AlfredHealth

Annual Report 2016-17

theAlfred

Caulfield HOSPITAL

Sandringham HOSPITAL

MSHC MELBOURNE SEXUAL HEALTH CENTRE


theAlfred

Our story

Across our diverse organisation, we value and respect life from beginning to end.

We provide treatment, care and compassion to the people of Melbourne and Victoria. Our research and education programs advance the science of medicine and health and contribute to innovations in treatment and care. Through partnerships we build our knowledge and share it with the world.

Our purpose

To improve the lives of our patients and their families, our communities and humanity.

Our beliefs

Patients are the reason we are here – they are the focus of what we do.

How we do things is as important as what we do.

Respect, support and compassion go hand in hand with knowledge, skills and wisdom. Safety and care of patients and staff are fundamental.

Excellence is the measure we work towards every day. Through research and education we set new standards for tomorrow.

We work together. We all play vital roles in a team that achieves extraordinary results.

We share ideas and demonstrate behaviours that inspire others to follow.

About this report

This annual report outlines the operational and financial performance for Alfred Health from 1 July 2016 to 30 June 2017. We have aimed to include all our reportable data in the one publication, so information normally found in the Quality Account is included here.

There were two relevant Ministers for the period. The Minister for Health was the Hon. Jill Hennessy MP and the Minister for Mental Health, Minister for Housing, Disability and Ageing, the Hon. Martin Foley MP.

Alfred Health is a metropolitan health service established under section 181 of the *Health Services Act 1988* (Vic) in June 2000.

This report is available on line at: **alfredhealth.org.au**

Glossary

DHHS	Department of Health and Human Services
PCF	Patients Come First
RAP	Reconciliation Action Plan
GEM	Geriatric Evaluation and Management
STRIDE	Service To Reduce Risk, Improve Independence and Decrease Emergency

Front cover: No matter the challenges and high demand for our care, patients are always our main focus.

Contents

About Alfred Health

Highlights

106,683
Emergency presentations (Alfred and Sandringham)

111,923
episodes of inpatient care

11,665
elective surgeries performed

96 lung transplants + **20** heart transplants

97.4 per cent
of elective waitlist patients treated within clinically recommended times

1,498
major trauma patients

8,002
total trauma patients

9,016
employees

524
volunteers

Alfred Health is one of Australia's major health services, with three hospital campuses – The Alfred, Caulfield Hospital and Sandringham Hospital – as well as several clinics and a range of community-based services.

We care for people, from children to the elderly, across Victoria. With a broad range of statewide programs, our services reach far beyond our local community of southern and Bayside Melbourne to care for Victorians.

With a growing population throughout the state, we are constantly expanding our care – in the community, in the home and in hospital. Our work is not confined to lifesaving procedures; it extends to intensive rehabilitation to help our patients regain as much function, independence and wellbeing as possible.

As a teaching institution, clinical research and education are at the forefront of our practice. With acutely unwell patients, we are in the best position to translate medical research into clinical practice. We also partner with key stakeholders, including Metropolitan Ambulance, CFA, Victoria Police and other specialists to ensure the best and latest care for our patients.

Developing our staff is part of our commitment to excellence. Patients are at the centre of all we do and we continue to seek ways to improve the patient experience.

Three hospital campuses

theAlfred

The Alfred, a major tertiary referral hospital, is best known as one of Australia's busiest emergency and trauma centres and home to many statewide services including the Victorian Adult Burns Service, Heart and Lung Transplant Service and Psychiatric Intensive Care Service. This site is also home to the Alfred Medical Research and Education Precinct.

Caulfield HOSPITAL

Caulfield Hospital specialises in community services, rehabilitation, aged care and aged mental health. The hospital delivers many services through outpatient and community-based programs and plays a statewide role in providing rehabilitation services, which includes the Acquired Brain Injury Rehabilitation Centre.

Sandringham HOSPITAL

Sandringham Hospital is community focused, providing hospital healthcare needs for the local area through emergency, paediatrics, general medicine and outpatient services. The hospital works closely with the Royal Women's Hospital onsite and local community healthcare providers.

Image (left): Staying fit and well is the aim of Activate programs held at Caulfield Hospital for older people in our community.

Community services and clinics

Melbourne Sexual Health Centre has dedicated clinics for men and women, onsite testing for sexually transmitted infections and provides counselling, advice and health information.

Community clinics meet the growing expectations of our patients for treatment in their communities or at home. We have developed numerous clinics to deliver this care, including new services such as Hope (a psychiatric program aiming to reduce suicide rates), a new drug and alcohol service, rehabilitation programs and we are continuing important work with the Hospital Admission Risk Program.

Our catchments

Alfred Health's catchment reflects our role in the provision of tertiary, statewide and specialised health services. Our local catchment includes the local government areas of Bayside, Glen Eira, Melbourne, Port Phillip, Kingston and Stonnington. This primary catchment (which now numbers over 650,000) has grown by approximately 15 per cent (75,000 people) between 2011 and 2016.

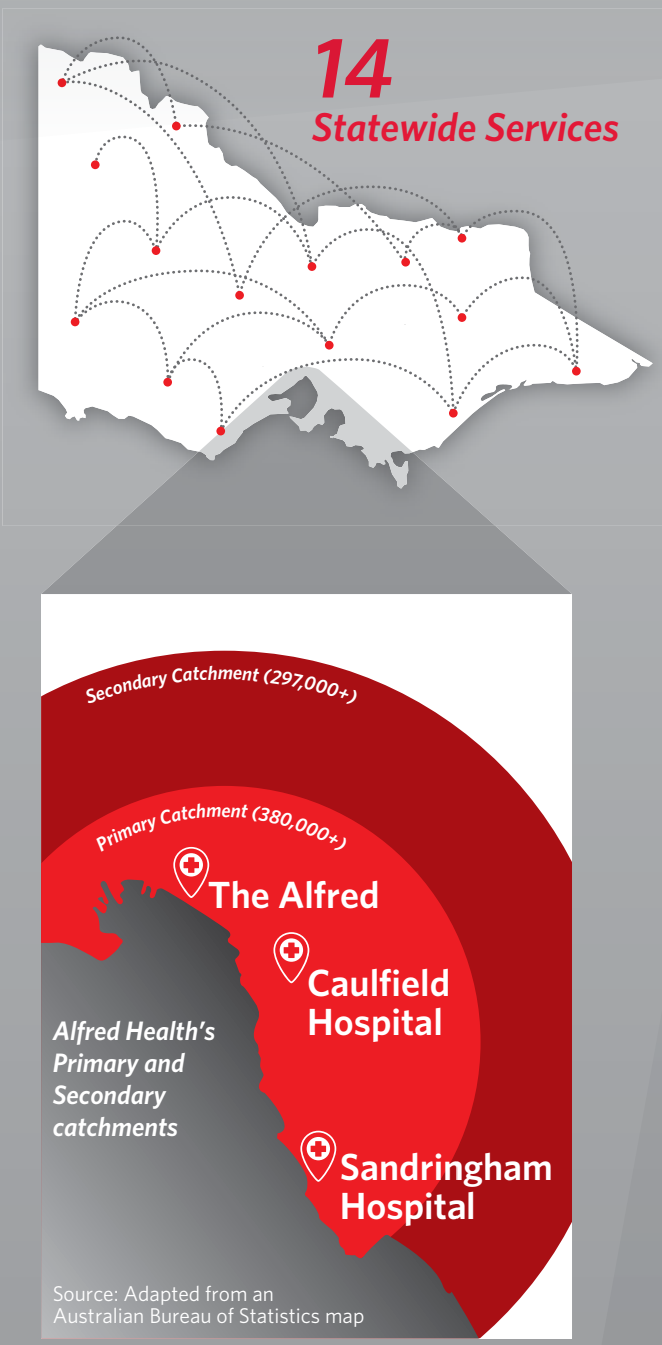
Our statewide services provide care to those residing around Victoria and Australia.

Clinical services

We provide the most comprehensive range of adult specialist medical and surgical services in Victoria. We offer almost every form of medical treatment across our multiple sites and three hospital campuses.

Clinical services include:

- Aged care (Geriatric Evaluation and Management, Acute)
- Allied health
- Cancer care (Bone Marrow Transplantation, Radiotherapy, Oncology, Haematology, Cancer Surgery)
- Cardiothoracic services (Heart and Lung Transplantation, Cardiology, Cardiac Surgery, Cardiac Rehabilitation, Respiratory Medicine, Thoracic Surgery, Adult Cystic Fibrosis)
- Emergency Medicine, Intensive Care, Burns and Adult Major Trauma
- Ear, Nose and Throat (Head and Neck Surgery)
- Gastrointestinal (Gastroenterology, Gastrointestinal Surgery)
- General Medicine
- General Surgery
- Neurosciences (Neurology, Neurosurgery)
- Ophthalmology
- Orthopaedics
- Palliative care
- Pathology (Anatomical, Clinical Biochemistry, Laboratory Haematology, Microbiology)
- Pharmacy
- Psychiatry (adult, child, adolescent, youth, aged)
- Radiology and Nuclear Medicine
- Rehabilitation (Acquired Brain Injury Rehabilitation Centre, amputee, cardiac, spinal, neurological, orthopaedic)
- Renal services (Nephrology, Haemodialysis, Renal Transplantation)
- Specialist medicine (Asthma, Allergy and Clinical Immunology, Dermatology, Endocrinology/Diabetes, Hyperbaric, Infectious Diseases, Rheumatology)
- Specialist surgery (Dental, Faciomaxillary, Plastic, Vascular)
- Urology



Alfred Health National Service

- **Paediatric Lung Transplant Service**

Alfred Health Statewide Services

1. **Bariatric Service**
2. **Clinical Haematology and Haemophilia Services**
3. **Cystic Fibrosis Service**
4. **Heart and Lung Transplant Service**
5. **Hyperbaric Medicine Service**
6. **Major Trauma Service**
7. **Malignant Haematology and Stem Cell Transplantation Service**
8. **Psychiatric Intensive Care Service**
9. **Sexual Health Service**
10. **Specialist Rehabilitation Service**
11. **Victorian Adult Burns Service**
12. **Victorian HIV/AIDS Service**
13. **Victorian Melanoma Service**
14. **Victorian Neuropathology Laboratory Service**

Chair and Chief Executive's Year in Review

A strong performance by a dedicated team

As the new Chair of one of Australia's leading health services, I am delighted to present Alfred Health's Annual Report for 2016-17.

