of service at WDHS.



Community
Recognition



Our Volunteers

At WDHS, we are proud to acknowledge the invaluable contributions made by our dedicated volunteers. As we reflect on the past year's achievements, we recognise the immeasurable impact these selfless individuals have on our organisation and the communities we serve.

CHARLIE WATT VOLUNTEER OF THE MONTH RECIPIENTS

JULY

Ann Walter
HBH Auxiliary

AUGUST

Joan Taggart
WDHS Opportunity Shop

SEPTEMBER

Neville Linke
Community Transport Hamilton

OCTOBER

Betty Huf
WDHS Opportunity Shop

NOVEMBER

Carmel Schlaghecke
Meals on Wheels Hamilton

DECEMBER

Ann Braz
Meals on Wheels Coleraine

JANUARY

Elsie Hill
Meals on Wheels Hamilton

FEBRUARY

Robert Cook
Community Transport Hamilton

MARCH

Wendy Salter
The Grange

APRIL

Judy Sommerville
Palliative Care Hamilton

MAY

Peter Jensen
Community Transport Hamilton

JUNE

Margaret Rowe
Meals on Wheels Hamilton

VOLUNTEER HOURS

SERVICE	Number of Volunteers	Hours	Kms
Aged Care The Birches	5	591	
Aged Care Coleraine	4	1,186	
Aged Care The Grange	12	1,105	
Community Transport Coleraine	4	665	16,132
Community Transport Hamilton	35	2,159	111,684
Community Transport Merino	11	657	23,890
District Nursing	1	175	
Healthy Leg Club	1	264	
WDHS Opportunity Shop	27	6,634	
Meals on Wheels Coleraine	12	251	
Meals on Wheels Hamilton	38	2,020	
Palliative Care	7	125	
Social Support Group Coleraine	2	157	
Social Support Group Hamilton/ Penshurst	5	107	
Ward Volunteers Administration	2	342	
Ward Volunteers Theatre Buddies	1	40	
Visitor Access Concierge	14	93	
FUNDRAISING VOLUNTEERS			
Annual Appeal	96	192	
Golf Tournament	22	84	
Courtyard For a Cause	11	25	
Auxiliaries	14	640	
Total	324	17,512	151,706

Our Fundraising

WDHS sincerely thanks the Southern Grampians community for their incredible support throughout the 2024–25 financial year. Together, we raised \$552,362 to fund vital equipment and infrastructure projects across our campuses. Your generosity and commitment help us provide the best possible care and enhance the experiences of our patients, residents, and their families. We are proud to work alongside such a dedicated community in building a healthier future for our region.

Thanks to generous donations from Leonie Schurmann (in memory of Bruce) and Peter's Project, the Cancer Centre team purchased three much needed treatment chairs for patients.

EVENTS & APPEALS

◦ Annual Appeal	\$59,520
◦ Christmas Appeal	\$15,700
◦ Courtyard For a Cause	\$8,500
◦ Coleraine Clay Shoot	\$19,500
◦ Golf Tournament	\$18,130

MAJOR EVENT SPONSORS

◦ Groke Hamilton	\$6,500
◦ WDHS Opportunity Shop	\$5,000

AUXILIARY DONATIONS

◦ Coleraine Bookshop	\$5,402
◦ Coleraine Opportunity Shop	\$1,500
◦ Hamilton Base Hospital Auxiliary	\$9,960
◦ WDHS Opportunity Shop	\$30,000

BEQUESTS

◦ Estate of Peter McKellar Hyde	\$154,016
◦ Estate of Elizabeth (Isabel) McGrath	\$70,000
◦ Estate of Neville Albert Taylor	\$34,908

GIFTS OVER \$3,000

◦ Advantage Feeders
◦ R Agar
◦ T & C Brooks
◦ Byaduk Spring Show
◦ Equity Trustees - Louis Lesser Charitable Fund
◦ Geelong Gentlemen's Lunch
◦ Hamilton Base Hospital Auxiliary
◦ WDHS Opportunity Shop
◦ K Moore
◦ Peter's Project Foundation
◦ Rotary Club of Hamilton
◦ L Schurmann
◦ J Ussher



Gifts over \$100

- o B Aarons
- o K Addinsll
- o L Addinsall
- o Advantage Feeders
- o R Agan
- o C Alcock
- o N & K Allen
- o M & A Archer
- o G & C Armstrong
- o H Aspinall
- o G Aydon
- o D Bailey
- o W Bailey
- o Y Barber
- o J Barnes
- o J & K Baulch
- o J Bensch
- o P & J Besgrove
- o Bethlehem Lutheran Church Tabor
- o M Biviano
- o G Black
- o W & C Blackwell
- o G & B Botterill
- o G & H Bowtell
- o J Bragg
- o H Brian
- o C & C Brinkmann
- o D & C Brooks
- o A & J Brown
- o R & J Brown
- o A & J Brumby
- o C Burger
- o R Burrowes
- o T Burrowes
- o Byaduk Spring Show
- o G Cadden
- o K & M Campbell
- o M & A Carter
- o C Casey
- o Christ Church Anglican Women's Guild
- o R Church
- o P Clarke
- o S Clarke
- o Coast To Country Building Approvals
- o G & L Coggins
- o I & S Colclough
- o Coleraine Field and Game Club
- o Coleraine Opportunity Shop
- o Coleraine Pedal Car Grand Prix
- o B Connolly
- o P & D Cook
- o B Cordy
- o D Crawford
- o K & A Creek
- o CWA - Hawkesdale Branch
- o L Dahlenburg
- o A De Vries
- o J Dempster
- o E Dix
- o D Douglas
- o J Duyvestant
- o D & M Dyer
- o H & P Elsworth
- o Estate of David Leslie Scott
- o Estate of Elizabeth (Isabel) McGrath
- o Estate of Peter McKellar Hyde
- o Estate of The Late Neville Albert Taylor
- o Eventide Lutheran Homes
- o P & L Falkenberg
- o M Fenech
- o E Fenton
- o M Ferguson
- o I & S Field
- o Finchetts
- o Findex
- o B Finlay
- o F & N Fitzgerald
- o P Fitzgerald
- o R & K Fitzgerald
- o P Flinn
- o P & J Forsyth
- o P & H Fry
- o Geelong Gentlemen's Lunch
- o George Williamson Trust
- o J Gerdtz
- o M & M Godden
- o K Gordon
- o A Gough
- o H Gough
- o J & M Gough
- o Grampians Golf Club - Ladies
- o A Gubbins
- o C Gunn
- o J Gustus
- o B Guthridge
- o A Habel
- o Hamilton Base Hospital Auxiliary
- o Hamilton Golf Club

- Hamilton T.O.W.N. Club Inc
- S Hards
- J Hayes
- E Healy
- I Heard
- J Hedley
- E Henderson
- T & H Henry
- F Hill
- A & I Hill
- C & S Hines
- J & S Hockey
- H Holcombe
- A Hornby
- J & L Howman
- J Hudson
- L Hudson
- R & K Huf
- IGA Hamilton - Ritchies
- J Iredell
- L Jacobson
- H Jansen
- T Jarvis-Ball
- John Russell MacPherson Fund
- V Jones
- J Hadley & L Kahn
- C Kautsky
- J Kautsky
- B & W Kearney
- M Keen
- S Keen
- B & E Kelly
- E Kelly
- D & J Kerr
- A Kuffer
- P & H Langford
- S Langley
- M Laurence
- J & G Lawton
- J Le Souef
- F Lennox
- J Lewis
- P & H Lewis
- A Liberman
- N Linke
- R Linke
- Louis Lesser Charitable Trust
- Louisa Henty Estate
- R & E Macgugan
- D & S Mackinnon
- E & M Maclean
- N & H MacLean
- J & J Maggs
- Makers Market
- S & D Mansbridge
- J McDonald
- W McDonald
- J & R McErvale
- D & S McFarlane
- J McIntosh
- J & A McIntosh
- J McIntyre
- D McKellar
- D & A McNaughton
- P & J Menzel
- Merino Digby Lions Club
- D & H Milich
- B Miller
- E Mills
- H Mirtschin
- P Mitchell
- S Mitchell
- M Moffatt
- Monaro's Out West
- K Moore
- G Mutch
- J Nagorcka
- E & D Napier
- R Nineham
- Y Onderwater
- O Osolio
- L Parsons
- A & K Patterson
- K Peach
- J Pearse
- Peshurst Combined Churches
Carols Association
- Peter Ham Agronomy
- B Phillips
- R Raleigh
- R Ramsay
- G Rentsch
- M & V Rentsch
- C Richardson
- P Robinson
- R Robinson
- Rotary Club of Hamilton
- V & S Rowett
- J Royle
- A Cass & L Ryan
- P Ryan
- W Sainsbury
- T Sandison
- K & B Satchell
- L Schneider
- L Schurmann
- T Sellers
- G & N Sharrock
- C Smith
- R Smith
- E, K, J & G Smith
- N Smooker
- F & D Soulsby
- South West Prime Lamb Group Inc
- D & C Spring
- S Stanley
- Stanley Heath Fund
- J Steele
- R Stevenson
- D Stewart
- The Peter's Project Foundation
- C Thomas
- D & R Thomson
- B Todd
- E & J Tonissen
- R Tonissen
- L Toyer
- M Urquhart
- J Ussher
- I Walton
- B Watson
- G & S Watt
- J Watt
- J & J Watt
- WDHS Opportunity Shop
- B Williams
- G & D Williamson
- I & M Willsher
- B Woodward
- J Woolacott
- J & A Wyld
- P & L Young
- B & P Zimmermann
- J & S Zwar

Report from Director of Corporate Services

Operating Result

The Net Operating Result is the key financial performance indicator by which WDHS is measured in its annual Statement of Priorities, signed by both the Board Chairperson and the Minister for Health.

For the financial reporting period, the Health Service delivered a modest operating surplus of \$150,000 against total revenues of \$130.543 million. This result is marginally above the budgeted target surplus of \$112,000. While the surplus represents only a small proportion of overall revenue, it reflects disciplined financial management within a constrained funding environment and provides confidence that the organisation is on track with its financial sustainability objective.

This result was achieved despite the broader financial pressures facing the Victorian health sector, alongside a 4.8% increase in operational expenditure and a 3.11% increase in patient activity levels. Cost growth reflects heightened workforce expenses, supply chain pressures, and rising utility and service costs. Careful financial management and targeted cost-containment strategies, including Department of Health Budget Action Plans, have been essential in offsetting these impacts and ensuring the Health Service remained within its overall budget parameters.

The Net Result from Transactions—which includes operating and capital income, expenditure, finance costs, and depreciation—showed a deficit of \$6.283 million, representing a \$2.694 million improvement from the prior year.

This improvement was primarily due to revenue and income from transactions increasing by \$12.138 million (10.2%). A detailed reconciliation of the Net Result from Transactions to the Net Operating Result can be found on page 31.

For 2024–25, WDHS's overall net result, after accounting for other economic flows, gains/losses on financial instruments, and non-financial assets, was a deficit of \$6.173 million.

At year end, the Health Service's cash and cash equivalents increased from \$49.257 million to \$54.639 million. This balance comprises \$33.829 million in trust funds and \$20.810 million available for operational use. The 9.7% increase in the cash position was primarily attributable to the receipt of additional refundable accommodation deposits relating to residential aged care.

Another key indicator monitored by the Department of Health is the Health Service's Adjusted Asset Ratio (ACAR). For the period ending 30 June, the Health Service reported an ACAR of 1.20, compared with the statewide target of 0.70.

Organisational Growth

For the 2025 financial year, the Health Service's total revenue increased from \$118.405 million to \$130.543 million, reflecting growth in funding and service activity. Over the same period, total expenditure rose from \$127.382 million to \$136.826 million, driven by higher operating costs, workforce expenses, and investment in service delivery.

The Health Service's patient activity target for 2024–25 was 9,380 National Weighted Activity Units (NWAU) across acute care, emergency department, sub-acute care, and non-admitted care. The Health Service recorded 9,535 NWAU, exceeding the target by 1.8%. Compared with the previous financial year, this represents an increase of 287.29 NWAU (3.11%).

Community Support

In 2024–25, community donations and fundraising totalled \$552,362, providing vital support to the Health Service. These funds made a significant contribution towards infrastructure improvements and the purchase of new medical equipment, directly enhancing service capacity and patient care. The generosity of community donors continues to play an important role in enabling the Health Service to deliver high-quality healthcare beyond what core funding alone can support.

Looking Ahead

While the financial outlook for the coming year remains tight, the Health Service is well positioned to manage these pressures. Continued focus will be placed on workforce sustainability, efficiency improvements, and proactive financial planning and modelling. Longer term, strategic investment in infrastructure and digital capability will be critical to supporting the evolving needs of our community.

- Nicholas Starkie with Scott Richard's from Finchetts, who donated \$1,000 in sales from their stand at Sheepvention



Reviews & Study Expenses

Name of review	Reason for review / study	Terms of reference / scope	Anticipated outcomes	Estimated cost for the year (excl. GST)	Final cost if completed (excl. GST)	Publicly available (Y/N) and URL
Hamilton Base Hospital ED Workplace Safety Upgrade Feasibility Review	Increase in OVA incidents	Feasibility study for the proposed refurbishment/ upgrade of the HBH ED to improve workplace safety and general amenity	Improving workplace safety and general amenity of ED	\$14,235	\$14,235	No
Accommodation Review	Optimisation of accommodation offerings for staff and contractors	Review accommodation offerings and booking processes to improve optimisation and establish a clear process	Report on accommodation options and recommendations	\$22,880	\$22,880	No
Proposed Merger Reports	Determine Feasibility of proposed merger of WDHS & CMH	Undertake independent Due Dilligence and Business Case	Completed Due Diligence and Business Case	\$85,000		No

Note: (a) Table does not include reviews or studies that may be Commercial-in-Confidence or commercially sensitive, or where the release may be detrimental to Government operations (e.g. by pre-empting the finalisation of policy decisions prior to their announcement by Government).

Commercial-in-Confidence (CiC) Grants

Not applicable. WDHS did not administer any grants, transfer payments or Commercial-in-Confidence grants in 2024-25.

Government Advertising Campaigns

WDHS declares a nil report for the 2024-25 financial year, as no government advertising activities or campaigns triggered the disclosure threshold of \$100,000 in expenditure.

Year in Brief

	2025 \$000	2024 \$000	2023 \$000	2022 \$000	2021 \$000
Operating Result	150	(5,041)	105	508	187
Total revenue	130,543	118,405	114,419	101,838	93,684
Total expenditure	(136,826)	(127,382)	(116,120)	(105,640)	(97,625)
Net result from transactions	(6,283)	(8,977)	(1,701)	(3,802)	(3,941)
Total other economic flows	110	555	79	(192)	1,848
Net result	(6,173)	(8,422)	(1,622)	(3,994)	(2,093)
Total assets	242,066	242,132	216,622	213,555	195,342
Total liabilities	(66,792)	(60,685)	(55,544)	(50,753)	(42,722)
Net assets / Total equity	175,274	181,447	161,078	162,802	152,620

Reconciliation between the net result from transactions reported in the model to the operating result as agreed in the Statement of Priorities.

	2025 \$000	2024 \$000	2023 \$000	2022 \$000	2021 \$000
Operating Result*	150	(5,041)	105	508	187
Capital and specific items					
Capital purpose income	4,588	5,354	6,546	2,739	4,006
Specific income					
Assets provided free of charge	253	106	527	1,114	621
Assets received free of charge					
Expenditure for capital purpose	(126)	(57)	(191)	(187)	(71)
Depreciation and amortisation	(11,598)	(8,609)	(8,235)	(8,153)	(8,125)
Impairment of non-financial assets					
Finance costs	(166)	(103)		(5)	(6)
Other	616	(627)	(453)	182	(553)
Net result from transactions	(6,283)	(8,977)	(1,701)	(3,802)	(3,941)

* The net operating result is the result for which the Health Service is monitored against in its Statement of Priorities

Consultancies & ICT

In 2024-25 WDHS engaged five consultancies where the total fees payable to the consultants were less than \$10,000. The total expenditure incurred in 2024-25 relating to these consultancies was \$11,734 (excluding GST). In 2024-25 there were seven consultancies where the total consultants' fees payable were \$10,000 or greater. The total expenditure incurred during 2024-25 in relation to these consultancies is \$140,776 (excluding GST). For details of consultancies over \$10,000 refer to the table below.

Consultancies > \$10,000						
Consultant	Purpose of Consultancy	Start Date	End Date	Total Approved Project Fee (exc GST)	Expenditure 2024-25 (exc GST)	Future Expenditure (exc GST)
Acumenity Australia Pty Ltd	Coleraine Health Service Review	10/09/2024	31/05/2025	\$13,125	\$13,125	-
Boroko Consulting Pty Ltd	Governance Project Support	24/12/2024	14/04/2025	\$17,000	\$17,000	-
Catherine Cosgrave	Delivery of Attract Connect Workshop	31/10/2024	30/06/2025	\$12,000	\$12,000	-
Jackie Austin Consulting	People & Culture Consultancy	01/01/2025	30/06/2025	\$11,000	\$11,000	-
Kelloway Lonsdale Pty Ltd	Merger Considerations	03/10/2025	13/01/2025	\$37,510	\$37,510	-
Power Solutions Dtd Pty Ltd	PPM Costing Services	09/07/2025	13/01/2025	\$22,205	\$22,205	-
Sensum Vic Pty Ltd	Project Management Optima \$21,789 & Peshurst Redvelopment \$6,148	01/12/2024	30/06/2025	\$27,937	\$27,937	-
Total				\$ 140,776	\$ 140,776	-

ICT Expenditure

For the 2024-25 reporting period, WDHS had a total ICT expenditure of \$3,478,039, with the details shown below.

All operational ICT expenditure	ICT expenditure related to projects to create or enhance ICT capabilities		
	Business as Usual (BAU) ICT expenditure	Non-Business As Usual (non-BAU) ICT expenditure	
Total	(Total = Operational expenditure and capital expenditure)	Operational expenditure	Capital expenditure
\$3,025,481	\$452,558	\$226,898	\$225,660

Social Procurement

Case Study

Supporting Local Youth Employment through Westvic Staffing Solutions

Over the past year, WDHS has strengthened its commitment to local employment by partnering with Westvic Staffing Solutions, a registered provider under the Victorian Government's Social Procurement Framework (SPF). Together, we are creating meaningful job opportunities for young people in our rural community.

WDHS recognises the vital role local employment plays in building strong communities and supporting the social and economic wellbeing of our region.

Through this partnership, young job seekers are gaining valuable experience and securing employment across a wide range of roles in our organisation.

This collaboration directly aligns with the SPF, ensuring that government spending not only achieves value for money but also delivers positive social and economic benefits.

In the past 12 months, our partnership with Westvic has enabled the recruitment and placement of young people in both clinical and non-clinical roles, including:

- Administration / business support
- Environmental and food services
- Maintenance and facilities
- Entry-level clinical support roles

By employing local youth, we are:

- Reducing barriers to employment in rural areas
- Building the future healthcare workforce
- Strengthening community resilience by keeping jobs local
- Providing career pathways in health and related industries

Social procurement is now firmly embedded in our workforce strategy. We are proud of the progress made with Westvic Staffing Solutions and remain committed to expanding opportunities for young people—helping secure stronger employment outcomes for our community into the future.

Social Procurement Framework (SPF)

SPF Objective	SPF Outcome	2024-25 SPF Reporting Metrics	
Opportunities for Victorian Aboriginal people	Purchasing from Victorian Aboriginal businesses	Number of Victorian Aboriginal businesses engaged	1
		Total expenditure with Victorian Aboriginal businesses (excl. GST)	\$5,535
Opportunities for Victorians with disability	Purchasing from Victorian social enterprises and	Number of Victorian social enterprises (led by a mission for people with disability) and Australian Disability Enterprises engaged (Group 1)	1
		Total expenditure with Victorian social enterprises (led by a mission for people with disability) and Australian Disability Enterprises (excl. GST) (Group 1)	\$6,144
Opportunities for Victorian priority jobseekers	Purchasing from Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers	Number of Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers engaged	1
		Total expenditure with Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers (excl. GST)	\$377,228
Sustainable Victorian social enterprises and Aboriginal businesses	Purchasing from Victorian social enterprises and Aboriginal businesses	Number of Victorian social enterprises engaged	2
		Total expenditure with Victorian social enterprises (excl GST) (Group 1)	\$383,372
		Number of Victorian businesses engaged	1
		Total expenditure with Victorian Aboriginal businesses (excl GST)	\$5,535

Asset Management Accountability Framework

The following sections summarise WDHS assessment of maturity against the requirements of the Asset Management Accountability Framework (AMAF). The AMAF is a non-prescriptive, devolved accountability model of asset management that requires

compliance with 41 mandatory requirements.

These requirements can be found on the DTF website (<https://www.dtf.vic.gov.au/infrastructure-investment/asset-management-accountability-framework>).

The WDHS target maturity rating is 'competence', meaning systems and processes fully in place, consistently applied and systematically meeting the AMAF requirement, including a continuous improvement process to expand system performance above AMAF minimum requirements.

Operation (requirements 26-40)

WDHS has met or exceeded its target maturity level under most requirements within this category. WDHS did not comply with some requirements in the areas of monitoring and preventative action and information management. Monitoring and preventative action is an area of material non-compliance. WDHS is developing a plan for improvement to establish processes to proactively identify potential asset performance failures and identify options for preventive action.

Disposal (requirement 41)

WDHS has met its target maturity level in this category.

Leadership and Accountability (requirements 1-19)

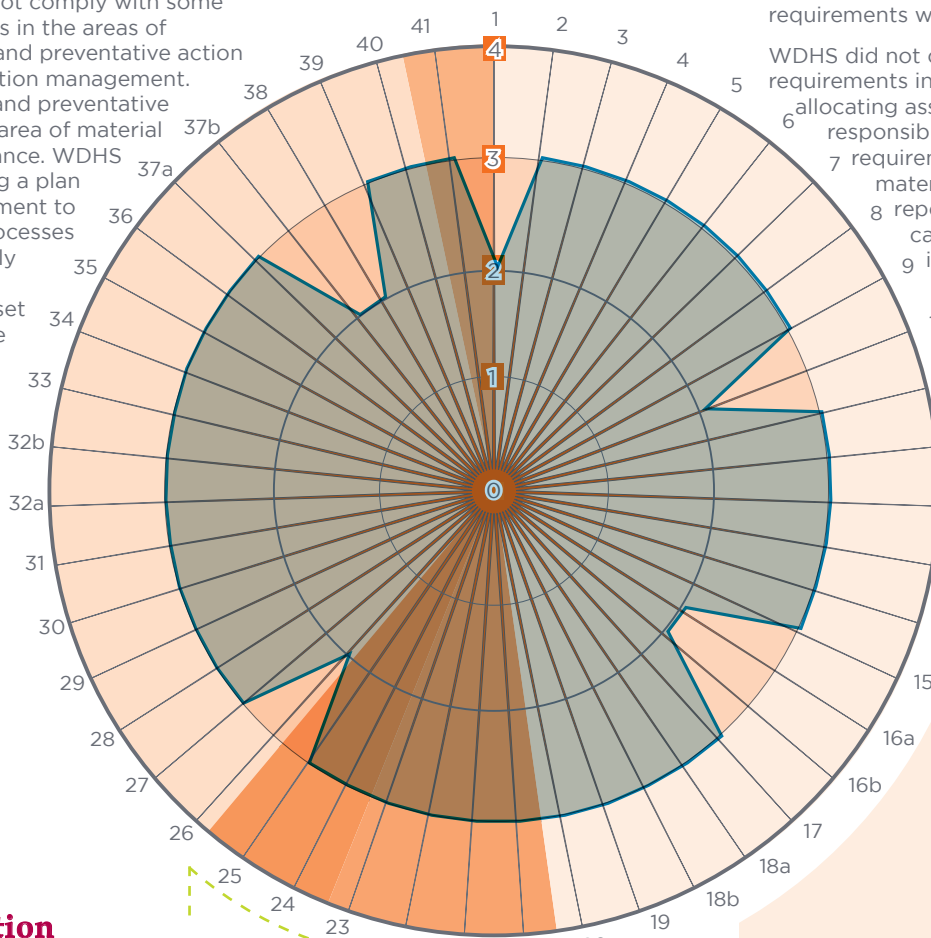
WDHS has met or exceeded its target maturity level under most requirements within this category. WDHS did not comply with some requirements in the areas of allocating asset management responsibility and other requirement. There is no material non-compliance reported in this category. A plan for improvement is in place to improve WDHS's maturity rating in these areas.

Acquisition (requirements 24 and 25)

WDHS has met or exceeded its target maturity level in this category.

Planning (requirements 20-23)

WDHS has met or exceeded its target maturity level in this category.



Legend

Status	Scale
Not Applicable	N/A
Innocence	0
Awareness	1
Developing	2
Competence	3
Optimising	4
Unassessed	U/A



◆ Professor Fergus Cameron, Associate professor Dr Peter Simm, Chief Executive, Rowena Clift, local patient, Nate Mackenzie, Dr Fadh Yusof and WDHS Diabetes Educator / Support Nurse, Ebony Wilson celebrate 25 years of Royal Children's Hospital (RCH) quarterly Diabetes Clinics at WDHS.



Statement of
Priorities...

● ● ● ● ● ● ● ●



Statement of Priorities

Part A:

In 2024 - 25 WDHS assisted with the following state-wide priorities to develop and implement important system reforms, including modernising our health system through redesigned governance; driving system reforms that deliver better population health, high-quality care and improved patient outcomes and experiences; and reforming clinical services to ensure we are delivering our community the best value care.

Excellence in Clinical Governance:

Improve paediatric patient outcomes by implementing the “ViCTOR track and trigger” observation chart and escalation system whenever children have observations taken.

All paediatric patients are assessed, and their observations are documented using the ViCTOR track and trigger observation charts. Care is escalated if any observation falls within the purple zone, if three observations are simultaneously recorded in the orange zone, or whenever the clinician has concerns.

This process aligns with the standards outlined in the ViCTOR charts and supports improved outcomes for paediatric patients.

Further enhance the SAPSE (Serious Adverse Patient Safety Event) process within the Health Service to better manage clinical risk.

Over the past financial year WDHS enhanced the review process to identify and respond to SAPSE incidents. On a fortnightly basis, a review group meet to look at all ISR 1 and 2 reported clinical incidents. This process is used to support the identification and response to clinical risk.

Establish Community Advisory Board with representation from all campuses - to support WDHS and CMH Consumer Engagement Framework.

A new Community Advisory Committee has commenced with community and staff members from Hamilton, Casterton, Merino, Coleraine and Peshurst attending.

Participate in Timely Access to Care program and establish Central Access unit responsible for patient flow and staffing resources.

The Clinical Access and Resource Unit (CARU) has made measurable progress toward the key objectives outlined in its original business case. Established in December 2024, the Unit has successfully recruited to all positions and is now fully operational.

Since its inception, CARU has tackled several systemic challenges by: improving transition access between acute, sub-acute, and aged care settings; optimising bed and workforce management; and centralising nursing recruitment and accommodation logistics. By integrating existing resources and streamlining processes, the unit has reduced financial costs and eased administrative pressures on managers.

Early outcomes show clear improvements in workforce coordination, bed utilisation, accommodation management, and the application of Safe and Timely Care standards. CARU has also provided vital leadership in organisational flow, particularly through enhanced discharge planning, stronger escalation protocols, and closer alignment with emergency care benchmarks.

The efficiencies achieved—particularly in agency staffing, accommodation, and bed management—have already delivered cost savings for WDHS, while strengthening patient flow and overall service delivery.

Continue to progress towards ESIS reporting compliance and transition to ESIS reporting health service.

Work is continuing to progress toward meeting the requirements of ESIS reporting, supported through the broader Trak Edition Electronic Medical Record (EMR) project. A gap analysis, undertaken with support from South West Healthcare, has identified several areas for improvement. However, achieving full compliance will require the allocation of additional resources.

At this stage, no further funding rounds are available to support implementation. WDHS continues to highlight this need as a standing item at quarterly performance meetings with the Department of Health.

Operate Within Budget:

Deliver on the key initiatives as outlined in the Budget Action Plan (BAP).

As of 30 June 2025, 56.36% of the total BAP target was realised. There were a number of initiatives that could not be commenced due to timing, sensitivity or other factors. Though the Health Service only achieved 56.36%, it was able to generate an operating surplus.

Utilise data analytics and performance metrics to identify areas of inefficiency and waste and make evidence-based decisions to improve financial sustainability and operational performance.

The new position of Data Analyst has been approved by the Classification Review Panel. This is a permanent part-time position in the Improvement and Innovation Unit for an initial 12 months. This role will be responsible for report and extract development along with maintenance and analysis tasks primarily using several databases and Power BI. They will work with key WDHS stakeholders to understand and support the Hospital's reporting and data extraction requirements. WDHS is also proposing that the new South West Local Area Network consider implementing a digital health strategy.

Improving Equitable Access to Healthcare & Wellbeing:

Address service access issues and equity of health outcomes for priority communities, including LGBTIQ+ communities, multicultural communities, people with disability and rural and regional people including more support for primary, community, home-based and virtual care, and addiction services.

WDHS has re-established its Diversity and Inclusion Committee, with the Community Advisory Committee now more reflective of the diversity within our local community.

In partnership with the local Aboriginal Community Controlled Health Organisation (ACCHO) and the Radiology service, WDHS is covering the 'gap payment' costs for Aboriginal and Torres Strait Islander community members referred for radiology appointments. This initiative is designed to improve access to affordable care and support efforts to close the health gap.