In my short time in this role, I have been impressed by the culture of care evident throughout Alfred Health and the dedication of staff to care for people locally as well as people Victoria-wide who are treated through 14 statewide services.

The results for 2016-17 speak to this dedication. It is a strong performance that carefully balances timely quality care with expert clinical governance and sound financial management. This excellent performance has been sustained over many years.

I acknowledge the leadership of Helen Shardey as the former Chair and for her role in strengthening Alfred Health, as well as Sara Duncan and David Shaw who finished serving on the Board at the year end.

Michael Gorton
Chair

Michael Gorton
Chair
Alfred Health

22 August 2017

The Year in Review

In a challenging year, the Alfred Health team responded with professionalism and compassion to deliver the best possible care for our community.

Our emergency, trauma and critical care capability was needed more than ever before:

- More than 106,000 people presented at our two emergency departments and we treated more than 8,000 trauma patients.
- Almost 98 per cent of our elective waitlist patients were treated within clinically recommended times.
- More than 11,300 surgeries were completed, including additional surgical work that helped ease elective surgery waiting lists at other public hospitals.

There was growth across almost all activity indicators, with the health service undertaking more than 111,000 episodes of patient care.

Importantly 95.6 per cent of Alfred Health patients rated their care as 'good', 'very good' or 'exceptional'. And 96 per cent felt they were treated with respect and dignity. These are essential markers of quality and care.

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This was achieved while delivering a surplus of $0.2million and continuing to exceed the state's requirements for hand hygiene, post-discharge follow-up, staff flu immunisations and cleaning standards.

Caring for all Victorians

Increased demand was seen across the many state-wide services we provide for our Victorian community.

There was sustained growth in our major trauma program, with almost 1,500 patients recovering from severe trauma, requiring our intensive care expertise. By comparison, we treated 1,400 such major trauma patients in the previous year.

There was a corresponding lift in the number of patients supported through our Rehabilitation Services at Caulfield Hospital. Our Acquired Brain Injury Unit, which opened in 2014, now accounts for almost 40 per cent of all rehabilitation occupied bed days at Caulfield.

Through our heart and lung transplantation program, dozens of Australians were given a second chance at life with our clinicians performing 96 lung, 20 heart and 28 kidney transplants.

Leading cardiac services

As the only Victorian health service able to provide the full range of adult cardiac care from heart failure through to cardiac rehabilitation, The Alfred continued to treat some of the most complex cardiac cases in the state. Due to our specialisation and increased regional referrals, cardiac admissions have grown by 42 per cent over the last five years.

Our constant improvement in cardiac clinical practice – as with many of our other specialities – is a result of direct involvement in global research and clinical trials. As a case in point, this year, we were the first hospital in Australia to participate in trialling Trans catheter Aortic Valve Implantation (TAVI). If successful, this could eliminate the need for open heart surgery for many patients.

Challenges

Growing demand – particularly for acute inpatient beds – challenged the health service. An additional 33 inpatient beds were opened during the year. At times limited bed capacity reduced our ability to provide timely care.

To address capacity in the short term, planning is underway for a new ward on the fifth floor of The Alfred's main ward block – the last remaining ward space available for development. Planned to open in 2018, this new ward will support the early recovery of trauma patients.

Day Procedure Centre: The go ahead for the Sandringham Hospital's new Day Procedure Centre will also contribute extra capacity. The specially-designed facility, due to open in 2018, will free up bed space for patients from the emergency department.

The centre has been made possible through a successful local capital appeal supported by the local community and businesses, with the Victorian State Government generously matching the funds raised.

Infrastructure: Ageing infrastructure presented another challenge during the year. Flooding from thunderstorms in late December damaged an operating theatre as well as the recovery suite at The Alfred. This incident demonstrated the infrastructure – much of which dates back to the late 1960s – struggles with significant weather events.

The Victorian Government generously provided $9.4million in funding to help address the stormwater and other essential infrastructure issues in the short term.

There were significant infrastructure achievements during the year, particularly the redevelopment of The Les and Eva Erdi Emergency and Trauma Centre at The Alfred, which is due to open in early 2018.

Safety and wellbeing of staff

One of the most concerning challenges in healthcare at present is the increasing incidence of aggression and violence towards staff while they provide care.

Our staff have the unequivocal right to a safe workplace and there is zero tolerance for aggressive or violent behaviour from patients or the community towards staff. It is also an issue of patient care as we know staff welfare and quality patient care go hand-in-hand.

In early March we launched an internal campaign, encouraging staff to report these incidents to the health service and Victoria Police. In addition, we fully endorsed and promoted the Victorian Government's excellent Worksafe campaign that tackles this issue.

Our stance on building a respectful culture and improving patient safety in surgery was further strengthened under a new agreement with the Royal Australasian College of Surgeons. The Memorandum of Understanding commits both organisations to work closely to address issues around discrimination, bullying and sexual harassment in surgery and the broader healthcare sector.

Supporting vulnerable communities

Partnerships underpinned our response to better supporting our more disadvantaged communities.

This year we started formulating the basis of our Vulnerable Persons Strategy, by bringing together our staff and consumers as well as many community and government agencies including Victoria Police. This work will continue in 2017-18 as we develop a detailed action plan and related programs.

More than one-in-10 individuals presenting to The Alfred's emergency department face insecure housing.

Through our mental health service, we continued partnerships with organisations specialising in supporting people experiencing homelessness and drug and alcohol addiction. This work improves our understanding of our community and opens patient pathways post-discharge.

With the help of Reconciliation Australia our local elders and staff we developed our Reconciliation Action Plan (RAP). The RAP, which will be launched early next year, aims to create enduring relationships with our local Aboriginal community built on the basis of respect and understanding.

Research and patient care

Clinical research goes hand in hand with clinical practice at Alfred Health, with this approach bringing major benefits to our patients. Major achievements this year included:

- **Progression on landmark peanut vaccine** trials led by respiratory physician Professor Robyn O'Hehir. The treatment uses new technology to reset the immune system to tolerate peanuts without any allergic reactions.
- **Australia's first dedicated blood cancer research centre** established by The Alfred and Monash University thanks to a $1.2 million grant from the Australian Cancer Research Foundation (ACRF).
- **Expansion of PrepX:** The ground-breaking study which is providing people at risk of HIV with access to the life-changing medication, Pre-exposure prophylaxis (PrEP). The study, supported by The Alfred, the Victorian AIDS Council and the Victorian Government expanded into rural and regional sites.
- **First Chair of Oncology** created in honour of Tony Charlton, who spent more than 20 years supporting The Alfred. Eminent researcher and clinician, Professor John Zalcberg OAM accepted the inaugural position. The role will foster the transfer of research into clinical practice, making a positive difference to the lives of thousands of Victorians fighting cancer.

Connected care

Central to Alfred Health's strategic plan is our eTQC (electronic Total Quality Care) initiative. This five-year program (2016–21) will transition the health service to an integrated electronic medical information system, digitising our health system as a result. It will improve data quality and accessibility and better support how we deliver clinical care.

eTQC is a significant undertaking that relies on engaging the whole organisation in its development and delivery. Substantial progress was made during the year and the first phase of eTQC is due to go live in late 2018.

Support

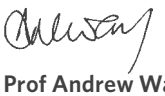
My gratitude goes to the unstinting support of my Board and Executive team during the year.

Particular thanks must go to our outgoing chair Ms Helen Shardey, who for the past six years, has supported, guided and believed in Alfred Health. We also warmly welcome our new chair, Michael Gorton to his role.

To our community – your generosity whether it is through volunteering, supporting our many events or becoming a donor, truly makes a difference to our patients and our staff every day.

And to our frontline staff – your unfailing commitment to our patients is the bedrock of our great public healthcare service.

Andrew Way
Chief Executive



Prof Andrew Way
Chief Executive
Alfred Health

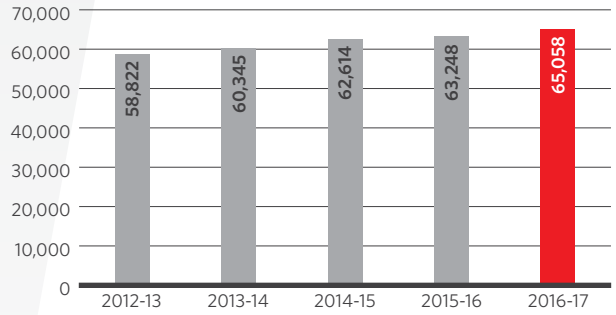
22 August 2017

Key indicators 2016–17

Alfred Emergency Department presentations

3% 1 YEAR *up almost **3 per cent** on last year and...*

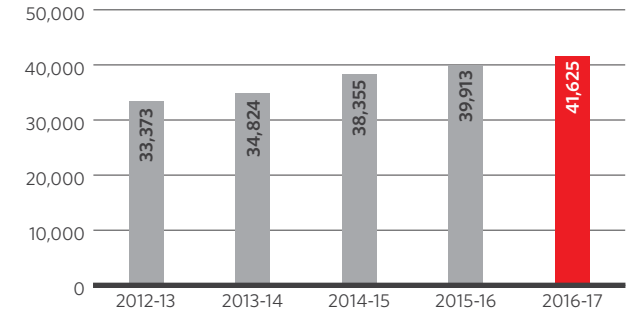
10.6% 4 YEARS ***10.6 per cent** increase over four years*



Sandringham Emergency Department presentations (including Urgent Care Centre at Sandringham)