Implement mandatory cultural safety training and assessment for all staff in alignment with the Aboriginal and Torres Strait Islander cultural safety framework, and developed and/or delivered by independent, expert, and community-controlled organisations, Kinaway or Supply Nation certified Aboriginal businesses.

WDHS is working with Winda-Mara Aboriginal Corporation to develop a local, on-country education program. Recently, Board Directors and senior leadership participated in a cultural immersion experience at Budj Bim, deepening their understanding of local history and culture.

In addition, WDHS will be exploring a localised education package through the South West Local Health Service Network (SWLHSN), further strengthening cultural awareness and inclusivity across the organisation.

Develop Memorandum of understanding with Winda-Mara and appoint Aboriginal Liaison Officer across WDHS and CMH.

An Aboriginal Liaison Officer (ALO) was recently appointed, however, has since resigned. WDHS is in the process of updating its Memorandum of Understanding with Winda-Mara Aboriginal Corporation to continue strengthening partnerships and support for the community.

Alongside this, the Aboriginal Employment Plan has been updated in collaboration with Winda-Mara representatives, reinforcing WDHS's commitment to creating meaningful employment pathways and opportunities.

A Stronger Workforce:

Utilising Clinical Services Plan, develop workforce plan for WDHS and CMH.

A new Workforce Plan is currently in development, aligned with the Clinical Services Plan and shaped by the requirements of the SWLHSN.

This plan will ensure our workforce is well-prepared to meet future service needs and community expectations.

Utilising data from Clinical Services Plan, develop new model of care for subacute services and community nursing.

A review of the Hospital in the Home program is currently underway to identify opportunities to improve the use of non-bed-based services.

At the same time, a review of bed utilisation at the Coleraine campus is being undertaken to ensure the best use of assets, including exploring the potential introduction of sub-acute beds.

Moving From Competition to Collaboration:

Partner with headspace Hamilton, Live4Life and WVPHN to develop youth mental health services for Southern Grampians communities.

WDHS is the lead agency for the Southern Grampians Live4Life program – a suicide prevention and health promotion initiative delivered across the Shire in partnership with local secondary colleges and community agencies, including headspace Hamilton.

To strengthen this collaboration, WDHS has established a separate service agreement with headspace Hamilton to deliver youth-focused services directly from the local headspace premises.

Actively participate in Regional Aged Care Reform Partnership to collaborate on Aged Care Reform activities.

The Regional Aged Care Partnership ceased in May 2025 following the resignation of the Lead. Despite this, WDHS remains actively engaged in managing the ongoing Aged Care Reform changes. In late May, the Australian Government announced a delay to the commencement of the new Aged Care Act, which will now take effect from 1 November 2025.

In response to this revised timeline, and to new legislation and guidance from the Australian Government, WDHS continues to review relevant rules and legislation and implement the necessary changes to systems and processes.

A key focus has been preparing for the introduction of the Support at Home Program, which will replace the Home Care Packages and Commonwealth Home Support Program. This transition requires significant system changes, and in collaboration with Heywood Rural Health and Moyne Health Services, WDHS has engaged Stewart Brown & Associates to support the financial modelling process.

In addition, WDHS continues to review compliance with the Strengthened Aged Care Standards through an internal workgroup, ensuring readiness for the upcoming reforms and a strong focus on quality and safety in aged care delivery.

Further building and strengthening the South West Victorian Health Services Network through collaborating on models of care by leveraging and enhancing consistency of clinical information (Trak Editions) and services to support care continuity, closer to home.

The new South West Region, Trak Edition Electronic Health Record (EHR) platform is scheduled to go live in May 2026, despite some delays. It will replace the current Trak 2018 system and will be implemented across Acute, Sub-acute, Emergency, Theatre, Allied Health, and Community Services. WDHS has active representation on key working groups and committees.

Phase 1 will support best-practice, evidence-based care across the region by:

- Standardising clinical processes and data collection to reduce clinical risk
- Enabling a transition from hybrid systems to a comprehensive electronic health record

Benefits for patients include:

- Improved continuity of care across multiple services and sites
- Reduced need to repeat information during care transitions
- More timely and coordinated access to clinical information by care teams

Phase 2 will deliver electronic Medication Management (eMM), including electronic prescribing via Trak, and a dedicated Maternity module – further enhancing safety and quality of care.

Statement of Priorities

Part B: Key 2024-25 Health Service Performance Priorities

Key Performance Measure	Target	Actual
HIGH QUALITY AND SAFE CARE		
INFECTION PREVENTION AND CONTROL		
Percentage of healthcare workers immunised for influenza	94%	100%
CONTINUING CARE		
Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations	≥ 0.645	4.821
ADVERSE EVENTS		
Percentage of reported sentinel events for which a root cause analysis (RCA) report was submitted within 30 business days from notification of the event	N/A	N/A
AGED CARE		
Public sector residential aged care services overall star rating	100%	100%
PATIENT EXPERIENCE		
Percentage of patients who reported positive experiences of their hospital stay	95%	95.5%
ABORIGINAL HEALTH		
The gap between the number of Aboriginal patients who discharged against medical advice compared to non-Aboriginal patients	0%	0%
The gap between the number of Aboriginal patients who 'did not wait' presenting to hospital emergency departments non-Aboriginal patients	0%	2%
STRONG GOVERNANCE, LEADERSHIP AND CULTURE		
ORGANISATIONAL CULTURE		
People matter survey – Percentage of staff with an overall positive response to safety culture survey questions	80%	65%
TIMELY ACCESS TO CARE		
EMERGENCY CARE		
Percentage of patients transferred from ambulance to emergency department within 40 minutes	80%	98%
Number of emergency patients with a length of stay in the ED greater than 24 hours	0	0
Mean ED length of stay (admitted) in minutes	240	129
Mean ED length of stay (non-admitted) in minutes	306	245
Inpatient length of stay in minutes	4,357	4,399

Part B: Key 2024-25 Health Service Performance Priorities

Key Performance Measure	Target	Actual
SPECIALIST CLINICS		
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe	95%	88.9%
HOME BASED CARE		
Percentage of admitted bed days delivered at home	5.0%	3%
EFFECTIVE FINANCIAL MANAGEMENT		
Operating result (\$M)	0.0	0.150
Variance percentage between the forecast andf actual operating result for the current financial year ending 30 June	+/-5.00%	Achieved
Adjusted current asset ratio	0.70	1.20
Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June.	\$6.447m	\$6.173m

Note: The data included in this annual report was accurate at the time of publication and is subject to validation by official sources from the Department of Health.

Statement of Priorities

Part C: State Funding

FUNDING TYPE	Activity Achieved
CONSOLIDATED ACTIVITY FUNDING	
Acute admitted, subacute admitted, emergency services, non-admitted NWAU	9,447
ACUTE ADMITTED	
Acute admitted DVA	78
Acute admitted TAC	8
Other Admitted	3
SUBACUTE / NON-ACUTE, ADMITTED & NON-ADMITTED	
Palliative Care Non-admitted	68
Subacute - DVA	17
Transition Care - Bed days	846
Transition Care - Home days	1,169
AGED CARE	
Residential Aged Care	56,402
HACC	2,861
Aged Care Other	31,943
MENTAL HEALTH AND DRUG SERVICES	
Mental Health Residential	1,095
PRIMARY HEALTH	
Community Health / Primary Care Programs	2,953
SMALL RURAL	
Small Rural Other specified funding	175





📍 Birds-eye view of the Hamilton Base Hospital campus.



General Information

*Disclosures &
Attestations*



Disclosures Required Under Legislation

Additional Information Available on Request

In accordance with FRD 22 and the Financial Management Act 1994, health services must include the following statement in the Report of Operations:

In compliance with the requirements of the Standing Directions 2018 under the Financial Management Act 1994, details in respect of the items listed below have been retained by the Health Service and are available on request to the relevant Ministers, Members of Parliament and the public, subject to the provisions of the Freedom of Information Act 1982.

The following information must be retained and made available upon request:

- (a) a statement that declarations of pecuniary interests have been duly completed by all relevant officers;
- (b) details of shares held by a senior officer as nominee or held beneficially in a statutory authority or subsidiary;
- (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 entity;
- (e) details of any major external reviews carried out on the entity;
- (f) details of major research and development activities undertaken by the entity;
- (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 entity to develop community awareness of the entity and its services;
- (i) details of assessments and measures undertaken to improve the occupational health and safety of employees;
- (j) a general statement on industrial relations within the entity and details of time lost through industrial accidents and disputes;

(k) a list of major committees sponsored by the entity, the purposes of each committee and the extent to which the purposes have been achieved; and

(l) details of all consultancies and contractors including:

(i) consultants/contractors engaged;

(ii) services provided; and

(iii) expenditure committed to for each engagement

This information is available on request from:

Email: ceo@wdhs.net

Phone: (03) 5551 8512

Building Act (1993)

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.

Infrastructure Projects

- The Birches Palliative Care Garden (Dec 2024)
- Grange Salto Doors Install (June 2025)
- Kitchen Dishwasher Replacement (Nov 2024)
- Kitchen Evaporative Cooler Replacement (Oct 2024)
- Old Boiler House Storage (June 2025)
- Upgrade of Fire Manual Call Points (June 2025)
- McKellar Office Accommodation (Dec 2025)
- HBH Air Handling Unit Replacement (June 2025)

Building Compliance

- Sub-Acute Cladding Replacement building permit (issued June 2025)

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.

The Health Service has taken all practical measures to comply with its obligations under the Act.

These include:

- Promoting the principles of the Act to people in care relationships who receive our services and to the wider community (e.g. distributing printed material about the Act at community events or service points; providing links to state government resource materials on our website; providing digital and/or printed information about the Act to our partner organisations)
- Ensuring our staff have an awareness and understanding of the care relationship principles set out in the Act (e.g. developing and implementing a staff awareness strategy about the principles in the Act and what they mean for staff; induction and training programs offered by the organisation include discussion of the Act and the statement of principles therein)
- Considering the care relationships principles set out in the Act when setting policies and providing services (e.g. reviewing our employment policies such as flexible working arrangements and leave provisions to ensure that these comply with the statement of principles in the Act; developing a satisfaction survey for distribution at assessment and review meetings between workers, carers and those receiving care)
- Implementing priority actions in Recognising and Supporting Victoria's Carers: Victorian Carer Strategy 2018-22.

Freedom of Information Act (1982)

During 2024-25, WDHS received 129 applications. Of these requests, 0 were from Members of Parliament, 0 from the media, and the remainder from the general public.

WDHS made 129 FOI decisions during the 12 months ended 30 June 2025

There were 129 decisions made within the statutory time periods. No decisions were made outside time.

Of the total decisions made, 125 granted access to documents in full, 1 was withdrawn and 3 had no documents.

Of requests finalised, the average number of days over/under the statutory time (including extended timeframes) to decide the request was 0 days.

During 2024/25, five requests were subject to a complaint/internal review by Office of the Victorian Information Commissioner. Two requests progressed to the Victorian Civil and Administrative Tribunal (VCAT).

Local Jobs First Act (2003)

WDHS complies with the Local Jobs Act 2003. Administered by the Victorian Industry Participation Policy (VIIP), this supports Victorian businesses and workers by ensuring that small and medium size enterprises (SMEs) are given a full and fair opportunity to compete for both large and small government contracts, helping to create job opportunities, including for apprentices, trainees and cadets.

- 1/. The number and total value of contracts commenced and/or completed in the financial year to which the VIIP Plan was required: Nil
- 2/.The number and percentage of 'local content' committed under contracts that commenced in the reporting period where a VIIP Plan was not required (due to nil or limited contestability): 2 to report
- 3/.The number of small and medium sized businesses engaged as either the principal contractor or as part of the supply chain:

The total number of small and medium sized businesses engaged: 2
- 4/.The percentage of 'local content' committed under contracts that commenced and/or completed in the reporting period to which a VIIP Plan was required split by projects:

State-wide based: 97%

5/.For contracts commenced, a statement of total VIIP Plan commitments (local content, employment, engagement of apprentices/trainees and skills/technology transfer outcomes) achieved as a result of these contracts: N/A

6/.For contracts completed, a statement of total VIIP Plan outcomes (local content, employment, engagement of apprentices/trainees and skills/technology transfer outcomes) achieved as a result of these contracts:

Nil Contracts completed for final plan outcome to be reported.

Public Interest Disclosure Act (2012)

WDHS has in place appropriate procedures for disclosure in accordance with the *Public Interest Disclosure Act 2012*. No public interest disclosures were made under the Act in 2024/25. Disclosures of improper conduct or detrimental action can be made to the WDHS Chief Executive or Public Interest Disclosure Coordinator or to IBAC. Disclosures by a person who is a member, officer or employee of WDHS can also be made to the aforementioned persons. WDHS staff members may also make a disclosure to their Manager or Supervisor, or the Manager or Supervisor of the person who is the subject of the disclosure.

Contact details for the CEO and the Public Interest Disclosure Coordinator are as follows;

WDHS Chief Executive
P.O. Box 283
HAMILTON VIC 3300

Phone (03) 5551 8215

Public Interest Disclosure Coordinator
Mr Nicholas Starkie
Director of Corporate Services
P.O. Box 283
HAMILTON VIC 3300

Phone: (03) 5551 8213
nicholas.starkie@wdhs.net

A disclosure that relates to a Board Member must be made to IBAC or the Victorian Ombudsman. Disclosures relating to the Chief Executive Officer ideally should be made to IBAC.

Independent Broad-based Anti-Corruption Commission (IBAC)
GPO Box 24234
Melbourne Vic 3000
Level 1, 459 Collins Street
Melbourne Vic 3000

Internet: www.ibac.vic.gov.au

Tel: 1300 735 135

The Ombudsman Victoria
Level 9, 459 Collins Street (North Tower)
Melbourne Vic 3000
(DX 210174)

Internet: www.ombudsman.vic.gov.au

Email: ombudvic@ombudsman.vic.gov.au

Tel: 9613 6222

Toll Free: 1800 806 314

National Competition Policy

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

Safe Patient Care Act (2015)

WDHS has no matters to report in relation to its obligations under section 40 of the *Safe Patient Care Act 2015*.

Environmental Performance

WDHS continues to demonstrate leadership in sustainability across all campuses. Our updated Environmental Management Plan (2025–2028) will guide our efforts over the next three years, focusing on:

- reducing emissions through energy management and climate change mitigation
- building climate resilience through adaptation initiatives
- minimising energy and resource use
- reducing waste generation

Progress is already underway in several key areas, with energy efficiency, resource conservation, and waste reduction at the forefront. WDHS is preparing to enter into an Energy Performance Contract (EPC), which will significantly cut gas-related emissions through the electrification and modernisation of plant equipment and appliances.

General notes

1. Information in this report is sourced from data provided by retailers and in some cases data manually uploaded by health services into Eden Suite. Data has not been externally validated. All annual values represent a year ending 30 June.
2. Emissions are calculated using the carbon factors for the year in which the emissions were generated. For health services provided with energy (electricity and steam) under the co-generation ESA (energy services agreement) carbon factors provided by the energy retailer are used.

To further reduce our carbon footprint, we plan to expand our fleet of electric vehicles over the next 12 to 36 months and install additional EV charging stations across the Health Service.

Waste disposal remains a significant cost for WDHS. In response, we are rolling out a range of initiatives to reduce waste volumes and improve sorting practices. This includes the introduction of a waste education module as part of our staff induction program, aimed at minimising contamination of recyclable and clinical waste streams.

Healthcare is inherently resource-intensive, but through the collective efforts of our dedicated staff, WDHS is committed to reducing our environmental impact and promoting a more sustainable future.

3. Electricity consumption values exclude line losses; some energy retailers include losses in reported values.

4. Occupied bed days (OBD) include both inpatient and aged care data, unless stated otherwise.



Environmental Report	2024-25	2023-24	2022-23
GREENHOUSE GAS EMISSIONS			
G1 Total Scope 1 (direct) greenhouse gas emissions ^{(CO₂-e(t))}			
Carbon Dioxide	1,314.52	1,623.62	1,569.55
Methane	2.54	3.02	3.29
Nitrous Oxide	1.10	1.92	1.46
Total	1,318.16	1,628.55	1,574.30
Scope 1 GHG emissions from stationary fuel (F2 Scope 1) ^{(CO₂-e(t))}	1,262.75	1,428.70	1,560.97
Scope 1 GHG emissions from vehicle fleet (T3 Scope 1) ^{(CO₂-e(t))}	55.40	199.86	13.32
Medical/Refrigerant gases			
Total Scope 1 (direct) greenhouse gas emissions ^{(CO₂-e(t))}	1,318.16	1,628.55	1,574.30
G2 Total Scope 2 (indirect electricity) greenhouse gas emissions ^{(CO₂-e(t))}			
Electricity	2,124.69	2,037.75	2,017.78
Total Scope 2 (indirect electricity) greenhouse gas emissions ^{(CO₂-e(t))}	2,124.69	2,037.75	2,017.78
G3 Total Scope 3 (other indirect) greenhouse gas emissions associated with commercial air travel and waste disposal ^{(CO₂-e(t))}			
Commercial air travel	3.90		
Waste emissions (WR5)	220.09	220.77	236.92
Indirect emissions from Stationary Energy	402.46	398.61	429.34
Indirect emissions from Transport Energy	18.78	50.61	3.39
Paper emissions			
Water emissions	72.19	69.57	59.81
Any other Scope 3 emissions			
Total Scope 3 greenhouse gas emissions ^{(CO₂-e(t))}	717.42	739.55	729.45
G(Opt) Net greenhouse gas emissions ^{(CO₂-e(t))}			
Gross greenhouse gas emissions (G1 + G2 + G3) ^{(CO₂-e(t))}	4,160.26	4,405.86	4,321.53
Total gross reported greenhouse gas emissions per bed-day ^{(CO₂-e(t)/OBD)}	0.05	0.06	0.06
Any Reduction Measures Offsets purchased (EL4-related)			
Any Offsets purchased			
Net greenhouse gas emissions ^{(CO₂-e(t))}	4,160.26	4,405.86	4,321.53
ELECTRICITY USE			
EL1 Total electricity consumption segmented by source ^(MWh)			
Purchased	3,213.56	3,098.20	2,937.30
Self-generated	750.40	724.52	725.94
EL1 Total electricity consumption ^(MWh)	3,963.96	3,822.72	3,663.24
EL2 On site-electricity generated ^(MWh) segmented by:			
Consumption behind-the-meter			
Solar Electricity	750.40	724.52	725.94
Total Consumption behind-the-meter ^(MWh)	750.40	724.52	725.94
Exports			
EL2 Total On site-electricity generated ^(MWh)	750.40	724.52	725.94

Environmental Report

	2024-25	2023-24	2022-23
EL3 On-site installed generation capacity (kW converted to MW) segmented by:			
Diesel Generator	1.53	1.53	1.53
Solar System	0.39	0.39	0.39
EL3 Total On-site installed generation capacity ^(MW)	1.92	1.92	1.92
EL4 Total electricity offsets segmented by offset type ^(MWh)			
RPP (Renewable Power Percentage in the grid)	587.91	581.22	552.21
EL4 Total electricity offsets ^(MWh)	587.91	581.22	552.21

STATIONARY ENERGY

F1 Total fuels used in buildings and machinery segmented by fuel type ^(MJ)			
Natural gas	23,243,169.20	24,983,538.20	26,635,263.70
LPG	934,554.90	2,331,578.70	3,109,879.90
Diesel	119,660.00		
F1 Total fuels used in buildings ^(MJ)	24,297,384.10	27,315,116.90	29,745,143.60
F2 Greenhouse gas emissions from stationary fuel consumption segmented by fuel type ^{(CO₂-e(t))}			
Natural gas	1,197.72	1,287.40	1,372.52
LPG	56.63	141.29	188.46
Diesel	8.40		
F2 Greenhouse gas emissions from stationary fuel consumption ^{(CO₂-e(t))}	1,262.75	1,428.70	1,560.97

TRANSPORTATION ENERGY

T1 Total energy used in transportation (vehicle fleet) within the Entity, segmented by fuel type ^(MJ)			
Non-executive fleet - Gasoline	715,043.60	2,561,142.50	197,029.90
Petrol	715,043.60	2,561,142.50	197,029.90
Non-executive fleet - Diesel	100,163.10	378,847.60	
Diesel	100,163.10	378,847.60	
Electricity for Road Vehicles from Victorian Government Facilities	33,923.60		
Electricity (Transport Energy)	33,923.60		
Total energy used in transportation (vehicle fleet) ^(MJ)	849,130.30	2,939,990.10	197,029.90
T2 Number and proportion of vehicles in the organisational boundary segmented by engine/fuel type and vehicle category			
T3 Greenhouse gas emissions from transportation (vehicle fleet) segmented by fuel type ^{(CO₂-e(t))}			
Non-executive fleet - Gasoline	48.35	173.18	13.32
Petrol	48.35	173.18	13.32
Non-executive fleet - Diesel	7.05	26.67	
Diesel	7.05	26.67	
Electricity for Road Vehicles from Victorian Government Facilities	6.23		
Electricity (Transport Energy)	6.23		
Total Greenhouse gas emissions from transportation (vehicle fleet) ^{(CO₂-e(t))}	61.64	199.86	13.32

Environmental Report

2024-25

2023-24

2022-23

T4 Total distance travelled by commercial air travel (passenger km travelled for business purposes by entity staff on commercial or charter aircraft)

Total distance travelled by commercial air travel	17,360.00		
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T(opt1) Total vehicle travel associated with entity operations (1,000 km)

Total vehicle travel associated with entity operations (1,000 km)			
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T(opt2) Greenhouse gas emissions from vehicle fleet (CO₂-e(t) per 1,000 km)

CO ₂ -e(t) per 1,000 km			
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TOTAL ENERGY USE

E1 Total energy usage from fuels, including stationary fuels (F1) and transport fuels ^(T1) (MJ)

Total energy usage from stationary fuels (F1) (MJ)	24,297,384.10	27,315,116.90	29,745,143.60
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Total energy usage from transport (T1) (MJ)	849,130.30	2,939,990.10	197,029.90
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Total energy usage from fuels, including stationary fuels (F1) and transport fuels ^(T1) (MJ)	25,146,514.40	30,255,107.00	29,942,173.50
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E2 Total energy usage from electricity ^(MJ)

Total energy usage from electricity (MJ)	14,270,256.48	13,761,803.90	13,187,654.42
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E3 Total energy usage segmented by renewable and non-renewable sources ^(MJ)

Renewable	4,817,943.31	4,700,684.67	4,601,335.61
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Non-renewable (E1 + E2 - E3 Renewable)	34,564,903.97	39,316,226.23	38,528,492.31
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E4 Units of Stationary Energy used normalised: (F1+E2)/normaliser

Energy per unit of Aged Care OBD (MJ/Aged Care OBD)	691.71	759.68	801.90
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Energy per unit of LOS (MJ/LOS)	1,862.09	2,126.24	2,401.30
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Energy per unit of bed-day (LOS+Aged Care OBD) (MJ/OBD)	504.36	559.71	601.15
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Energy per unit of Separations (MJ/Separations)	4,247.07	4,793.67	5,494.34
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Energy per unit of floor space (MJ/m ²)	1,569.19	1,671.29	1,746.80
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WATER USE

W1 Total units of metered water consumed by water source ^(kL)

Potable water (kL)	44,132.80	41,456.20	35,307.47
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Total units of water consumed (kL)	44,132.80	41,456.20	35,307.47
------------------------------------	-----------	-----------	-----------

W2 Units of metered water consumed normalised by FTE, headcount, floor area, or other entity or sector specific quantity

Water per unit of Aged Care OBD (kL/Aged Care OBD)	0.79	0.77	0.66
--	------	------	------

Water per unit of LOS (kL/LOS)	2.13	2.15	1.97
--------------------------------	------	------	------

Water per unit of bed-day (LOS+Aged Care OBD) (kL/OBD)	0.58	0.56	0.49
--	------	------	------

Water per unit of Separations (kL/Separations)	4.86	4.84	4.52
--	------	------	------

Water per unit of floor space (kL/m ²)	1.80	1.69	1.44
--	------	------	------

Environmental Report

2024-25

2023-24

2022-23

WASTE AND RECYCLING

WR1 Total units of waste disposed of by waste stream and disposal method (kg)

Landfill (total)			
General waste - compactors	146,998.17	147,463.00	155,852.00
Offsite treatment			
Clinical waste - incinerated	1,091.18	1,094.04	831.63
Clinical waste - sharps	504.15	505.85	316.52
Clinical waste - treated	21,060.84	21,117.36	25,515.47
Recycling/recovery (disposal)			
Cardboard	15,896.00	18,199.00	30,970.00
Commingled	2,032.38	2,674.64	3,347.36
Organics (food)	11,636.00	10,437.00	7,279.00
Organics (garden)	16,104.14	10,493.00	144.00
Paper (confidential)			1,708.00
PVC	146.00	1,231.00	489.00
Toner & print cartridges	4.50		
Total units of waste disposed (kg)	215,473.35	213,214.89	226,452.98

WR1 Total units of waste disposed of by waste stream and disposal method (%)

Landfill (total)			
General waste	68.22%	69.16%	68.82%
Offsite treatment			
Clinical waste - incinerated	0.51%	0.51%	0.37%
Clinical waste - sharps	0.23%	0.24%	0.14%
Clinical waste - treated	9.77%	9.90%	11.27%
Recycling/recovery (disposal)			
Cardboard	7.38%	8.54%	13.68%
Commingled	0.94%	1.25%	1.48%
Organics (food)	5.40%	4.90%	3.21%
Organics (garden)	7.47%	4.92%	0.06%
Paper (confidential)			0.75%
PVC	0.07%	0.58%	0.22%
Toner & print cartridges	0.00%		

WR2 Percentage of office sites covered by dedicated collection services for each waste stream

Printer cartridges

Batteries

e-waste

Soft plastics

Environmental Report	2024-25	2023-24	2022-23
WR3 Total units of waste disposed normalised by FTE, headcount, floor area, or other entity or sector specific quantity, by disposal method			
Total waste to landfill per patient treated ^{((kg general waste)/PPT)}	1.51	1.58	1.74
Total waste to offsite treatment per patient treated ^{((kg offsite treatment)/PPT)}	0.23	0.24	0.30
Total waste recycled and reused per patient treated ^{((kg recycled and reused)/PPT)}	0.47	0.46	0.49
WR4 Recycling rate (%)			
Weight of recyclable and organic materials (kg)	45,819.01	43,034.64	43,937.36
Weight of total waste (kg)	215,473.35	213,214.89	226,452.98
Recycling rate (%)	21.26%	20.18%	19.40%
WR5 Greenhouse gas emissions associated with waste disposal ^{(CO₂-e(t))}			
CO ₂ -e(t)	220.09	220.77	236.92

NORMALISATION FACTORS

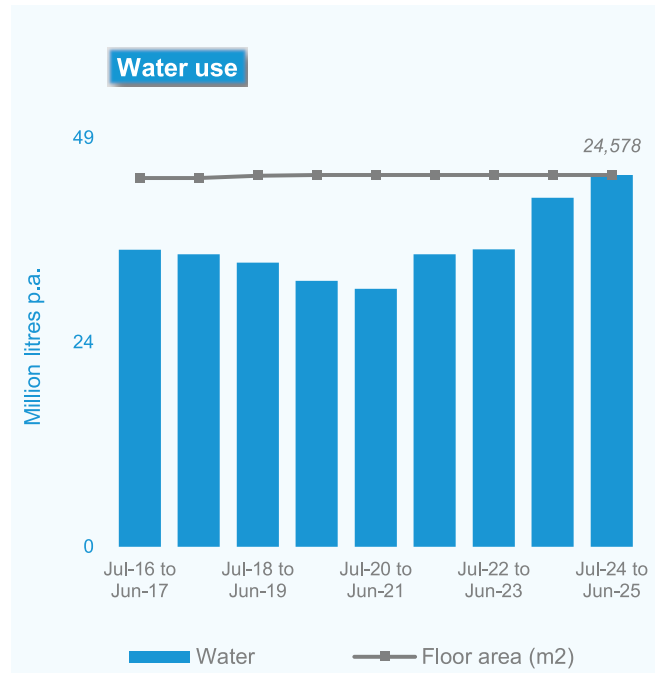
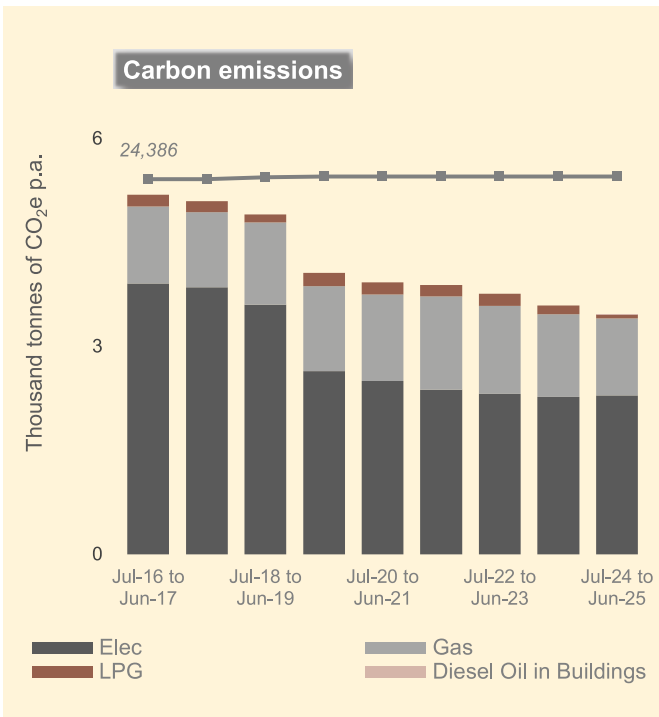
1000km (Corporate)			
1000km (Non-emergency)			
Aged Care OBD	55,757.00	54,071.00	53,539.00
ED Departures	12,012.00	11,415.00	10,117.00
FTE	616.00	621.00	593.00
LOS	20,712.00	19,319.00	17,879.00
OBD	76,469.00	73,390.00	71,418.00
PPT	97,562.00	93,374.00	89,349.00
Separations	9,081.00	8,569.00	7,814.00
TotalAreaM2	24,578.00	24,578.00	24,578.00