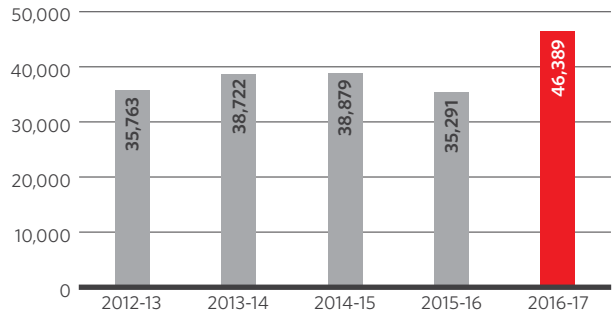
4.3% 1 YEAR *up almost **4.3 per cent** on last year and...*

24.7% 4 YEARS ***24.7 per cent** increase over four years*



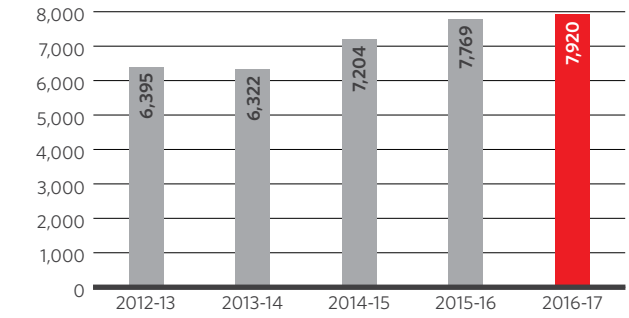
GEM (older patients at Caulfield Hospital) bed days, including GEM at Home,– up 30 per cent over five years

30% 5 YEARS *up **30 per cent** over five years*



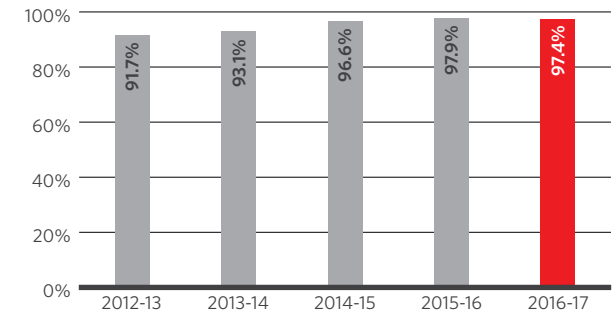
Emergency Operating Room procedures (Alfred)

24% 5 YEARS *up **24 per cent** over five years*



Percentage of elective waitlist patients treated within clinically recommended times (Alfred Health)

90% 5 YEARS *consistently over **90 per cent** for five years.*



Our employees

Ensuring our staff have a safe and healthy workplace has been an ongoing focus, as well as engaging staff in this process. System improvements were also central, including the development of a new Occupational Health and Safety strategy.

Recruiting and retaining

We welcomed 2016 new employees.

Headcount

Staff numbers have grown by 16 per cent over the last five years, as services have expanded and demand increased.

Highlights

9,016
employees as at 30 June

547
length of service awards

2012–13	2013–14	2014–15	2015–16	2016–17
7,741	7,989	8,432	8,570	9,016

	2016				2017			
	Casual	Full Time	Part Time	Grand Total	Casual	Full Time	Part Time	Grand Total
Caulfield	137	614	723	1,474	144	646	761	1,551
Sandringham	368	91	314	773	387	96	331	814
The Alfred	561	2,786	2,976	6,323	590	2,931	3,130	6,651
Grand Total	**1,066**	**3,491**	**4,013**	**8,570**	**1,121**	**3,673**	**4,222**	**9,016**

Workforce (EFT)

		Current Month FTE		YTD FTE*	
	Hospitals Labour Category	2016	2017	2016	2017
1	Nursing	2,399	2,532	2,380	2,371
2	Administration/ Clerical	912	989	888	977
3	Medical Support	554	557	538	545
4	Hotel & Allied Services	189	207	195	211
5	Medical Officers	194	204	191	205
6	Hospital Medical Officers	509	531	503	537
7	Sessional Clinical	153	155	146	157
8	Ancillary Staff (Allied Health)	878	987	869	941

* *The average EFT is calculated based on the weighted average of employees in each category in the 2016–17 year.*

Image (right): An environment of great teamwork by our surgical teams brings positive results.

Our employees *(continued)*

Occupational health and safety

Long-term strategy

Every day our staff encounter challenging situations and circumstances that can impact on their health, safety and wellbeing at work.

A long-term strategy has been approved to create a culture where staff are safe, healthy and supported at work, focusing on:

- injury prevention
- staff wellbeing
- healthy work environment
- supporting staff returning to work following an incident or injury.

Over the past 12 months, we:

- completed a review of how manual handling and occupational violence issues are managed across the organisation
- developed and implemented an occupational violence prevention and management training program
- established an organisational commitment to prevent and manage bullying and harassment.

Health and safety representation

This year staff representation numbers on occupational health and safety issues improved significantly, with 18 new Health and Safety Representatives (HSRs). All HSRs underwent training programs, which included updates on legislative changes and occupational violence issues.

Occupational violence

With violence a too frequent occurrence in healthcare, we have developed extensive policies on the management of patient behaviour and advised staff about support available for them through counselling and with legal action, should violence occur in the workplace.

We have also developed an Occupational Violence and Aggression Prevention Action Plan, working with key internal and external stakeholders.

Occupational violence statistics*		2016–17
1.	Workcover accepted claims with an occupational violence cause per 100 FTE	0.218
2.	Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0.02
3.	Number of occupational violence incidents reported	516
4.	Number of occupational violence incidents reported per 100 FTE	8.68
5.	Percentage of occupational violence incidents resulting in a staff injury, illness or condition	29%

* *Figures include WorkCover claims awaiting confirmation of status by Worksafe as of 30 June 2017*

Manual handling

Our efforts to reduce injuries occurring due to manual handling continue. This year we:

- developed local, individually tailored programs to establish a positive safety culture around manual handling activities
- expanded the existing SafeMoves program beyond ward areas into departments, including radiotherapy and cardiology
- introduced new methods to manage bariatric patients by updating organisational guidelines, purchasing new equipment like beds and hoists and held a Bariatric Interdisciplinary Study Day, which was attended by healthcare professionals from across the state
- upgraded our manual handling equipment, including the installation of 26 overhead hoists in patient rooms to address an increase in injuries resulting from repositioning patients in bed or getting them in and out of bed. This equipment reduces the risk of injury to staff, while also providing a safe transfer method for patients.

WorkCover claims

A new system to more effectively manage WorkCover claims and support staff to return to work was implemented this year. *InjuryConnect* allows us to monitor and improve return to work timeframes and claim management processes.

The majority of WorkCover claims this year relate to manual handling injuries.

91 WorkCover standard claims

Incident Type	Number *
Exposure to noise, chemicals, etc.	3
Hit or hit by, excluding violence	1
Mental stress	2
Occupational violence	9
Other	2
Slips, trips & falls	16
Manual handling	58
Grand Total	**91**

* *Figures include claims awaiting Worksafe confirmation of status.*

Health and wellbeing

We continue to foster a workplace where staff can be as healthy as possible so they can continue to provide good patient care. Projects this year included:

- A '*Good News for Smokers*' campaign, encouraging staff to quit. This included providing funded nicotine replacement therapy and best practice individual or group support. The result: 53 per cent of participants remained smoke free an average of five months later.
- Expansion of our sit-to-stand program to include meeting rooms. Following the success of an initial trial, three sit-to-stand meeting rooms have now been implemented across our sites, encouraging staff to undertake standing meetings and reduce sedentary behaviour.
- Promotion of active travel initiatives, with the Active Travel Zone winning a 2016 VicHealth award for 'Encouraging physical activity'.
- Enhanced health and fitness facilities for staff, with new onsite providers offering a wide range of services to The Alfred and Caulfield Hospital and outdoor training sessions in development for Sandringham Hospital.

New ways to de-stress

Staff working in healthcare may experience various pressures and stresses, so we have developed two new initiatives this year to help staff unwind, rejuvenate and continue giving great patient care:

- A mindfulness app, called *Treat*, was developed by two of our junior doctors, to help staff cope with work stress through meditation and self-reflection. The app has received positive feedback and been downloaded by large numbers. This builds on the success of the face-to-face seven-week *Treat* program, which involves meditation and mindfulness sessions, allowing staff to incorporate mindfulness throughout their work day.
- *Voices of Alfred* is a staff choir, which meets onsite weekly at lunch times, allowing Alfred staff to take a break and relax through singing. The choir is led by Dr Jonathon Welch, Founder of Choir of Hard Knocks.

Employee Assistance Program (EAP)

From February 2016 to March 2017, nearly 250 employees used our Employee Assistance program, provided by Davison Trahaire Corpsych. Assistance was given to employees seeking advice and counselling services for work and non-work related issues, and managers used the Managers Assist service for issues in managing employee and team issues.

Our EAP provider attended our sites at the request of staff or managers on nearly 30 occasions to provide trauma debriefing and individual and group counselling sessions, through their Trauma Assist service. The use of Trauma Assist has grown, as our staff become more aware of the importance of debriefing and managing emotional issues associated with providing high quality patient care in an emergency and trauma environment.

Employee relations

This year we completed the implementation of the recently renegotiated Nurses and Midwives Enterprise Bargaining Agreement, through a local Workplace Implementation Committee in association with the Australian Nursing and Midwifery Federation (ANMF). This resulted in successful implemention of new conditions and clauses of the agreement in advance of other major health services.

Driving innovation

One way the organisation is encouraging and building a culture of innovation and patient focus is through awarding innovation grants. This year, five were awarded for projects designed to improve patient care and experience:

1. **Targeted health literacy while you wait** – This project provides patients with relevant sexual health information while they wait to be seen at Melbourne Sexual Health Centre. Using free Wi-Fi, users are directed to key health literacy videos and educational videos (such as pre-exposure prophylaxis for gay men).
2. **Digital wayfinding** – A smart phone application has been developed (by PowerHealth Solutions) to help patients and visitors easily navigate their way around The Alfred, including wards, clinics and conveniences. The app, which runs on Apple and Android smart phones, complements the new physical signage.
3. **Sensory mindfulness** – A concept and screening tool has been developed for selected patients in our Emergency & Trauma Centre and Ward 4WB. The aim is to provide appropriate patients with imagery, music and sensory experiences to enhance their experience and reduce anxiety, fear, agitation and aggression. Based on patient survey feedback, research on available technology and content, the project team has engaged external consultants to build the device and recommend sensory content. The portable device prototype and library of visual and sensory content will be ready for phase one testing in early July 2017.
4. **Pressure injury prediction in ICU** – This project uses patients' data to predict their risk of developing a pressure injury during their ICU stay. The predicted risk is presented to their nurse, allowing early intervention to reduce the pressure injuries that our high-risk patients sustain.
5. **LINK-Assist** – This project uses a suite of resources to improve communication between patients and families and staff in the General Medical Unit. This includes improving identification of patients who require an interpreter, accessibility to inpatient and telephone interpreters, and orientation and training in language services for staff. The project has also allowed a pilot implementation of video-interpreting for patients with low-English proficiency and pilot of CALD-ASSIST, an app for Allied Health clinicians to conduct assessments in languages other than English.

Education and learning

We have developed two interactive and targeted training courses for frontline staff on the identification, management and de-escalation of patient aggression to safeguard our staff and improve patient management:

- **DAMA:** More than 300 staff attended a two-day De-escalation and Minimisation of Aggression (DAMA) course run by Alfred Health Psychiatry. The course covers causes of aggression in patients, in a predominately mental health setting, and educates staff about communication techniques, de-escalation, hospital protocols and responses.
- **AWARE:** This course for frontline and support staff had over 1000 participants in 2016–17. The course helps staff identify triggers and signs of potential escalation in behaviour, provides the skills to de-escalate behaviour, manage aggressive behaviour and gives practical techniques for self-protection. The AWARE trainers have developed tailored training programs for high risk/specialty areas, along with refresher programs for staff who have attended the one-day course.

Extensive training has also been provided on:

- manual handling
- providing feedback; and
- new online recruitment and online leave systems.

Our employees *(continued)*

Staff development

During 2016–17, we supported a range of education opportunities for staff, ensuring development continues in all areas. Also, major initiatives included those connected with the flagship *Respect and Quality Improvement* project:

- **Respect initiatives:** A key flagship project of our 2020 Strategic Plan is our Respect project, based on the vision and understanding that how we do things is as important as what we do. This project has seen:
  - investigation of the highly successful Schwartz Rounds concept (a structured forum where all staff regularly discuss the emotional and social aspects of working in healthcare).
  - an expansion in awareness and use of our EAP services including Trauma Assist and Manager Assist.

Operating suite cultural redesign

The development of a multi-faceted cultural redesign project in Surgical Services has brought leadership development for Associate Nurse Managers and daily 'huddles' to strengthen teamwork. This is all supported by the recently signed Royal Australasian College of Surgeons (RACS) Memorandum of Understanding which focuses on improving respect and collaboration.

Staff engagement – People Matter

The 2016 People Matter survey provided positive and encouraging results in employee
engagement, staff pride, willingness to recommend Alfred Health as a place to work and be treated, staff satisfaction and receiving feedback. It also highlighted key issues, such as:

- raising the awareness of bullying behaviour
- levels of stress within the workplace; and
- how the organisation implemented change.

Bullying: Extensive training and information was developed and shared across Alfred Health, including a Grand Round information session, updating of online mandatory training programs, detailed information at staff orientation, clearer reporting, briefings to the Board and investigations where necessary.

Stress management: New initiatives include growing awareness of EAP services, including Trauma Assist; the awarding of a new contract for a gym provider and the introduction of a regular choir.

Change management: Formal Workplace Implementation Committees were formed to ensure that newly negotiated Enterprise Bargaining Agreements were successfully managed with our workforce.

2017 People Matter survey: We again participated in the Victorian Public Sector Commission's annual and mandatory People Matter survey in May 2017. Results showed:

- ***33%*** of staff participated in the survey, an increase on 2016's results
- ***76%*** High rates of job satisfaction
- ***73%*** High rates of employee engagement

Overall, we maintained a strong position of engagement and agreement across all surveyed categories.

Improvements compared to 2016's results were recorded in areas including diversity, inclusiveness, our management and implementation of change and providing our staff with the right skills. High rates of agreement were also recorded for our staff delivering great service, having pride in their work and recommending someone to work or be treated here.

In the coming 12 months, we will continue to focus on:

- managing staff's work and non-work related stress
- continue efforts to remove bullying in the work place
- ensure our staff are getting regular and valuable feedback on their performance.

Zero tolerance – the right to a safe workplace

This year, we developed the *Zero Tolerance* campaign, which focuses on aggression and violence experienced by healthcare workers. *Zero Tolerance* is a reminder to patients, family members and carers who visit our hospitals and clinics that verbal abuse, aggressive or intimidating behaviour towards our staff is a serious matter. We have encouraged staff to report all incidents involving aggression from patients or visitors.

Zero Tolerance was complemented by the Victorian Government's *It's Never Ok* campaign.

Recognising excellence

Staff awards

The expertise of our staff was recognised in numerous ways during 2016–17:

- **Associate Professor Julian Elliott**, an HIV physician at The Alfred received the prestigious Commonwealth Health Minister's Award for Excellence in Health and Medical Research.
- **Professor Paul Myles**, The Alfred's Director of Anaesthesia and Perioperative Medicine, and his team were awarded Australian Trial of the Year for their global study exploring the risks associated with aspirin and Tranexamic acid (TXA).
- **Dr Trevor Ackerly**, Chief Radiation Oncology Physicist, was awarded the Australasian College of Medical Physicists and Engineers in Medicine (ACPSEM) Distinguished Service Award. This lifetime service award has only been awarded to 10 other people since its inception.
- **A/Professor Ibolya Nyulasi**, Manager Nutrition, received a Career Achievement award from the European Society For Clinical Nutrition and Metabolism. This recognised her contribution to the identification and definition of malnutrition, which had a major impact on improving clinical practice in nutritional care. A/Prof Nyulasi is the first Australian (and first non-European) recipient of this award.

Program awards – healthy workplace

- The Alfred's Active Travel Zone won a prestigious 2016 VicHealth award for 'encouraging physical activity'. Alfred Health was also a finalist in the categories of 'Promoting healthy eating' and 'Preventing tobacco use'.
- We were one of the first Australian healthcare services awarded 'gold' status at the International Standards for Smokefree Healthcare Service.
- The Alfred's Active Travel Zone won a Places Victoria Property Industry Award, with the project recognised for demonstrating a genuine commitment to changing attitudes away from car dependency and towards a healthy lifestyle in a way that can be measured and that can challenge peers.

Internal staff recognition

Our annual awards recognise outstanding individuals and teams who embody our beliefs. More than 129 nominations were received over six categories. Above Sandringham Emergency and Theatre staff accept a team award for Partnering with Patients.

2017 Nurses' Awards

This year, 56 nominations were received across four award categories, including the ICU pressure injury prevention team.

Australia Day Honours

Two Alfred Health clinicians were recognised in the Australia Day Honours List for 2017:

- **Professor Jamie Cooper** – awarded an Officer in the Order of Australia (AO), for his distinguished service to intensive care medicine in the field of traumatic brain injury as a clinician and to medical education as an academic, researcher and author.
- **Ms Catherine Beaufort** – awarded a Medal of the Order of Australia (OAM) for her service to radiotherapy and international relations.

Queen's Birthday Honours

- **Emeritus Professor Paul O'Brien** became an Officer (AO) in the General Division of the Order of Australia. He was recognised for "distinguished service to medicine as a clinical surgeon and researcher, particularly of the stomach and its physiology, as a mentor to surgeons, and through contributions to public health in Australia and internationally".

Our patients

Cementing our work with patients was the second Patients Come First strategy, launched this year, which is the umbrella for all our patient work, including celebrating diversity, encouraging feedback and involvement in helping further improve our services.

Who are our patients?

The current demographic of Alfred Health's catchment is similar to that of the total Victorian population, except we have a greater proportion of people aged between 20–39 years. In particular, there is a significantly higher proportion of people aged between 20–29 years (largely reflecting the number of students and young workers living within close proximity to the CBD).

Cultural diversity

Our patients come from a wide range of backgrounds. The languages most commonly spoken by our patients are:

- Greek
- Italian
- Cantonese
- Russian
- Mandarin
- Turkish

Supporting cultural diversity

In being responsive to different cultural and linguistic needs we:

- began a new project which examines data on length of stay and unplanned re-admission rates for culturally and linguistically diverse consumers.

  In this first phase of the project, we are seeking to identify any healthcare disparities at Alfred Health between English-speaking patients and those with a preferred language other than English. This working group includes Culturally and Linguistically Diverse (CALD) consumers, peak body community representatives and key staff.
- held 17 professional development sessions, training more than 350 staff and volunteers about providing individualised care to culturally and linguistically diverse patients.
- conducted a service-wide organisational survey in November 2016 to explore how our healthcare staff could be best supported to care for culturally and linguistically diverse patients. Using this feedback, we are further exploring ways to address highlighted needs.

Image (left): We care for patients from a diverse range of backgrounds.

Better access to interpreters

Ongoing review of Language Service's booking process and interpreter allocation has ensured patients with the greatest need for a face-to-face interpreter will have access to one. Telephone interpreting is always available for all other appointments at all hours of the day, seven days a week. Since March 2017, video interpreting has been trialled in The Alfred's General Medicine ward, which has been well received. There are future plans to expand this to outpatient services.

AUSLAN patients, patients with cognitive or hearing impairment or patients requiring psychiatry or neuropsychology assessments continue to receive a face-to-face language service.

Interpreter highlights

22,567
total occasions of interpreting

16,821
face-to-face occasions of interpreting

5,669
telephone interpreting occasions

77
video interpreting occasions

We encourage our patients to provide feedback so we can continue to improve services.