NOTE: Indicators are not reported where data is unavailable or an indicator is not relevant to the organisation's operations

Energy and water Performance Report

Expenditure

	Jul-23 to Jun-24 (\$ thousand)	Jul-24 to Jun-25 (\$ thousand)	Change from previous year
Electricity	\$644	\$682	5.9%
Natural Gas	\$420	\$431	2.6%
Liquefied Petroleum Gas	\$63	\$28	-55.2%
Potable Water	\$193	\$210	8.9%
TOTAL	\$1,321	\$1,352	2.4%

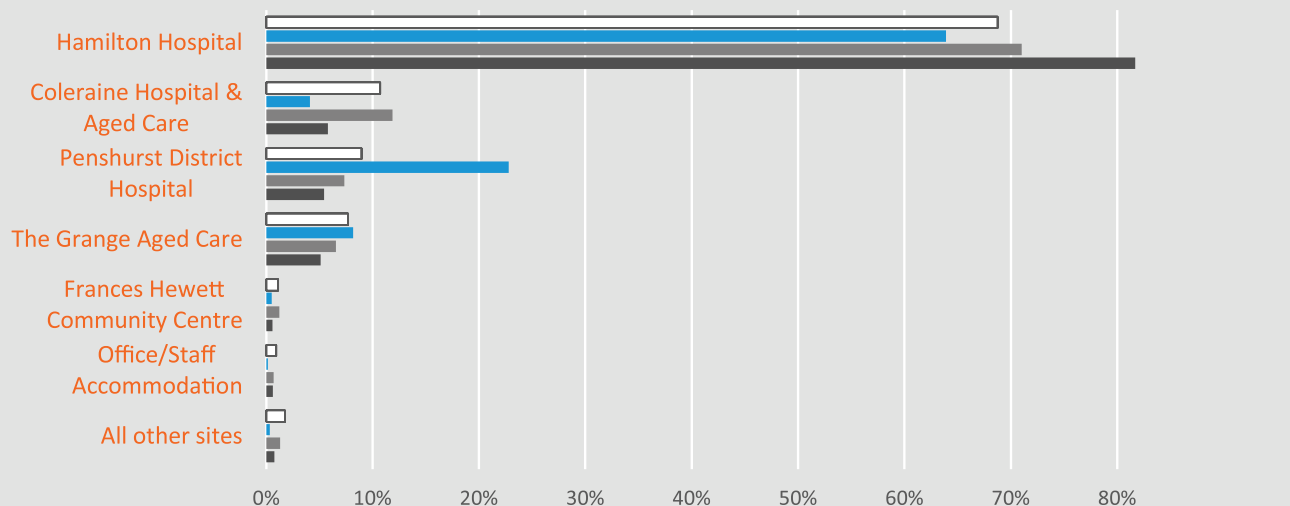


Carbon emissions: Carbon emission values represent total Scope 1 and 2 carbon emission from stationary energy (energy used in buildings).

Percentage of health service total

Expenditure Water use Emissions Gigajoules

Detailed information: Information on individual hospitals and values used in charts is available on separate site specific performance reports.



Attestations

Financial Management Compliance Attestation

I, Anna Sweeney, on behalf of the Responsible Body, certify that the Western District Health Service has complied with the applicable Standing Directions 2018 under the *Financial Management Act 1994* and Instructions.

Anna Sweeney
BOARD PRESIDENT
24 September 2025

Attestation on Managing Conflicts of Interest

I, Rowena Clift, certify that the Western District Health Service has put in place appropriate internal controls and processes to ensure that it has implemented a 'Conflict of Interest' policy consistent with the minimum accountabilities required by the VPSC. Declaration of private interest forms have been completed by all executive staff within Western District Health Service and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive board meeting.

Rowena Clift
DUAL CHIEF EXECUTIVE
24 September 2025

Attestation on Data Integrity

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

Rowena Clift
DUAL CHIEF EXECUTIVE
24 September 2025

Attestation on Integrity, Fraud and Corruption

I, Rowena Clift, certify that the Western District Health Service has put in place appropriate internal controls and processes to ensure that Integrity, fraud and corruption risks have been reviewed and addressed at Western District Health Service during the year.

Rowena Clift
ACCOUNTABLE OFFICER
24 September 2025

Healthshare Victoria Compliance

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

Rowena Clift
ACCOUNTABLE OFFICER
24 September 2025

BOARD MEMBERS', ACCOUNTABLE OFFICER'S AND CHIEF FINANCE & ACCOUNTING OFFICER'S DECLARATION

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2025 and the financial position of Western District Health Service at 30 June 2025.

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.



Anna Sweeney
Chairperson

Hamilton
24 September 2025



Rowena Clift
Dual Chief Executive

Hamilton
24 September 2025



Nicholas Starkie
Chief Finance and
Accounting Officer

Hamilton
24 September 2025

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.

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FRD 22	Nature and range of services provided	13-14
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FRD 22	Significant changes in key initiatives and expectations for the future	1-2
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FRD 22	Compliance with building and maintenance provisions of Building Act 1993	45
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	Reporting of compliance regarding car parking fees (if applicable)	N/A

Independent Auditor's Report

To the Board of Western District Health Service

Opinion	<p>I have audited the financial report of Western District Health Service (the health service) which comprises the:</p> <ul style="list-style-type: none"> • balance sheet as at 30 June 2025 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including material accounting policy information • board member's, accountable officer's and chief finance & accounting officer's declaration. <p>In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2025 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the <i>Financial Management Act 1994</i> and Australian Accounting Standards – Simplified Disclosures.</p>
Basis for Opinion	<p>I have conducted my audit in accordance with the <i>Audit Act 1994</i> which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the <i>Auditor's Responsibilities for the Audit of the Financial Report</i> section of my report.</p> <p>My independence is established by the <i>Constitution Act 1975</i>. My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 <i>Code of Ethics for Professional Accountants (including Independence Standards)</i> (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.</p> <p>I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.</p>
Board's responsibilities for the financial report	<p>The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards – Simplified Disclosures and the <i>Financial Management Act 1994</i>, and for such internal control as the Board determines is necessary to enable the preparation of a financial report that is free from material misstatement, whether due to fraud or error.</p> <p>In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.</p>

Auditor's responsibilities for the audit of the financial report

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

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

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

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



MELBOURNE
29 September 2025

Simone Bohan
as delegate for the Auditor-General of Victoria

Financial Statements

Comprehensive Operating Statement

For the Financial Year Ended 30 June 2025

	Note	2025 \$'000	2024 \$'000
Revenue and income from transactions			
Revenue from contracts with customers	2.1	107,997	95,584
Other sources of income	2.1	19,387	19,983
Non-operating activities		3,159	2,838
Total revenue and income from transactions		130,543	118,405
Expenses from transactions			
Employee expenses	3.1	(93,582)	(89,861)
Finance costs		(166)	(103)
Depreciation and amortisation	4.1(a), 4.1(b)	(11,598)	(8,609)
Other operating expenses	3.1	(31,480)	(28,809)
Total Expenses from transactions		(136,826)	(127,382)
Net result from transactions - net operating balance		(6,283)	(8,977)
Other economic flows included in net result			
Net gain/(loss) on sale of non-financial assets		15	257
Net gain/(loss) on financial instruments		44	(109)
Other gain/(loss) from other economic flows		51	407
Total other economic flows included in net result		110	555
Net result		(6,173)	(8,422)
Other economic flows - other comprehensive income			
Items that will not be reclassified to net result			
Changes in property, plant and equipment revaluation surplus		-	28,675
Changes in the fair value of equity instruments at fair value through other comprehensive income		-	116
Total other comprehensive income		-	28,791
Comprehensive result		(6,173)	20,369

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

Balance Sheet

As at 30 June 2025

	Note	2025 \$'000	2024 \$'000
Financial assets			
Cash and cash equivalents	6.2	54,639	49,257
Receivables	5.1	8,702	7,862
Contract assets		615	614
Investments and other financial assets	5.2	7,938	7,349
Total financial assets		71,894	65,082
Non-financial assets			
Prepayments		889	660
Inventories		82	136
Property, plant and equipment	4.1	169,201	176,254
Total non-financial assets		170,172	177,050
Total assets		242,066	242,132
Liabilities			
Payables	5.4	10,747	11,242
Contract liabilities	5.5	610	1,322
Borrowings	6.1	1,786	1,878
Employee benefits	3.1(b)	19,699	18,195
Other liabilities	5.6	33,950	28,048
Total liabilities		66,792	60,685
Net assets		175,274	181,447
Equity			
Reserves		165,300	160,930
Contributed capital		49,535	49,535
Accumulated (deficit)		(39,561)	(29,018)
Total equity		175,274	181,447

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

Cash Flow Statement

For the Financial Year Ended 30 June 2025

	Note	2025 \$'000	2024 \$'000
Cash Flows from operating activities			
Operating grants from Government		107,197	90,597
Capital grants from State Government		3,302	3,368
Patient fees received		7,377	6,827
GST received from ATO		3,302	3,080
Interest and investment income received		3,017	2,608
Other receipts		8,234	7,849
Total receipts		132,429	114,329
Payments to employees		(92,727)	(86,907)
Payments to suppliers and consumables		(31,551)	(28,373)
GST paid to ATO		(3,155)	(2,837)
Finance costs		(166)	(103)
Total payments		(127,599)	(118,220)
Net cash flows from/(used in) operating activities		4,830	(3,891)
Cash Flows from investing activities			
Proceeds from sale of non-financial assets		325	291
Purchase of non-financial assets		(4,601)	(4,583)
Proceeds from sale of financial assets		-	401
Purchase of financial assets		(589)	-
Net cash flows from/(used in) investing activities		(4,865)	(3,891)
Cash flows from financing activities			
Repayment of borrowings and principal portion of lease liabilities		(346)	(273)
Repayment of accommodation deposits		(10,693)	(3,186)
Receipt of accommodation deposits		16,456	9,940
Net cash flows from/(used in) financing activities		5,417	6,481
Net increase/(decrease) in cash and cash equivalents held		5,382	(1,301)
Cash and cash equivalents at beginning of year		49,257	50,558
Cash and cash equivalents at end of year	6.2	54,639	49,257

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

Statement of Changes in Equity

For the Financial Year Ended 30 June 2025

	Property, Plant and Equipment Revaluation Surplus \$'000	Financial Assets through Other Comprehensive Income Revaluation \$'000	Restricted Specific Purpose Reserve \$'000	Contributed Capital \$'000	Accumulated (Surplus/ Deficit) \$'000	Total \$'000
Balance at 1 July 2023	111,490	190	20,949	49,535	(21,086)	161,078
Net result for the year	-	-	-	-	(8,422)	(8,422)
Other comprehensive income for the year	28,675	116	-	-	-	28,791
Transfer from/(to) accumulated (deficit)	-	-	(490)	-	490	-
Balance at 30 June 2024	140,165	306	20,459	49,535	(29,018)	181,447
Net result for the year	-	-	-	-	(6,173)	(6,173)
Transfer from/(to) accumulated (deficit)	-	-	4,370	-	(4,370)	-
Balance at 30 June 2025	140,165	306	24,829	49,535	(39,561)	175,274

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



▣ Grange Residential Care Staff

Financial Contents



How this report is structured

Western District Health Service presents its audited Tier 2 general-purpose financial statements for the financial year ended 30 June 2025 in the following structure to provide users with information about Western District Health Service's stewardship of the resources entrusted to it.

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Notes to the Financial Statements

For the Financial Year Ended 30 June 2025

Structure

- 1.1 Basis of preparation
- 1.2 Material accounting estimates and judgements
- 1.3 Reporting entity
- 1.4 Economic dependency

Note 1 About this Report

These financial statements represent the financial statements of Western District Health Service for the year ended 30 June 2025.

Western District Health Service is a not-for-profit entity established as a public agency in 1862 under the Health Services Act 1988 (Vic). A description of the nature of its operations and its principal activities is included in the Report of Operations, which does not form part of these financial statements.

This section explains the basis of preparing the financial statements.

Note 1.1 Basis of preparation

These financial statements are general purpose financial statements which have been prepared in accordance with *AASB 1060 General Purpose Financial Statements – Simplified Disclosures for For-Profit and Not-for-Profit Tier 2 Entities (AASB 1060)* and Financial Reporting Direction 101 Application of Tiers of Australian Accounting Standards (FRD 101).

Western District Health Service is a Tier 2 entity in accordance with FRD 101. These financial statements are the first general purpose financial statements prepared in accordance with Australian Accounting Standards – Simplified Disclosures. Western District Health Service's prior year financial statements were general purpose financial statements prepared in accordance with Australian Accounting Standards (Tier 1). As Western District Health Service is not a 'significant entity' as defined in FRD 101, it was required to change from Tier 1 to Tier 2 reporting effective from 1 July 2024.

These general purpose financial statements have been prepared in accordance with the FMA and applicable Australian Accounting Standards (AASs), which include interpretations, issued by the Australian Accounting Standards Board (AASB).

Where appropriate, those AASs paragraphs applicable to not-for-profit entities have been applied. Accounting policies selected and applied in these financial statements ensure 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 accrual basis of accounting has been applied in preparing these financial statements, whereby assets, liabilities, equity, income and expenses are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

Consistent with the requirements of *AASB 1004 Contributions*, contributions by owners (that is, contributed capital and its repayment) are treated as equity transactions and, therefore, do not form part of the income and expenses of Western District Health Service.

The financial statements have been prepared on a going concern basis (refer to Note 1.4 Economic Dependency).

The financial statements are presented in Australian dollars.

The amounts presented in the financial statements have been rounded to the nearest thousand dollars. Minor discrepancies in tables between totals and sum of components are due to rounding.

The annual financial statements were authorised for issue by the Western District Health Service Board's Finance and Risk Committee on 24th September 2025.

Note 1.2 Material accounting estimates and judgements

Management makes estimates and judgements when preparing the financial statements.

These estimates and judgements are based on historical knowledge and the best available current information and assume any reasonable expectation of future events. Actual results may differ.

Revisions to estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision.

The material accounting judgements and estimates used, and any changes thereto, are disclosed within the relevant accounting policy.

Note 1.3 Reporting entity

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

Western District Health Service's principal address is:

20 Foster Street
HAMILTON VIC 3300

Note 1.4 Economic dependency

Western District Health Service is a public health service governed and managed in accordance with the Health Services Act 1988 and its results form part of the Victorian General Government consolidated financial position. Western District Health Service provides essential services and is predominantly dependent on the continued financial support of the State Government, particularly the Department of Health, and the Commonwealth funding via the National Health Reform Agreement (NHRA). The State of Victoria plans to continue Western District Health Service's operations and on that basis, the financial statements have been prepared on a going concern basis.

Note 2 Funding delivery of our services

Western District Health Service's overall objective is to provide quality health service that will improve the health, wellbeing and the quality of life for our community. Western District Health Service is predominantly funded by grant funding for the provision of services. Western District Health Service also receives income from the supply of services.

Structure

2.1 Revenue and income from transactions

2.1 Revenue and income from transactions

	Note	2025 \$'000	2024 \$'000
Revenue from contracts with customers	2.1(a)	107,997	95,584
Other sources of income	2.1(b)	19,387	19,983
Total revenue and income from transactions		127,384	115,567

Note 2.1(a) Revenue from contracts with customers

	2025 \$'000	2024 \$'000
Government grants (State) - Operating	62,284	53,811
Government grants (Commonwealth) - Operating	33,598	30,120
Patient and resident fees	7,419	6,938
Private practice fees	112	59
Commercial activities	4,584	4,656
Total revenue from contracts with customers	107,997	95,584

How we recognise revenue from contracts with customers

Government grants

Revenue from government operating grants that are enforceable and contain sufficiently specific performance obligations are accounted for as revenue from contracts with customers under *AASB 15*.

In contracts with customers, the 'customer' is the funding body, who is the party that promises funding in exchange for Western District Health Service's goods or services. Western District Health Service's funding bodies often direct that goods or services are to be provided to third party beneficiaries, including individuals or the community at large. In such instances, the customer remains the funding body that has funded the program or activity, however the delivery of goods or services to third party beneficiaries is a characteristic of the promised good or service being transferred to the funding body.

This policy applies to each of Western District Health Service's revenue streams, with information detailed below relating to Western District Health Service's material revenue streams:

Government grant	Performance obligation
Activity Based Funding (ABF) paid as National Weighted Activity Unit (NWAU)	NWAU is a measure of health service activity expressed as a common unit against which the national efficient price (NEP) is paid. The performance obligations for NWAU are the number and mix of admissions, emergency department presentations and outpatient episodes, and is weighted for clinical complexity. Revenue is recognised at point in time, which is when a patient is discharged.
Commonwealth Residential Aged Care Grants	Funding is provided for the provision of care for aged care residents within facilities at Western District Health Service. The performance obligations include provision of residential accommodations and care from nursing staff and personal care workers. Revenue is recognised at the point in time when the service is provided with the aged care facility.

Patient and resident fees

Patient and resident fees are charges incurred by patients for services they receive. Patient and resident fees are recognised under *AASB 15* at a point in time when the performance obligation, the provision of services, is satisfied, except where the patient and resident fees relate to accommodation charges.

Accommodation charges are calculated daily and are recognised over time, to reflect the period accommodation is provided.

Note 2.1(b) Other sources of income

	2025 \$'000	2024 \$'000
Government grants (State) - Operating	11,460	12,736
Government grants (State) - Capital	3,297	2,849
Government grants (Commonwealth) - Capital	881	783
Capital donations	410	637
Assets received free of charge or for nominal consideration	253	106
Other income from operating activities	3,086	2,872
Total other sources of income	19,387	19,983

How we recognise other sources of income

Government grants

Western District Health Service recognises income of not-for-profit entities under *AASB 1058* where it has been earned under arrangements that are either not enforceable or linked to sufficiently specific performance obligations.

Income from grants without any sufficiently specific performance obligations or that are not enforceable, is recognised when Western District Health Service has an unconditional right to receive cash which usually coincides with receipt of cash. On initial recognition or the asset, Western District Health Service recognises any related contributions by owners, increases in liabilities, decreases in assets or revenue (related amounts) in accordance with other Australian Accounting Standards. Related amounts may take the form of:

- contributions by owners, in accordance with *AASB 1004 Contributions*
- revenue or contract liability arising from a contract with a customer, in accordance with *AASB 15*
- a lease liability in accordance with *AASB 16 Leases*
- a financial instrument, in accordance with *AASB 9 Financial Instruments*
- a provision, in accordance with *AASB 137 Provisions, Contingent Liabilities and Contingent Assets*.

Capital grants

Where Western District Health Service receives a capital grant it recognises a liability, equal to the financial asset received less amounts recognised under other Australian Accounting Standards. Income is recognised in accordance with *AASB 1058* progressively as the asset is constructed which aligns with Western District Health Service's obligation to construct the asset. The progressive percentage of costs incurred is used to recognise income, as this most accurately reflects the stage of completion.

Non-cash contributions from the Department of Health

The DH makes some payments on behalf of Western District Health Service as follows:

Supplier	Description
Victorian Managed Insurance Authority	The Department of Health purchases non-medical indemnity insurance for Western District Health Service which is paid directly to the Victorian Managed Insurance Authority. To record this contribution, such payments are recognised as income with a matching expense in the net result from transactions.
Department of Health	Long Service Leave (LSL) revenue is recognised upon finalisation of movements in LSL liability in line with the long service leave funding arrangements with the DH.

Note 3 The cost of delivering our services

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

Structure

3.1 Expenses incurred in the delivery of services

Note 3.1 Expenses incurred in the delivery of services

	Note	2025 \$'000	2024 \$'000
Employee expenses	3.1(a)	93,582	89,861
Other operating expenses	3.1(c)	31,480	28,809
Total expenses incurred in the delivery of services		125,062	118,670

Note 3.1(a) Employee expenses

	2025 \$'000	2024 \$'000
Salaries and wages	72,090	68,612
Defined contribution superannuation expense	7,419	6,576
Defined benefit superannuation expense	79	81
Agency expenses	6,522	7,866
Fee for service medical officer expenses	7,472	6,726
Total employee expenses	93,582	89,861

How we recognise employee expenses

Employee expenses include salaries and wages, fringe benefits tax, leave entitlements, termination payments, WorkCover payments and agency expenses.

The amount recognised in relation to superannuation is employer contributions for members of both defined benefit and defined contribution superannuation plans that are paid or payable during the reporting period.

The defined benefit plan(s) provides benefits based on year of service and final average salary. The basis for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans. Western District Health Service does not recognise any defined benefit liabilities because it has no legal or constructive obligation to pay future benefits relating to its employees. Instead Western District Health Service accounts for contributions to these plans as if they were defined contribution plans.

The Department of Treasury and Finance discloses in its annual financial statements the net defined benefit cost related to the members of these plans as an administered liability.

Note 3.1(b) Employee related provisions

	2025 \$'000	2024 \$'000
Current provisions for employee benefits		
Accrued days off	254	221
Annual leave	6,911	6,105
Long service leave	8,509	7,881
Provision for on-costs	1,907	1,804
Total current provisions for employee benefits	17,581	16,011
Non-current provisions for employee benefits		
Long service leave	1,883	1,936
Provision for on-costs	235	248
Total non-current provisions for employee benefits	2,118	2,184
Total provisions for employee benefits	19,699	18,195

How we recognise employee-related provisions

Employee related provisions are accrued for employees in respect of accrued days off, annual leave and long service leave, for services rendered to the reporting date.

No provision has been made for sick leave as all sick leave is non-vesting and it is not considered probable that the average sick leave taken in the future will be greater than the benefits accrued in the future. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income as sick leave is taken.

Annual leave and accrued days off

Liabilities for annual leave and accrued days off are recognised in the provision for employee benefits as current liabilities because Western District Health Service does not have an unconditional right to defer settlement of these liabilities.

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

- nominal value - if Western District Health Service expects to wholly settle within 12 months or
- present value - if Western District Health Service does not expect to wholly settle within 12 months.

Long service leave

The liability for long service leave (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 Western District Health Service does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- nominal value - if Western District Health Service expects to wholly settle within 12 months or
- present value - if Western District Health Service does not expect to wholly settle within 12 months.

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

Provisions

Employment on-costs such as payroll tax, workers compensation and superannuation are not employee benefits. They are disclosed separately as a component of the provision for employee benefits when the employment to which they relate has occurred.

Note 3.1(c) Other expenses

	2025 \$'000	2024 \$'000
Other operating expenses		
Drug supplies	4,272	3,416
Medical and surgical supplies (including Prostheses)	4,019	4,097
Diagnostic and radiology supplies	631	619
Other supplies and consumables	10,516	9,580
Low value lease expenses	252	174
Fuel, light, power and water	1,552	1,402
Repairs and maintenance	741	822
Maintenance contracts	507	416
Medical indemnity insurance	1,251	1,044
Other administration expenses	7,739	7,239
Total other operating expenses	31,480	28,809

How we recognise other operating expenses

Expense recognition

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

Supplies and consumables

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

The following lease payments are recognised on a straight-line basis:

- short term leases – leases with a term of twelve months or less, and
- low value leases – leases with the underlying asset's fair value (when new, regardless of the age of the asset being leased) is no more than \$10,000.

Variable lease payments that are not included in the measurement of the lease liability, i.e. variable lease payments that do not depend on an index or a rate such as those based on performance or usage of the underlying asset, are recognised in the Comprehensive Operating Statement (except for payments which have been included in the carrying amount of another asset) in the period in which the event or condition that triggers those payments occurs. Western District Health Service's variable lease payments during the year ended 30 June 2025 was nil.

Other operating expenses

Other operating expenses generally represent the day-to-day running costs incurred in normal operations.

The DH also makes certain payments on behalf of Western District Health Service. These amounts have been brought to account in determining the operating result for the year, by recording them as revenue (Refer to Note 2.1(c)) and recording a corresponding expense.

Note 4 Key assets to support service delivery

Western District Health Service controls infrastructure and other investments that are utilised in fulfilling its objectives and conducting its activities. They represent the key resources that have been entrusted to Western District Health Service to be utilised for delivery of services.

Structure

4.1 Property, plant and equipment

4.2 Depreciation and amortisation

Note 4.1 Property, plant and equipment

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2025 \$'000	2024 \$'000	2025 \$'000	2024 \$'000	2025 \$'000	2024 \$'000
Land at fair value - Crown	3,230	3,230	-	-	3,230	3,230
Land at fair value - Freehold	2,847	2,847	-	-	2,847	2,847
Buildings at fair value	157,268	153,755	(9,731)	(33)	147,537	153,722
Works in progress at cost	2,062	2,663	-	-	2,062	2,663
Plant, equipment and vehicles at fair value	31,369	30,265	(17,844)	(16,473)	13,525	13,792
Total property, plant and equipment	196,776	192,760	(27,575)	(16,506)	169,201	176,254

How we recognise property, plant and equipment

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

The cost of constructed non-financial physical assets includes the cost of all materials used in construction, direct labour on the project and an appropriate proportion of variable and fixed overheads.

Note 4.1(a) Reconciliations of the carrying amounts of each class of asset

	Land \$'000	Buildings \$'000	Works in progress \$'000	Plant, equipment and vehicles \$'000	Total \$'000
Balance at 1 July 2024	6,077	153,722	2,663	13,792	176,254
Additions	-	-	2,945	1,954	4,899
Disposals	-	-	-	(354)	(354)
Net transfers between classes	-	3,546	(3,546)	-	-
Depreciation	-	(9,731)	-	(1,867)	(11,598)
Balance at 30 June 2025	6,077	147,537	2,062	13,525	169,201

Fair value assessments have been performed for all classes of assets in this purpose group and the decision was made that the movements were not material (less than or equal to 10%). As such, an independent revaluation was not required per FRD 103. In accordance with FRD 103, Western District Health Service has elected to apply the practical expedient in FRD 103 Non-Financial Physical Assets and has therefore not applied the amendments to AASB 13 Fair Value Measurement. The amendments to AASB 13 will apply if there is a full revaluation before the next scheduled independent revaluation, which is planned to be undertaken in 2029, in accordance with Western District Health Service's revaluation cycle.

Note 4.1(b) Right-of-use assets included in property, plant and equipment

The following tables are right-of-use assets included in the property, plant and equipment balance, presented by subsets of buildings and plant and equipment.

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2025 \$'000	2024 \$'000	2025 \$'000	2024 \$'000	2025 \$'000	2024 \$'000
Plant, equipment and vehicles at fair value	2,663	2,491	(450)	(334)	2,213	2,157
Total right-of-use assets	2,663	2,491	(450)	(334)	2,213	2,157

Note 4.1(c) Reconciliation of the carrying amount of each class of right of use asset

	Plant, equipment and vehicles \$'000	Total \$'000
Balance at 1 July 2024	2,157	2,157
Additions	710	710
Disposals	(340)	(340)
Depreciation	(314)	(314)
Balance at 30 June 2025	2,213	2,213

*How we recognise right-of-use assets***Initial recognition**

When Western District Health Service enters a contract, which provides the health services with the right to control the use of an identified asset for a period of time in exchange for payment, this contract is considered a lease.

Unless the lease is considered a short-term lease or a lease of a low-value asset (refer to Note 6.1 for further information) the contract gives rise to a right-of-use asset and corresponding lease liability.

The right-of-use asset is initially measured at cost and comprises the initial measurement of the corresponding lease liability, adjusted for:

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

Subsequent measurement

Right-of-use assets are subsequently measured at fair value, with the exception of right-of-use assets arising from leases with significantly below-market terms and conditions, which are subsequently measured at cost, less accumulated depreciation and accumulated impairment losses where applicable.

Western District Health Service has applied the exemption permitted under FRD 104 *Leases*, consistent with the optional relief in *AASB 16.Aus25.1*. Under this exemption, Western District Health Service is not required to apply fair value measurement requirements to right-of-use assets arising from leases with significantly below-market terms and conditions, where those leases are entered into principally to enable the entity to further its objectives.

Right-of-use assets are also adjusted for certain remeasurements of the lease liability (for example, when a variable lease payment based on an index or rate becomes effective).

Further information regarding fair value measurement is disclosed in Note 7.3.

4.1(d) Impairment of property, plant and equipment

The recoverable amount of the primarily non-financial physical assets of Western District Health Service, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under *AASB 13 Fair Value Measurement*, with the consequence that *AASB 136 Impairment of Assets* does not apply to such assets that are regularly revalued.

Note 4.2 Depreciation and amortisation*How we recognise depreciation*

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

Right-of-use assets are depreciated over the lease term or useful life of the underlying asset, whichever is the shortest. Where a lease transfers ownership of the underlying asset or the cost of the right-of-use asset reflects that the health service anticipates exercising a purchase option, the specific right-of-use asset is depreciated over the useful life of the underlying asset.

How we recognise amortisation

Amortisation is the systematic allocation of the depreciable amount of an asset over its useful life.