Patients Come First

The 2016 Patients Come First (PCF) strategy and plan was launched in March. The focus of the launch was compassionate care, with a consumer panel discussing what staff can do to be more respectful and compassionate to patients and their families.

Our roadmap of care follows eight PCF pillars of care:

1. #1 Access
2. #2 Respect
3. #3 Team
4. #4 Communication
5. #5 Comfort & environment
6. #6 Compassion
7. #7 Family & friends
8. #8 Leaving our care

Key projects from the PCF plan include greater engagement with our communities and focus on partnerships, equality, improving patient meals and compassion.

Patient information

This year we worked with consumers to ensure our range of information is easily understood and accessible by patients, their families and carers. Work included:

- ongoing review of patient information by consumers to ensure needs are met
- increase in the range and type of information available on our inpatient TVs
- introduction of digital screens in various areas of The Alfred, to display key information and events.

This year, the Patient Information and Access Working Group participated in:

- an awareness campaign around the introduction of hospital-wide new visiting hours
- the design of new wayfinding signage at The Alfred
- the annual review of the campus welcome guides and the suite of welcome videos available on Alfred Health TV and our website
- the development of the new wayfinding app – PowerNav – at The Alfred.

Patient feedback

Listening to our patients is an important way we can continually improve our services. Feedback is sought in a number of ways.

Victorian Healthcare Experience Survey (VHES)

Conducted by independent contractor the Ipsos Social Research Institute, this statewide survey documents patients' views of their hospital experience.

From March 2016–March 2017:

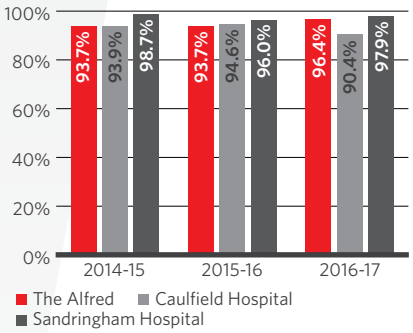
- an average of 92.6 per cent of Alfred Health patients rated their care as 'very good' or 'good', with all hospital campuses improving their rating over the previous 12 month period.
- 89.4 per cent felt they were 'always' treated with respect and dignity while in hospital.
- 80.9 per cent felt they were 'always' listened to and understood by the people looking after them in hospital, a five per cent increase on last year.

Our patients *(continued)*

Patient Experience Survey (PES)

This survey for patients and families is administered by our trained volunteers. We surveyed almost 3000 patients and families. Overall, 95.6 per cent of Alfred Health patients rated their care as 'good', 'very good' or 'exceptional'.

By campus, results were:



Other results showed that:

PES highlights

96 per cent
of our patients felt they were treated with respect and dignity

90 per cent
felt they were involved as much as they wanted to be in decisions about their treatment

93 per cent
felt staff provided all the information needed to help with health and wellbeing

Patients made it clear that areas for improvement included those involving physical comfort, with consistently negative feedback reflecting our ageing facilities in some areas, like Caulfield Hospital and inpatient wards.

Improving meals

Patient satisfaction on hospital meals continues to be too low, with 52 per cent rating hospital food as 'very good' or 'good'. This is an increase of 5 per cent on last year's rating. We have been working to improve satisfaction this year by:

- increasing meal temperature and tray presentation
- improving customer service around meal delivery, with better staff training and volunteer involvement
- introducing new menus at Caulfield and Sandringham Hospitals, with more diverse food options, and a new food allergy menu.

Compliments and complaints

We are always seeking feedback from our patients and in the 2016–17 year, we:

- received 1636 complaints, an increase of 493 complaints from last year. This equates to 3.5 complaints per 1000 bed days (not including Alfred Psychiatry), compared to 2.6 last year
- received 1136 compliments, an increase of 41 compliments from last year.

The significant increase in complaints and compliments is due in part to an increase in patients and complexity plus a greater ability to send feedback electronically to the Patient Liaison Office through our new website.

Improving patient experiences

Following feedback, we introduced some systemic improvements, which included:

- revising outpatient appointment letters to simplify content, format, readability, and instructions to Language Services to enable patients to attend appointments at the correct date, time and location
- early notification to outpatients regarding status changes, priority categorisation, and appointment cancellation in their preferred mode of communication (ie. text, letter, email)
- trial of independent patient gym access between 4–5pm to increase therapy available to patients after hours at Caulfield Hospital
- additional security services at Sandringham Hospital.

Caring for vulnerable people

This year we formed a Vulnerable People Committee, which creates one umbrella of care for vulnerable people, including those experiencing family violence, child safety issues, disability problems and elder abuse. The aim is to limit our patients' exposure to physical or emotional harm.

We are developing a *Vulnerable Persons Strategy* to bring together staff and consumers from across our health service to ensure a 'whole of hospital' approach. This was done in partnership with Victoria Police, family violence specialists, as well as sexual assault, LGBTIQ, sexual health, housing support, mental health and disability services.

Through our mental health service, we also continued partnerships with organisations specialising in disadvantaged communities, including the homeless and drug and alcohol addiction.

Supporting our LGBTIQ community

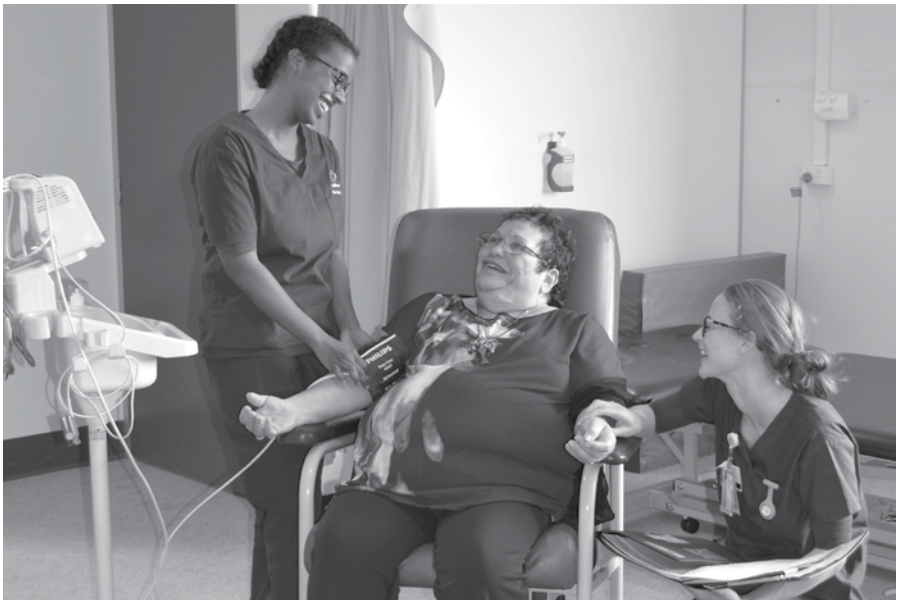
We are taking the lead on a LGBTIQ Victorian health sector forum – the first of its kind in Victoria. The forum will be held later in 2017 to give health services and peak bodies an opportunity to share ideas of practice supporting inclusive care, best practice, real stories from LGBTIQ patients and their experiences of healthcare. Forum participants will also contribute to the revision of the DHHS rainbow eQuality guide, which aims to build tangible strategies supporting inclusive care.

Our Aboriginal community

Our first Reconciliation Action Plan (RAP) has been completed. Developed by the RAP Working Group over two years, the RAP involved key stakeholder participation, including local Aboriginal Traditional Elders and Aboriginal staff and community representatives.

The RAP has been approved for conditional endorsement by Reconciliation Australia, with minimal changes. The RAP will be released in early 2017-18.

During the year, we established a new relationship with Koori Heritage Trust for assistance with future cultural awareness training.



Nurses Abshiro Abshiro and Chloe Small regularly care for indigenous patients like Judith Johnson (Auntie Jacko).

Improving discharge care

Discharge communication to community healthcare providers, especially to GPs, is important for the safe and effective handover of care when patients are returning home. Improvements over the past year have included:

- enhanced discharge summary templates containing key information and follow-up actions GPs require
- regular education and information to junior medical and clerical staff to ensure that discharge summaries are completed and sent in a timely way
- enhanced reporting of the discharge summaries KPI to Unit Heads, Program Directors and Nurse Managers so issues can be identified quickly and acted on.

As a result, discharge summaries verified within two working days has risen from 70 per to 80 per cent in 2016–17.

Wellbeing programs

Totally Smokefree

We undertook a '*Stop before the Op*' trial, which supported pre-admission patients to stop smoking prior to planned admissions at The Alfred. This trial resulted in a quadrupling of quit attempts. In the intervention group:

Trial results

More than 55 per cent
of patients made a quit attempt, compared to 11 per cent in control group

20 per cent
of patients were smokefree, compared to 8 per cent of the control group

42 per cent
reduced the number of cigarettes smoked per day compared to 8 per cent in the control group

Helping people find their way

As part of a project to improve overall patient experience, we have rolled out a wayfinding / signage project at The Alfred to assist visitors and patients find their way into and around the hospital. The project includes:

- external signage and 'gates' to show more clearly where patients and visitors should enter the site
- removal of 'non-patient' material and simplified wall and ceiling signage. The distinctive wall signage is modelled on a London Tube approach to movement, with designated stops being individual buildings and reception points.

Our patients *(continued)*

New approach to telehealth

To improve patient access to our statewide and specialist services, we are co-ordinating our approach to telehealth. We received a DHHS grant to improve telehealth efficiency, making it a viable alternative for our regional patients.

Units included in the pilot are Burns, Gastroenterology, Renal, Infectious Diseases, Respiratory–Lung Transplant and Cystic Fibrosis. As well as reducing unnecessary travel, it is hoped the pilot will result in improved collaboration with our regional partners, improved assessment of burns injuries (with better decision making on whether the injury can be treated locally) and improved regional systems for antimicrobial stewardship and infection prevention.

Cystic fibrosis and telehealth

A new advisory group, focusing on cystic fibrosis (CF), is using telehealth technology to ensure the voice of patients and families living with CF is heard. The group, which includes eight consumers, CF Victoria representative and key Alfred Health staff, use teleconferencing due to the risk of infection for those with this condition. It has also allowed easier accessibility for rural and regional patients wanting to be involved. The group is focused on improving our care and services, including infrastructure and food requirements.

New disability scheme

The National Disability Insurance Scheme (NDIS) is rolling out across Victoria. We are working to ensure our service profile and staff are prepared for roll-out, particularly in the Bayside Peninsula area for April 2018. The NDIS has meant a shift to the person with a disability, who can choose their own model of care. We are working on systems and processes to support eligible people in the transition to NDIS.

Patient car parking

Our car parking policy, which seeks to reduce the financial burden of vulnerable patients who frequently attend our health service, is reviewed annually.

Alfred Health complies with the DHHS hospital circular on car parking fees. Details of car parking fees and concession benefits can be viewed at:

The Alfred:

www.alfredhealth.org.au/the-alfred/patients-families-friends/before-you-arrive/parking-at-the-alfred

Caulfield Hospital:

www.alfredhealth.org.au/caulfield/patients-families-friends/before-you-arrive/parking-at-caulfield-hospital

Sandringham Hospital:

www.alfredhealth.org.au/sandringham/patients-families-friends/before-you-arrive/parking-at-sandringham-hospital

Safe Patient Care Act 2015

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

Patient escalation of care processes

The *Let me know* program was implemented in 2014 and encourages patients and their families to raise concerns directly with nurses and doctors if they are worried that the patient is deteriorating or "not quite right". If the family feel they are not being heard or are still concerned about the patient's condition, they can ring a dedicated hotline and speak with a senior nurse who will attend to the patient within 15 minutes. In the first year of inception there were 23 calls, which matches international benchmarks and indicates that our escalation systems for patient deterioration work well. In 2015-16 there were 32 calls and in 2016-17, calls increased to 65, following work on building awareness of the program.

Carer involvement

The *Carers Recognition Act 2012* (Vic) promotes and values the role of people in carer relationships and recognises the contribution that carers and people in carer relationships make to the social and economic fabric of the Victorian community. We have taken measures to comply with our obligations under the Act, ensuring that the needs of carers are recognised and responded to when the person for whom they care is admitted to Alfred Health or when the carer is admitted to Alfred Health.

Delivering quality care

As well as treating complex conditions and ensuring our patients recover well in hospital, we have introduced new initiatives to tackle increasing behaviours of concern and the symptoms of delirium. We remain on target for infection control measures.

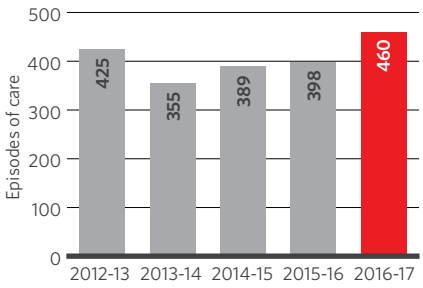
Alfred Health highlights

Growth in statewide services

We are responsible for 14 statewide services, with our expert staff providing a range of care for Victorians throughout the state. Demand for care continues to increase, with a growing population. We have responsibility for providing paediatric lung transplants nationally and statewide services include major trauma, hyperbaric medicine, psychiatric intensive care service and rehabilitation services, among others.

- Trauma figures have increased year on year
- Lung transplants remain steady
- Rehabilitation for older patients has grown dramatically
- Burns inpatient admissions have increased from 389 in 2014–15 to 460 this year, an 18 per cent increase over three years.

Burns care increase



Elective surgery: Supporting all Victorians

We partnered with Western Health and Monash Health to support the statewide aims for timely access for surgical patients and enabled more than 100 patients to access orthopaedic, ENT or vascular surgery earlier than expected by transferring to The Alfred or Sandringham Hospital. In particular, the orthopaedic work with Western Health allowed us to pilot an effective model to consider for future elective surgery partnerships.

Benefits of innovation

Since several projects won innovation grants last year, patients have reaped the benefits.

- **ICU alerts** – Providing automated alerts to clinicians when a decision has been made to discharge a patient from ICU has now become part of routine practice at The Alfred. Whenever a patient is discharged from the ICU, the alert system automatically allocates the patient to stratified and targeted follow-up on the general ward, tailored to the patient's needs. This leads to better patient care and improved use of ICU resources. A structured assessment of the program is presently underway and a scientific paper describing the development of the alerts system has been provisionally accepted for publication in a major Intensive Care journal.

Image (right): Surgery at Alfred Health can include fixing a broken wrist, replacing a hip or undertaking complicated heart surgery.

Delivering quality care *(continued)*

New project tackling concerning behaviours

Behaviours of Concern (BOC), such as physical or verbal aggression and self-harm, have become more common due to more complex patients, some with serious mental illness, others experiencing drug or alcohol withdrawal. This year, several initiatives were introduced to manage this behaviour more effectively. One with early success has been the introduction of the PSY-BOC call in Alfred inpatient Psychiatry in February 2017.

The initiative is the equivalent of a Metcall (which supports early deterioration of physical health). Staff identify patients with behaviours of concern early, with the aim of preventing behavioural health deterioration and to reduce the use of restrictive interventions, such as restraint or seclusion.

The PSY-BOC response team explores possible approaches to manage patient distress including sensory-based calming approaches, de-escalation strategies and use their knowledge of patient triggers, their preferred calming techniques and family feedback to support alternatives to restrictive interventions.

The initiative follows analysis of incidents, which found missed early intervention and prevention opportunities and a rise in seclusion rates over six consecutive months.

The first three months of data show:

- 67 PSY-BOC calls
- Seclusion rates post implementation are below the statewide target of 15

February	6
March	14
April	8
May	1
June	4

- Reduced aggression towards staff:
  - 89 incidents in three months prior
  - 48 incidents three months after

A new BoC program at Caulfield Hospital is on page 22.

Mental Health scorecard is on page 28.

Addressing delirium

In response to increasing clinical concern about delirium, we are running a large-scale project exploring its prevention and treatment. A 2016 audit indicated that 18–21 per cent of patients on medical and surgical wards had delirium. Literature shows that 10–18 per cent of patients over 65 years have delirium on admission and up to 8 per cent develop it while in hospital. Delirium contributes to long-term cognitive decline, discharge to residential care, increased length of stay, falls and premature death.

Our delirium project is focusing on:

- improving the patient and carer experience of delirium
- improving identification and management of delirium
- minimising preventable delirium – which is potentially preventable in 30 per cent of cases where risk factors are present
- better orientation with new clocks and environmental changes
- staff education and consumer engagement.

Outpatient Demand Management Strategy

With demand for our outpatient services increasing, due to demographic changes, the Better Care Victoria Innovation Fund provided a grant to implement a 'whole of systems' approach to deliver timely access to outpatient services. This will include:

- an electronic referral system for GP referrals
- new models of care to address the needs of patients waiting for their first appointment.

A pilot, involving five GP practices, will be trialled in high demand clinics including Orthopaedics, Neurosurgery, Rheumatology and ENT (Ear Nose Throat). It is hoped outcomes will include an increased quality of referrals, improved patient satisfaction with wait time for first appointment and a reduction in non-urgent outpatient waitlists.

Outpatient highlights

More than 160
outpatient referrals received each day

Over 230,000
outpatient appointments conducted annually

Better Care STRIDE service

In December 2016, we received a $424,000 grant from Better Care Victoria's Innovation Fund to trial a collaborative program with Ambulance Victoria (AV) aimed at reducing falls and reducing the numbers of non-urgent patients transported to our Emergency Departments.

The STRIDE program will target those over 65 years who fall at home from a standing height or lower, who can be attended to at home and do not require hospital treatment. Following an assessment by Ambulance Victoria, a physiotherapist or occupational therapist will come to the patient's home to undertake a post-fall screen, conduct a falls risk assessment and provide falls prevention intervention. The service is available in Stonnington, Glen Eira and Port Phillip from 7am to 5pm.

The service model has been developed, clinicians recruited and the service began in May 2017.

Hospital guardian project

We are part of a pilot project, along with two other health services and the Office of the Public Advocate, to improve the current guardianship process and increase support for healthcare workers involved in the process.

With a current lack of guardians to meet a growing demand for guardianship services, it is hoped dedicated hospital guardians will see a reduction in:

- the time between registration of a VCAT order, guardian allocation and decisions
- total length of hospital stay
- likelihood of hospital readmission within 28 days of discharge, and
- referral of patients awaiting guardian allocation to the Transitional Care Program.

This pilot will run until February 2018, with recommendations to be completed by April 2018.

Significant operational activities

The Alfred

The Alfred is a major tertiary referral hospital providing a comprehensive range of acute and mental health services to local residents. It is also a teaching hospital with strong roots in integrating clinical practice with research discoveries, providing many statewide services. Once again we saw increases in Emergency Department presentations and major trauma.

Significant developments and initiatives in 2016–17

Complex procedures:

- **High transplant rates:** We continue to perform many transplants to save lives:
  - 93 adult and three paediatric lung transplants
  - 20 heart transplants
  - 28 kidney transplants
  - stem cell transplants for cancer patients – 47 allogeneic (donated cells) and 67 autologous (own cells).
- **ECMO (extracorporeal membrane oxygenation):** The Alfred has become an expert at this technique used in intensive care which provides both cardiac and respiratory support to patients whose heart and lungs are unable to work effectively on their own.

Responsive to demand

Demand for emergency care at The Alfred continued this year, with more than 65,000 presentations. This represents a 3 per cent increase on last year's Emergency Department presentations and a 10.6 per cent increase over the last four years. We also saw a 7 per cent increase in major trauma patients, with 1,498 major traumas and 8,002 trauma patients in all.