Useful lives of non-current assets

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

	2025	2024
Buildings	7 to 50 years	7 to 50 years
Plant, equipment and vehicles (including leased assets)	3 to 40 years	4 to 40 years

Note 5 Other assets and liabilities

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

Structure**5.1 Receivables****5.2 Investments and other financial assets****5.3 Impairment of financial assets****5.4 Payables****5.5 Contract liabilities****5.6 Other liabilities****Note 5.1 Receivables**

	Note	2025 \$'000	2024 \$'000
Current receivables			
Contractual			
Trade receivables		2,050	1,874
Patient fees		883	841
Allowance for impairment losses	5.3	(204)	(311)
Amounts receivable from governments and agencies		64	210
Total contractual receivables		2,793	2,614
Statutory			
GST receivable		208	356
Total statutory receivables		208	356
Total current receivables		3,001	2,970
Non-current receivables			
Contractual			
Long service leave - Department of Health		5,701	4,892
Total non-current receivables		5,701	4,892
Total receivables		8,702	7,862

(i) Financial assets classified as receivables

Total receivables		8,702	7,862
GST receivable		(208)	(356)
Total financial assets classified as receivables	7.1	8,494	7,506

How we recognise receivables

Receivables consist of:

- Contractual receivables, including debtors that relate to goods and services. These receivables are classified as financial instruments and are categorised as 'financial assets at amortised cost'. They are initially recognised at fair value plus any directly attributable transaction costs. The health service holds contractual receivables with the objective to collect the contractual cash flows and therefore they are subsequently measured at amortised cost using the effective interest method, less any impairment.
- Statutory receivables, including Goods and Services Tax (GST) input tax credits that are recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment) but are not classified as financial instruments for disclosure purposes. The health service applies AASB 9 for initial measurement of the statutory receivables and as a result, statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

Note 5.2 Investments and other financial assets

	Operating Fund		Specific Purpose Fund		Capital Fund		Total	
	2025 \$'000	2024 \$'000	2025 \$'000	2024 \$'000	2025 \$'000	2024 \$'000	2025 \$'000	2024 \$'000
Current								
Financial assets at amortised cost								
Term deposits > 3 months	-	-	-	-	517	503	517	503
Total current financial assets	-	-	-	-	517	503	517	503
Non-current								
Financial assets at amortised cost								
Term deposits > 12 months	4,833	4,496	-	-	-	-	4,833	4,496
Financial assets at fair value through OCI								
Equities	-	-	2,588	2,350	-	-	2,588	2,350
Total non-current financial assets	4,833	4,496	2,588	2,350	-	-	7,421	6,846
Total investments and other financial assets	4,833	4,496	2,588	2,350	517	503	7,938	7,349
Represented by:								
Health service investments	4,833	4,496	2,588	2,350	517	503	7,938	7,349
Total investments and other financial assets	4,833	4,496	2,588	2,350	517	503	7,938	7,349

How we recognise investments and other financial assets

Western District Health Service's investments and other financial assets are made in accordance with Standing Direction 3.7.2 - Treasury Management, including the Central Banking System.

Western District Health Service manages its investments and other financial assets in accordance with an investment policy approved by the Board.

Investments are recognised when Western District Health Service enters into a contract to either purchase or sell the investment (i.e. when it becomes a party to the contractual provisions to the investment). Investments are initially measured at fair value, net of transaction costs.

Western District Health Service classifies its other financial assets between current and non-current assets based on the Board's intention at balance date with respect to the timing of disposal of each asset. Term deposits with original maturity dates of three to twelve months are classified as current, whilst term deposits with original maturity dates in excess of 12 months are classified as non-current.

All financial assets, except for those measured at fair value through the Comprehensive Operating Statement, are subject to annual review for impairment, in accordance with Note 5.3.

Note 5.3 Impairment of financial assets

	2025	2024
Impairment loss on contractual receivables		
In other economic flows	(107)	311
	(107)	311

How we recognise impairment of financial assets

Western District Health Service records the allowance for expected credit loss for the relevant financial instruments applying AASB 9's expected credit loss approach. Western District Health Service's contractual receivables and statutory receivables are subject to this impairment assessment. Contract assets recognised are also subject to the impairment requirement of AASB 9, however contract assets are immaterial.

Western District Health Service applies the simplified approach, which requires the loss allowances to always be measured at an amount equal to lifetime expected credit losses. The loss allowance is based on assumptions about risk of default and expected loss rates.

Contractual receivables at amortised cost

Western District Health Service has grouped contractual receivables on shared credit risk characteristics and days past due and has selected the expected credit loss rate based on Western District Health Service's past history, existing market conditions, as well as forward looking estimates at the end of the financial year.

The expected credit loss rates applied at 30 June 2025 vary from 0% for contractual receivables that are current to 100% for contractual receivables that are more than 90 days past due (30 June 2024: from 0% to 100%).

Statutory receivables at amortised cost

The statutory receivables are considered to have low credit risk, taking into account the counterparty's credit rating, risk of default and capacity to meet contractual cash flow obligations in the near term. As a result, the loss allowance recognised for these financial assets during the period was limited to 12 months of expected credit losses. No loss allowance has been recognised.

Note 5.4 Payables

	Note	2025 \$'000	2024 \$'000
Current payables			
Contractual			
Trade creditors		1,301	641
Accrued salaries and wages		3,034	3,749
Accrued expenses		2,718	3,618
Deferred capital grant income	5.4(a)	1,863	2,739
Inter hospital creditors		561	455
Amounts payable to governments and agencies		1,270	39
Total contractual payables		10,747	11,241
Statutory			
GST payable		-	1
Total statutory payables		-	1
Total payables		10,747	11,242
(i) Financial liabilities classified as payables			
Total payables		10,747	11,242
Deferred grant income		(1,863)	(2,739)
GST payable		-	(1)
Total financial liabilities classified as payables	7.1	8,884	8,502

How we recognise payables

Payables consist of:

- Contractual payables, including payables that relate to the purchase of goods and services. These payables are classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to the Western District Health Service prior to the end of the financial year that are unpaid.
- Statutory payables, including Goods and Services Tax (GST) payable are recognised and measured similarly to contractual payables but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

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

Note 5.4(a) Movement in deferred capital grant income

	2025 \$'000	2024 \$'000
Opening balance of deferred capital grant income	2,739	3,003
Grant consideration for capital works received during the year	3,302	2,585
Deferred capital grant income recognised as income due to completion of capital works	(4,178)	(2,849)
Closing balance of deferred capital grant income	1,863	2,739

How we recognise deferred capital grant income

Grant consideration was received from DH to support the construction of the emergency department and Penshurst stage 3 development.

Capital grant income is recognised progressively as the asset is constructed, since this is the time when Western District Health Service satisfies its obligations. The progressive percentage of costs incurred is used to recognise income because this most closely reflects the percentage of completion of the building works.

As a result, Western District Health Service has deferred recognition of a portion of the grant consideration received as a liability for the outstanding obligations.

Note 5.5 Contract liabilities

	2025 \$'000	2024 \$'000
Current		
Contract liabilities	610	1,322
Total contract liabilities	610	1,322

How we recognise contract liabilities

Contract liabilities include consideration received in advance from government grants for performance targets. Balance is consistent with prior year.

Contract liabilities are derecognised and recorded as revenue when promised goods and services are transferred to the customer. Refer to Note 2.1.

Note 5.6 Other liabilities

	Note	2025 \$'000	2024 \$'000
Current monies held in trust			
Patient monies		121	148
Refundable accommodation deposits		33,390	27,600
Other monies		439	300
Total other liabilities		33,950	28,048
* Represented by:			
- Cash assets	6.2	33,829	28,032
		33,829	28,032

How we recognise other liabilities

Refundable Accommodation Deposit (RAD)/Accommodation Bond liabilities

RADs/accommodation bonds are non-interest-bearing deposits made by some aged care residents to Western District Health Service upon admission. These deposits are liabilities which fall due and payable when the resident leaves the home.

RAD/accommodation bond liabilities are recorded at an amount equal to the proceeds received, net of retention and any other amounts deducted from the RAD/accommodation bond in accordance with the *Aged Care Act 1997*.

Note 6 How we finance our operations

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

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

Structure

- 6.1 Borrowings**
- 6.2 Cash and cash equivalents**
- 6.3 Commitments for expenditure**

Note 6.1 Borrowings

	Note	2025 \$'000	2024 \$'000
Current borrowings			
Lease liability	6.1(a)	645	565
Total current borrowings		645	565
Non-current borrowings			
Lease liability	6.1(a)	1,141	1,313
Total non-current borrowings		1,141	1,313
Total borrowings	7.1	1,786	1,878

How we recognise borrowings

Borrowings refer to funds raised through lease liabilities.

Borrowings are classified as financial instruments. Interest bearing liabilities are classified at amortised cost and recognised at the fair value of the consideration received directly attributable to transaction costs and subsequently measured at amortised cost using the effective interest method.

Terms and conditions of borrowings

30 June 2025	Note	Weighted average interest rate (%)	Carrying Amount	Nominal Amount	Maturity Dates				
					Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years	Over 5 years
Lease liabilities	6.1	4.25%	1,786	1,869	62	124	565	1,118	-
Total Financial Liabilities			1,786	1,869	62	124	565	1,118	-

30 June 2024	Note	Weighted average interest rate (%)	Carrying Amount	Nominal Amount	Maturity Dates				
					Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years	Over 5 years
Lease liabilities	6.1	4.25%	1,878	1,878	21	63	481	1,313	-
Total Financial Liabilities			1,878	1,878	21	63	481	1,313	-

Interest Expense

	2025 \$'000	2024 \$'000
Interest on lease liabilities	166	103
Total interest expense	166	103

Note 6.1(a) Lease liabilities

The following table sets out the maturity analysis of lease liabilities, showing the undiscounted lease payments to be made after the reporting date.

	2025 \$'000	2024 \$'000
Not longer than one year	750	610
Longer than one year but not longer than five years	1,118	1,337
Minimum future lease liability	1,868	1,947
Less unexpired finance expenses	(82)	(69)
Present value of lease liability	1,786	1,878

How we recognise lease liabilities

A lease is defined as a contract, or part of a contract, that conveys the right for Western District Health Service to use an asset for a period of time in exchange for payment.

To apply this definition, Western District Health Service ensures the contract meets the following criteria:

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

Western District Health Service's lease arrangements consist of the following:

Type of asset leased	Lease term
Leased plant, equipment, and vehicles	3 years

All leases are recognised on the balance sheet, with the exception of low value leases (less than \$10,000 AUD) and short-term leases of less than 12 months. Western District Health Service has elected to apply the practical expedients for short-term leases and leases of low-value assets. As a result, no right-of-use asset or lease liability is recognised for these leases; rather, lease payments are recognised as an expense on a straight-line basis over the lease term, within "other operating expenses" (refer to Note 3.3).

The following low value and short term lease payments are recognised in profit or loss:

	2025 \$'000	2024 \$'000
Expenses relating to leases of low-value assets	252	174
Total amounts recognised as expense	252	174

Initial measurement

The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease if that rate is readily determinable or Western District Health Service's incremental borrowing rate. Our lease liability has been discounted by rates of 2%.

Lease payments included in the measurement of the lease liability comprise the following:

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

Subsequent measurement

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

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

Note 6.2 Cash and cash equivalents

	Note	2025 \$'000	2024 \$'000
Cash on hand (excluding monies held in trust)		23	23
Cash at bank (excluding monies held in trust)		20,787	21,202
Total cash held for operations		20,810	21,225
Cash at bank (monies held in trust)		33,829	28,032
Total cash held as monies in trust		33,829	28,032
Total cash and cash equivalents	7.1	54,639	49,257

Note 6.3 Commitments for expenditure

	Less than 1 year	1-5 Years	Over 5 years	Total
30 June 2025	\$'000	\$'000	\$'000	\$'000
Capital expenditure commitments	3,059	-	-	3,059
Total commitments (inclusive of GST)	3,059	-	-	3,059
Less GST recoverable	278	-	-	278
Total commitments (exclusive of GST)	2,781	-	-	2,781
Commitments outstanding for 30 June 2024 – nil.				

Expenditure Commitments

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

Short term and low value leases

Western District Health Service discloses short term and low value lease commitments which are excluded from the measurement of right of use assets and lease liabilities. Refer to note 6.1 for further information.

Note 7 Financial instruments, contingencies and valuation judgements

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

Structure

- 7.1 Financial instruments
- 7.2 Contingent assets and contingent liabilities
- 7.3 Fair value determination

Note 7.1 Financial instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Due to the nature of Western District Health Service's activities, certain financial assets and financial liabilities arise under statute rather than a contract (for example, taxes, fines and penalties). Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*.

	Carrying amount	Net gain/(loss)	Total interest income/(expense)	Fee income/(expense)	Impairment loss
	\$'000	\$'000	\$'000	\$'000	\$'000
Financial assets at amortised cost					
Cash and cash equivalents	6.2	54,639	-	2,764	-
Receivables	5.1	8,494	-	-	(107)
Investments and other financial assets	5.2	5,350	-	252	-
Financial assets at fair value through other comprehensive income					
Investments and other financial assets	5.2	2,588	-	-	-
Total financial assets ⁱ		71,071	-	3,016	(107)
Financial liabilities at amortised cost					
Payables	5.4	8,884	-	-	-
Borrowings	6.1	1,786	-	166	-
Other financial liabilities - Refundable Accommodation Deposits	5.6	33,390	-	-	-
Other financial liabilities - patient/other monies in trust	5.6	560	-	-	-
Total financial liabilities ⁱ		44,620	-	166	-

		Carrying amount	Net gain/ (loss)	Total interest income/ (expense)	Fee income/ (expense)	Impairment loss
		\$'000	\$'000	\$'000	\$'000	\$'000
Financial assets at amortised cost						
Cash and cash equivalents	6.2	49,257	-	2,383	-	-
Receivables	5.1	7,506	-	-	-	311
Investments and other financial assets	5.3	4,999	-	150	-	-
Financial assets at fair value through net result						
Investments and other financial assets	5.3	2,350	124	-	-	-
Total financial assets¹		64,112	124	2,533	-	311
Financial liabilities at amortised cost						
Payables	5.4	8,502	-	-	-	-
Borrowings	6.1	1,878	-	103	-	-
Other financial liabilities - Refundable Accommodation Deposits	5.6	27,600	-	-	-	-
Other financial liabilities - patient/other monies in trust	5.6	448	-	-	-	-
Total financial liabilities¹		38,428	-	103	-	-

¹The carrying amount excludes statutory receivables (i.e. GST receivable) and statutory payables (i.e. GST payable and revenue in advance).

How we categorise financial instruments

Financial assets at amortised cost

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

- the assets are held by Western District Health Service solely to collect the contractual cash flows, and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding on specific dates.

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

Western District Health Service recognises the following assets in this category:

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

Financial assets at fair value through other comprehensive income

A financial asset that meets the following conditions is subsequently measured at fair value through other comprehensive income:

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

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

Western District Health Service recognises investments in equity instruments in this category.