As well as the usual daily care, The Alfred responded to three major incidents that saw several critically injured patients transported to the hospital at the same time. Despite the seriousness of all three events, all hospital patients survived:

- **Springvale bank fire:** In November, an incident at a Springvale bank involving a flammable accelerant injured 27 people. Six people were brought to The Alfred suffering serious burns, with two of them critically ill.
- **Thunderstorm asthma:** In late November, both Alfred and Sandringham Hospital Emergency Departments were inundated with people suffering respiratory distress due to 'thunderstorm asthma'. The combination of hot weather, thunderstorms and high pollen count saw the EDs treat:
  - 110 more patients than on an average Monday night at The Alfred
  - 90 more patients than usual at Sandringham Hospital
  - higher than usual Emergency admissions the following day
  - two people in ICU, with the majority discharged soon after treatment.

Staff numbers doubled during the crisis, with nurses, doctors, pharmacists and respiratory specialists coming back to work to meet the increased demand.

- **Bourke St incident:** In January, seven seriously injured patients were treated at The Alfred following an incident in the Bourke St mall where pedestrians were hit by a vehicle. Three of those patients arrived in a critical condition, requiring intensive care.

We are accustomed to responding to high influxes of patients.

Delivering quality care *(continued)*

Partnerships and collaborative care

Recognising that working with other experts in the field leads to even better care for patients, we have entered into several new collaborations this year:

- **Heart transplant/VAD collaboration:** The first meeting between Alfred and St Vincent's Hospitals was held in Sydney, marking the start to a new collaboration between the two programs, which is designed to share knowledge and expertise.
- **Neurosurgery:** A collaborative clinical partnership has been developed between Peninsula Health and The Alfred to ensure timely patient access to expert treatment for patients living on the Mornington Peninsula.

We shared our expertise internationally:

- **Saudi Arabia partnership:** A medical team from the King Saud Medical City Hospital visited The Alfred this year to learn more about our trauma program.
- **Alfred trauma software:** The Alfred-developed Trauma Reception and Resuscitation (TRR) software is being used in China. We are collaborating with Corsyn Guangdong Information Technology to modify and localise the software for use in Chinese hospitals. The software uses algorithms to generate real-time prompts that are triggered by patient physiological signs, diagnoses and clinical interventions.

Advances in care

Advances in technology and expertise at The Alfred has led to numerous advances in our care:

- Medical staff are receiving training on the Ex vivo lung perfusion (EVLP), a process of preparing donor lungs outside the body prior to transplant surgery. By repairing and restoring the lungs using this process, it is hoped the available donor pool will significantly increase.
- The Alfred's pulmonary endarterectomy (PEA) program is now the busiest in Australia. PEA involves removing old blood clots from the pulmonary arteries in the lungs. There has been a 50 per cent increase in patient numbers over the last two years.

Cancer care

The Alfred runs Australia's biggest centre for blood cancer treatment. Attendances at our myeloma clinic continue to rise, with patients travelling from around Australia for treatment. In the last four years, those treated for myeloma rose from 1151 in 2013–14 to 1746 this year, an increase of 52 per cent.

Radiotherapy

After suffering water damage in The Alfred's radiation oncology unit in April 2016, the centre was left with only one of its four linear accelerator (linacs) working. Two were repaired and back in use in May and June 2016. A third was replaced and entered clinical use in October 2016.

- Brachytherapy image guidance – verification in real time (BIG-VIRT) – was introduced. This Alfred Radiation Oncology-patented technology provides a completely new way of determining accurately and quickly that high-dose rate brachytherapy treatments for men with prostate cancer are being delivered by the technology exactly as planned. This breakthrough, which has been progressively introduced over the last 18 months, ensures perfection with every treatment. We continue to work to make it more practical.
- The Alfred Radiation Oncology Physics group helped lead a statewide project to create a centralised artificial-intelligence based system for radiotherapy treatment planning for head-and-neck and prostate cancer. This centralised computer server and software brought together the best radiotherapy plans from all over the state, for specific anatomic sites. By using this computer-analysed collective wisdom, we were able to create better treatment plans, with the prostate cancer model now widely used around Victoria.

Seed brachytherapy was performed on The Alfred's ***1,000th patient***

Expansion to Gippsland cancer program

Radiation oncology services at the Gippsland Cancer Care Centre continue to be provided by The Alfred. In 2016–17 we:

- purchased new technology called GateCT and AlignRT, which replicates the technology at The Alfred and allows better planning and treatment of chest cancers by adapting to the respiratory motion
- commenced treatment with stereotactic radiotherapy for brain cancers and introduced Stereotactic Ablative Radiotherapy (SABR) – a high precision technique that delivers a higher dose of radiation directly to a range of tumours
- secured funding for an Alfred-led seed brachytherapy program, with the launch due later this year.

Care in the home

Our home renal dialysis program is one of the busiest in the state. Currently, 124 people manage their renal replacement therapy within their own homes. Evidence suggests patients in control of their own therapy have better outcomes. We are well above the state target of 35 per cent of patients involved in home dialysis, with a 58 per cent incidence rate in the 2016 calendar year. Over the last three years home dialysis has risen from 46 per cent of patients in 2014 to 54 per cent in 2015 (incidence rate – new cases). The prevalence rate has just dipped below the state target of 35 per cent, with a number of patients recently having renal transplants and coming off dialysis. We are due to be back on target shortly with a number of patients being trained for home therapy.

The Alfred home dialysis program has recently celebrated our longest-term patient who has spent 16 years on dialysis at home. These patients are supported by The Alfred renal home before hospital team.

Leading cardiac care

The Alfred provides a full range of adult cardiac care, treating the most complex cardiac cases.

Global cardiac trial

The Alfred was the first hospital to take part in a global trial which could eliminate the need for open heart surgery in some patients suffering the common heart valve disease, aortic stenosis. The Transcatheter Aortic Valve Implantation (TAVI) procedure is currently reserved for patients not well enough to undergo open heart surgery. The trial will determine whether the procedure is suitable for low-risk patients, or those who would usually have open-heart surgery to replace their aortic valve. The worldwide trial will involve 500 patients – half will have TAVI, half will have surgery, and researchers will compare patient outcomes.

Sharing expertise

Our doctors are sharing their cardiac expertise overseas using teleconferencing technology to live stream two procedures from our operating theatres. One procedure addresses a leaking heart valve using MitraClip, a less invasive alternative to open heart surgery, where patients are only required to stay in hospital for two to three days. The Alfred is leading the way in Australia for these procedures and teaches cardiologists across the Asia-Pacific.

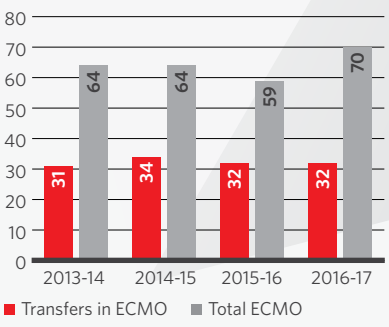
Increase in VADs

With more cases of heart failure, we are using more ventricular assist devices (VAD) – a mechanical pump – to keep people alive or as a bridge to transplant. This year we implanted a HeartMate bi-VAD in a patient with cardiomyopathy – the fifth of this type of implant in the world and the first outside of Europe.

Expert technique

ECMO (extracorporeal membrane oxygenation)

The Alfred has become an expert at this technique used in intensive care which provides both cardiac and respiratory support to patients whose heart and lungs are unable to work effectively on their own. Very sick patients are treated at The Alfred with ECMO and we also transfer patients in from hospitals around the state, using our own staff to ensure they make it to our hospital safely.



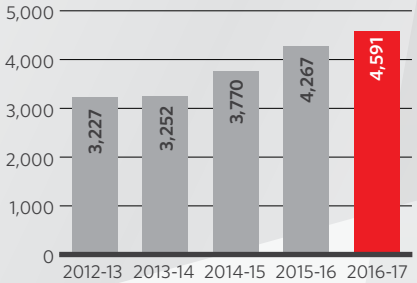
Growth in admissions

Cutting edge procedures and leading cardiac specialist care has resulted in a growth in cardiology admissions over the last five years. We have seen a 42 per cent increase in patients needing treatment for heart conditions since 2012–13, from 3227 patients to 4591.

Specialist services:

- heart transplantation
- heart failure
- pulmonary hypertension/ investigation
- management and evaluation
- ECMO (extra-corporeal membrane oxygenation)
- cardiac MRI
- cardiac rehabilitation
- cardiac surgery
- cardiac interventions

Cardiology admissions



Cardiology and cardiac surgery

The Clinical Integrated network for cardiac care began seeing patients in 2014. Since then, there has been an overall growth of approximately 47 per cent in cardiology and cardiac surgery provided to patients from regional and outer metropolitan catchment areas. This allows patients timely access to highly advanced cardiac care unable to be provided within their local community.

Delivering quality care *(continued)*

Caulfield Hospital

Caulfield Hospital specialises in community services, rehabilitation, aged care and aged mental health. The hospital's statewide role in rehabilitation services includes the Acquired Brain Injury Rehabilitation Centre (ABI) and Transitional Living Service, which works to further independence before discharge. The ABI Unit has become a key facility, comprising 37 per cent of all rehabilitation bed days.

This year, the hospital's work in Geriatric Evaluation and Management (GEM), which includes rehabilitation for older patients with chronic or complex conditions, rose by 24 per cent.

Behaviour management project

Following the success of a psychology-led interdisciplinary approach to behaviour management in our Acquired Brain Injury Unit, DHHS funded a similar model to be implemented across Caulfield's subacute aged care and rehabilitation wards. The project aims to implement a consistent collaborative approach to behaviour management and improve patient and staff safety and quality of care.

The project has involved:

- assessing the extent of the problem and current gaps
- up-skilling and credentialing psychologists to deliver a consistent level of service.

As a first step, 77 patients have been referred and interdisciplinary behaviour management plans developed, reviewed and clearly documented in the patients' file. A full project evaluation is due in December 2017.

GEM at Home review

The GEM at Home program celebrated its one-year anniversary this year. The program provides home-based care for older patients who would otherwise require an inpatient stay. The team of nurses, geriatricians, pharmacists and Allied Health professionals travel to patients' homes on a daily basis (seven days a week). Patients also have access to 24-hour phone support.