Financial assets at fair value through net result

Western District Health Service initially designates a financial instrument as measured at fair value through net result if:

- it eliminates or significantly reduces a measurement or recognition inconsistency (often referred to as an "accounting mismatch") that would otherwise arise from measuring assets or recognising the gains and losses on them, on a different basis
- it is in accordance with the documented risk management or investment strategy and information about the groupings was documented appropriately, so the performance of the financial asset can be managed and evaluated consistently on a fair value basis, or
- it is a hybrid contract that contains an embedded derivative that significantly modifies the cash flows otherwise required by the contract.

The initial designation of the financial instruments to measure at fair value through net result is a one-time option on initial classification and is irrevocable until the financial asset is derecognised.

Western District Health Service recognises listed equity securities as mandatorily measured at fair value through net result and has designated all managed investment schemes as well as certain 5-year government bonds as fair value through net result.

Categories of financial liabilities

Financial liabilities at amortised cost

Financial liabilities are measured at amortised cost using the effective interest method, where they are not held at fair value through net result.

The effective interest method is a method of calculating the amortised cost of a debt instrument and of allocating interest expense in net result over the relevant period. The effective interest is the internal rate of return of the financial asset or liability. That is, it is the rate that exactly discounts the estimated future cash flows through the expected life of the instrument to the net carrying amount at initial recognition.

Western District Health Service recognises the following liabilities in this category:

- payables (excluding statutory payables and contract liabilities)
- borrowings and
- other liabilities (including monies held in trust).

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
- Western District 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
- Western District Health Service has transferred its rights to receive cash flows from the asset and either:
 - has transferred substantially all the risks and rewards of the asset, or

- has neither transferred nor retained substantially all the risks and rewards of the asset but has transferred control of the asset.

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

Derecognition of financial liabilities

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

When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified, such an exchange or modification is treated as a derecognition of the original liability and the recognition of a new liability. The difference in the respective carrying amounts is recognised as an 'other economic flow' in the comprehensive operating statement.

Reclassification of financial instruments

A financial asset is required to be reclassified between amortised cost, fair value through net result and fair value through other comprehensive income when, and only when, Western District Health Service's business model for managing its financial assets has changed such that its previous model would no longer apply.

A financial liability reclassification is not permitted.

Note 7.2 Contingent assets and contingent liabilities

At balance date, the Board are not aware of any contingent assets or liabilities.

How we measure and disclose contingent assets and contingent liabilities

Contingent assets and contingent liabilities are not recognised in the balance sheet but are disclosed and, if quantifiable, are measured at nominal value.

Contingent assets and liabilities are presented inclusive of GST receivable or payable respectively.

Contingent assets

Contingent assets are possible assets that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the health service.

These are classified as either quantifiable, where the potential economic benefit is known, or non-quantifiable.

Contingent liabilities

Contingent liabilities are:

- possible obligations that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the health service, or
- present obligations that arise from past events but are not recognised because:
 - It is not probable that an outflow of resources embodying economic benefits will be required to settle the obligations or
 - the amount of the obligations cannot be measured with sufficient reliability.

Contingent liabilities are also classified as either quantifiable or non-quantifiable.

Note 7.3 Fair value determination

How we measure fair value

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

The following assets and liabilities are carried at fair value:

- Financial assets and liabilities at fair value through net result
- Financial assets and liabilities at fair value through other comprehensive income
- Property, plant and equipment and
- Right-of-use assets

In addition, the fair value of other assets and liabilities that are carried at amortised cost, also need to be determined for disclosure.

Valuation hierarchy

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

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

Western District Health Service determines whether transfers have occurred between levels in the hierarchy by reassessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period. There have been no transfers between levels during the period.

Western District Health Service monitors changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required. The Valuer-General Victoria (VGV) is Western District Health Service's independent valuation agency for property, plant and equipment.

Fair value determination: non-financial physical assets

AASB 2010-10 Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities amended *AASB 13 Fair Value Measurement* by adding Appendix F Australian Implementation Guidance for Not-for-Profit Public Sector Entities. Appendix F explains and illustrates the application of the principals in *AASB 13* on developing unobservable inputs and the application of the cost approach. These clarifications are mandatorily applicable annual reporting periods beginning on or after 1 January 2024. FRD 103 permits Victorian public sector entities to apply Appendix F of *AASB 13* in their next scheduled formal asset revaluation or interim revaluation process (whichever is earlier).

The last scheduled full independent valuation of all of Western District Health Service's non-financial physical assets was performed by VGV on 30 June 2024. The annual fair value assessment for 30 June 2025 using VGV indices does not identify material changes in value.

In accordance with FRD 103, Western District Health Service will reflect Appendix F in its next scheduled formal revaluation on 30 June 2029 or interim revaluation process (whichever is earlier). All annual fair value assessments thereafter will continue compliance with Appendix F.

For all assets measured at fair value, Western District Health Service considers the current use as its highest and best use.

Non-specialised land, non-specialised buildings and investment properties

Non-specialised land, non-specialised buildings, investment properties and cultural assets are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value. From this analysis, an appropriate rate per square metre has been applied to the asset.

Specialised land and specialised buildings

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

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

The market approach is also used for specialised land although it is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued.

The CSO adjustment reflects the valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement and considers the use of the asset that is physically possible, legally permissible and financially feasible.

For Western District Health Service, the current replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation.

Vehicles

Vehicles are valued using the current replacement cost method. Western District Health Service acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by experienced fleet managers in Western District Health Service's who set relevant depreciation rates during use to reflect the utilisation of the vehicles.

Furniture, fittings, plant and equipment

Furniture, fittings, plant and equipment (including medical equipment, computers and communication equipment) are held at fair value. When plant and equipment is specialised in use, such that it is rarely sold, fair value is determined using the current replacement cost method.

Significant assumptions

Description of significant assumptions applied to fair value measurement:

Asset class	Likely valuation approach	Material inputs (Level 3 only)	Range (weighted average)
Specialised land	Market approach	Community Service Obligations Adjustments ⁽¹⁾	25%
Specialised buildings	Current replacement cost approach	Cost per square metre	\$884
		Useful life	16 years
Non specialised buildings	Market approach	Fair market valuation	\$1,494,000
Plant and equipment	Current replacement cost approach	Cost per unit	\$6,600
		Useful life	7.3 years
Medical equipment	Current replacement cost approach	Cost per unit	\$14,230
		Useful life	10 years

¹ A community service obligation (CSO) of 20% was applied to the Western District Health Service's specialised land.

Note 8 Other disclosures

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

Structure

- 8.1 Responsible persons disclosures
- 8.2 Remuneration of executives
- 8.3 Related parties
- 8.4 Remuneration of auditors
- 8.5 Events occurring after the balance date
- 8.6 Joint arrangements

Note 8.1 Responsible persons disclosures

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

	Period
The Honourable Mary-Anne Thomas MP:	
Minister for Health	1 July 2024 - 30 June 2025
Minister for Health Infrastructure	1 July 2024 - 19 December 2024
Minister for Ambulance Services	1 July 2024 - 30 June 2025
The Honourable Melissa Horne MP	
Minster for Health Infrastructure	19 December 2024 - 30 June 2025
The Honourable Ingrid Stitt MP	
Minister for Mental Health	1 July 2024 - 30 June 2025
Minister for Aging	1 July 2024 - 30 June 2025
The Honourable Lizzy Blandthorn MP:	
Minister for Children	1 July 2024 - 30 June 2025
Governing Boards	
Ms A Sweeney (Chair of the Board)	1 July 2024 - 30 June 2025
Mr A Bradbury	1 July 2024 - 30 June 2025
Mr S Bunce	1 July 2024 - 30 June 2025
Mr B Colliton	1 July 2024 - 30 June 2025
Mr T Fraser	1 July 2024 - 30 June 2025
Ms G Jenkins	1 July 2024 - 30 June 2025
Ms A Hiscock	1 July 2024 - 30 June 2025
Mr G Walcott	1 July 2024 - 30 June 2025
Ms J McDonald	1 July 2024 - 30 June 2025
Accountable Officers	
Ms R Clift (Chief Executive)	1 July 2024 - 30 June 2025

Remuneration of Responsible Persons

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

	2025	2024
Income Band		
\$0 - \$9,999	-	1
\$10,000 - \$19,999	8	6
\$20,000 - \$29,999	1	1
\$120,000 - \$129,999	-	1
\$270,000 - \$279,999	-	1
\$330,000 - \$339,999	1	-
Total Numbers	10	10
	2025 \$'000	2024 \$'000
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	502	529

Amounts relating to Responsible Ministers are reported within the State's Annual Financial Report.

Note 8.2 Remuneration of executives

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

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered. Accordingly, remuneration is determined on an accrual basis.

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

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

	Total Remuneration	
	2025 \$'000	2024 \$'000
Total remuneration ⁱ	1,440	1,500
Total number of executives	7	8
Total annualised employee equivalent ⁱⁱ	7.0	7.0

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

Note 8.3 Related parties

The Western District Health Service is a wholly owned and controlled entity of the State of Victoria. Related parties of the health service include:

- all key management personnel (KMP) and their close family members and personal business interests
- cabinet ministers (where applicable) and their close family members
- jointly controlled operations –the South West Alliance of Rural Health and
- all health services and public sector entities that are controlled and consolidated into the State of Victoria financial statements.

Significant transactions with government related entities

The Western District Health Service received funding from the DH of \$77.041m (2024: \$69.396m). Balances outstanding as at 30 June 2025 are \$64k (2024: \$210k).

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

Professional medical indemnity insurance and other insurance products are obtained from the Victorian Managed Insurance Authority.

The Standing Directions of the Minister for Finance require the Western District Health Service to hold cash (in excess of working capital) in accordance with the State of Victoria's centralised banking arrangements.

All borrowings are required to be sourced from Treasury Corporation Victoria unless an exemption has been approved by the Minister for Health and the Treasurer.

Key management personnel

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

The Board of Directors and the Executive Directors of the Western District Health Service and its controlled entities are deemed to be KMPs. This includes the following:

KMPs	Position Title	KMPs	Position Title
Ms A Sweeney	Chair of the Board	Ms R Clift	Chief Executive Officer
Mr A Bradbury	Board Member	Mr N Starkie	Director of Corporate Services
Mr S Bunce	Board Member	Dr S Ping	Chief Medical Officer
Mr T Fraser	Board Member	Ms L Hedley	Director of Nursing
Ms G Jenkins	Board Member	Ms B Roberts	Director of Nursing Coleraine & Penshurst
Ms A Hiscock	Board Member	Mr J McInnes	Director of Primary & Preventative Health
Mr B Colliton	Board Member	Ms K Armstrong	Director of Aged Care
Ms J McDonald	Board Member	Ms A Kennedy	Director National Centre for Farmer Health
Mr G Walcott	Board Member		

Remuneration of key management personnel

The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the Parliamentary Salaries and *Superannuation Act 1968* and is reported within the State's Annual Report.

	2025 \$'000	2024 \$'000
Total compensation - KMPs ⁱ	1,942	2,029

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

Transactions with KMPs and other related parties

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

Procurement processes occur on terms and conditions consistent with the HealthShare Victoria and Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with the Western District Health Service, there were no related party transactions that involved key management personnel, their close family members or their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

There were no related party transactions with Cabinet Ministers required to be disclosed in 2025 (2024: none).

There were no related party transactions required to be disclosed for the Western District Health Service Board of Directors, Chief Executive Officer and Executive Directors in 2024 (2024: none).

Note 8.4 Remuneration of auditors

	2025 \$'000	2024 \$'000
Victorian Auditor-General's Office		
Audit of the financial statements	35	33
Total remuneration of auditors	35	33

Note 8.5 Events occurring after the balance sheet date

Subsequent to balance date the Boards of Western District Health Service (WDHS) and Casterton Memorial Hospital (CMH) have unanimously agreed on the 13 August 2025, to a voluntary merger of our two health services. This follows careful review of the business case, due diligence, and staff and community feedback. This merger is subject to the approval of the Minister for Health.

If approved by the Minister, the merged organisation will officially come into effect in March 2026, with a 12-month implementation phase to ensure a smooth transition. There will be no changes to services provided or redundancies as part of this process.

There are no other events occurring after the Balance Sheet date.

Note 8.6 Joint arrangements

		Ownership Interest	
Principal Activity		2025 %	2024 %
South West Alliance of Rural Health	ICT provision and support	6.47	6.46

For the year ended 30 June 2025 Western District Health Service's share of the joint operations financials was:		2025 \$'000	2024 \$'000
Total revenue and income		2,408	1,979
Total expenses		(2,265)	(2,030)
Total net result		143	(51)
Total other economic flows		22	9
Comprehensive result for the year		165	(42)
Total assets		2,492	2,777
Total liabilities		2,012	2,460
Total equity		480	317

Contingent liabilities and capital commitments

There are no known contingent liabilities or capital commitments held by the jointly controlled operations at balance date. Western District Health Service is involved in joint arrangements where control and decision-making are shared with other parties. Western District Health Service has determined the entities detailed in the above table are joint operations and therefore recognises its share of assets, liabilities, revenues and expenses in accordance with its rights and obligations under the arrangement.

Glossary of Terms

AHSSQA

Australian Health Service Safety and Quality Accreditation

ACFI

Aged Care Funding Instrument

ALO

Aboriginal Liaison Officer

BAP

Budget Action Plan

BOD

Board of Directors

BRICC

Ballarat Regional Integrated Cancer Centre

C4YB

Community 4 Youth Board

CDHS

Coleraine District Health Service

CE

Chief Executive

CSSD

Central Sterile Supply Department

DoH

Department of Health

DON

Director of Nursing

DRG

Diagnostic Related Group; 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

FACEM

Fellowship of Australasian College Emergency Medicine

FHCC

Frances Hewett Community Centre

FMIS

Financial Management Information System

FOI

Freedom of Information

FRD

Financial Reporting Directions

GCAHM

Graduate Certificate of Agricultural Health and Medicine

GEM

Geriatric Evaluation Management

GP

General Practitioner

HACC

Home and Community Care

HBH

Hamilton Base Hospital

HCP

Home Care Package

HITH

Hospital in the Home



HMG

Hamilton Medical Group

HMMC

Hamilton Midwifery Model of Care

HMO

Hospital Medical Officer

ICT

Information, Communication and Technology

ICU

Intensive Care Unit

IHI

Institute for Healthcare Improvement

ILU

Independent Living Unit

IMG

International Medical Graduates

KPI

Key Performance Indicator

Live4Life

Youth Mental Health Program

LGBTI

Lesbian, Gay, Bisexual, Transgender and / or Intersex

NCFH

National Centre for Farmer Health

NSQHS Standards

National Safety and Quality Health Service Standards

NWAU

National Weighted Activity Unit

OH&S

Occupational Health and Safety

OT

Occupational Therapy

PDHS

Penshurst & District Health Service

PHU

Public Health Unit

PPH

Primary & Preventative Health

QI

Quality Improvement

RN

Registered Nurse

SGSC

Southern Grampians Shire Council

SURC

Symptom Urgent Review Clinic

SWARH

South West Alliance of Rural Health

VET

Vocational Education and Training

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





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