In October 2016 we conducted a review of the first 12 months, which revealed:

- GEM at Home cared for 286 patients
- 45 per cent came directly to the program from The Alfred and Sandringham Hospitals, 9 per cent came directly from the community and the remainder transferred from an onsite subacute bed at Caulfield Hospital.
- Patients under the GEM at Home model had a shorter length of stay (18 days compared to 23.5 days when ward based) and less adverse incidents like falls or pressure areas.

There are plans to expand the successful GEM at Home service in the coming year.

Patient communication rounds

Following feedback that patients felt inundated on arrival, with the same questions asked by multiple people, we introduced weekly patient communication rounds in April 2016. The rounds allow patients and their families to meet with the whole interdisciplinary team at the same time to raise concerns, ask questions and clarify plans. The aim is to improve the patient experience and quality of care by increasing patient involvement in care. The rounds are held at a known time each week so family can attend. All teams have been involved in reviewing and making improvements to the rounds. Feedback from patients and families has been positive.

Post-discharge telephone calls

Caulfield Hospital's Aged Care teams introduced post-discharge phone calls in November 2016, following evidence that patients often encounter problems in their first few days after hospital discharge. Studies have shown that a phone call soon after discharge from an inpatient hospital can have a positive effect on readmission rates.

An initial audit has found issues are being identified and addressed in almost 50 per cent of phone calls and plans are underway for a more extensive evaluation.

Little Things Matter awards

Feedback from patients and families indicates that it is the small things that staff do over and above their allocated duties that make a difference to their experience at Caulfield. With this in mind, the Caulfield Hospital Patient Experience Committee launched the inaugural *Little Things Matter* awards in June 2017.

In the two-week nomination period, over 150 nominations were submitted from patients and families, in appreciation of the care and support they receive from a wide range of clinical and support staff. The awards will be held on a six-monthly basis.

Making Every Moment Count

During the year, we have expanded options for our rehabilitation patients to increase activity and engagement in their recovery, with the *Make Every Moment Count* program. New initiatives, which were developed in collaboration with patients, include:

- self-directed gym sessions
- table tennis coaching and support (provided in partnership with Table Tennis Victoria)
- the use of Recovery Buddy workbooks.

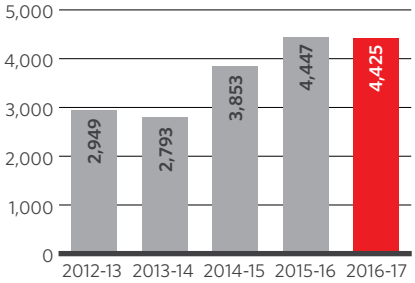
Patient feedback, combined with a prior direct observation patient activity audit, are being used to measure effectiveness.

Sandringham Hospital

Sandringham Hospital is community focused, providing hospital healthcare needs for the local area through emergency, paediatrics, general medicine and outpatient services. The hospital works closely with the Royal Women's Hospital on site, taking a partnership approach in providing maternal and gynaecological services.

Emergency admissions at Sandringham Hospital continue to increase, demonstrating ongoing community need. Over 41,000 presentations were made at the hospital's Emergency Department in the last year, up another 4 per cent on last year and from 33,000 five years ago. Ambulance arrivals also tell the tale of increasing community need.

Ambulance arrivals – Sandringham – up 50 per cent over five years



Boost to paediatric services

There has been a significant spike in the number of children visiting the Sandringham Emergency Department over the past year. In 2015, around 9000 children presented to emergency with a range of illnesses and injuries, but that figure has grown almost 8 per cent over the past year. There has been a consistent 5 to 10 per cent increase in paediatric presentations each month.

To meet the increased demand, two new paediatric specialists have been employed. They will help care for the 700 children treated each month, with about 60 of those transferred to specialist care.

Day Procedure Centre closer to reality

Plans to build a Day Procedure Centre at Sandringham progressed during the year. The hospital received a $1.6 million funding boost from the State Government plus significant contributions from Sandringham Community Bank and the community.

A Day Procedure Centre will mean local residents can undergo same-day surgery close to home and also more beds will be available for emergency overnight stays. The State Government funding will support the Day Procedure Centre as well as additional enabling works required to complete the project. It is expected that construction on the Centre will start later in 2017.

Dialysis at Sandringham has expanded, with an additional six chairs.

New dialysis program

Sandringham's busy dialysis unit expanded this year to offer a new form of 'hybrid dialysis' with an additional six chairs. Hybrid dialysis involves patients participating in the timing and delivery of their own care, including the supervised setting up and management of their own dialysis machine throughout treatment. Research has shown that if patients become more involved in their dialysis care, overall health outcomes are significantly improved. Feedback from patients has been extremely positive, particularly in terms of greater feelings of independence and flexibility in the timing of their treatments.

Transfer of the SCN

In September, management of the Special Care Nursery (SCN) at Sandringham Hospital was transferred to the Women's. The Women's maternity and Gynaecology Service was established at Sandringham three years ago. The addition of the SCN to the Women's fits with the philosophy of keeping mums and babies close together. As part of the arrangement, DHHS funded a $1.6 million refurbishment of the SCN, which improved the environment and increased capacity from six cots to eight.

Delivering quality care *(continued)*

Community clinics and programs

Melbourne Sexual Health Centre

A range of services relating to sexual health is offered at our Melbourne Sexual Health Centre (MSHC). This includes counselling, HIV Integrated Prevention, HIV clinic, results and information line, laboratory testing, pharmacy and STI screening. The centre is also heavily involved in research, seeking better treatments and care of patients.

Unprecedented demand

Demand for services at MSHC reached unprecedented levels this year. We provided a record 46,564 consultations in 2016 – a 9.6 per cent increase on last year. We diagnosed a record 2,730 cases of chlamydia (a 36 per cent increase), 1,719 cases of gonorrhoea (a 14.6 per cent increase) and 342 cases of infectious syphilis. This demand has been due to large increases in Melbourne's population, including rapidly rising numbers of international students and rising rates of sexually transmitted infections, most notably in men who have sex with men.

Refining our services

We have extended the scope of practice for nurses to see some symptomatic clients, introduced limited Medicare benefits and worked hard to ensure those in the greatest need are seen first. We are working closely with external services, referring some patients to highly trained general practitioners. Other demand management strategies introduced include a waitlist queue board and free WiFi.

Mouthwash trial

With condom use falling among men who have sex with men, we have been trialling a mouthwash to prevent gonorrhoea transmission. Our work with Monash University has revealed that gonorrhoea is always present in saliva of those with throat infections. Using mathematical models, we've shown that throat gonorrhoea is a critical site for its control. In laboratory tests, the mouthwash has worked well so we're now running clinical studies, which show early promising results. If successful, the mouthwash will be the first non-condom based intervention for gonorrhoea.

Antibiotic resistance

We have conducted research on an emerging sexually transmitted infection – *Mycoplasma genitalium* (MG) – for over a decade. We saw 528 cases of MG last year and our studies have shown up to 20 per cent of these infections are untreatable with currently available antibiotics. With new classes of antimicrobials urgently required, we studied the use of an antibiotic that has not previously been used to treat MG, successfully curing 75 per cent of infections. Data from a further study on the likelihood of MG infection in sexual contacts will provide an evidence-base for treatment and partner-notification guidelines and will assist decision making on preventative treatments.

Community clinics and programs

We provide a range of programs in the community, many of them health prevention initiatives designed to keep people out of hospital.

Hope

Alfred Psychiatry has recently commenced receiving referrals for the Suicide Prevention Assertive Outreach team – *Hope*. We are one of six mental health services funded for up to four years to provide assertive outreach care for anyone who has attempted or is thinking about suicide. *Hope* will care for those who are not linked with a tertiary mental health service and who are discharged from the hospital or Emergency Department. This innovative model of care involves clinical staff, a psychiatrist, psychologist and family therapist as well as practical help and support through a small team of psycho-social support workers who will engage with clients for up to three months.

New alcohol and drug service

In December 2016, the Southcity Clinic Addiction Medicine Service formally became part of Alfred Health. Co-located within St Kilda Rd Community Mental Health Clinic, the Southcity service assists clients with complex addictions and helps bridge the gap between drug addiction and our mental health services. We have also established an Alcohol and other Drug Nurse Practitioner (candidate) role to sit within community mental health and work with dual diagnosis clients.

Open Dialogue

The headspace Youth Early Psychosis Program has implemented an 'Open Dialogue' approach when responding to people experiencing mental illness. This approach, developed in Finland, involves a consistent family/social network approach to care, in which the primary treatment is carried out through meetings involving the young person together with his or her family members and extended social network. Other key components include continuity of clinicians, immediacy of response and flexibility of meeting time and place. This approach has great support from our service users and their families.

HARP and Healthlinks

Our Hospital Admission Risk Program is the focus of a new initiative called Healthlinks, aimed initially at patients with Chronic obstructive pulmonary disease (COPD) and heart failure, who have been identified as being at risk of hospital readmission. Patients with multiple serious illnesses (co-morbidities) will also be targeted. This year, HARP has:

- expanded its care with a comprehensive respiratory rehabilitation and education program for patients with COPD
- developed a comprehensive education program for people who present with heart failure and are at risk of avoidable representation
- employed a full-time registrar (working across both community and the wards) and a part-time medical consultant to support complex client care in the community.

Quality indicators

2016–17 highlights

The indicators included in this chapter demonstrate to our community the level of quality care we provide. These indicators are usually included separately in the Quality Account.

Quality indicators

Infection prevention

Infection prevention is crucial in reducing risks of hospital-acquired infection and improving patient safety and care.

SAB rate

Since 2012, we have implemented a number of sustainable hospital-wide initiatives to reduce *Staphylococcus aureus* bloodstream (SAB) infections, which are common in the community and serious. This includes ensuring insertion and maintenance of peripheral catheters is performed according to best available evidence. As a result, low rates of SAB infections related to delivery of healthcare have been observed at Alfred Health since this time. These rates are consistently below the target for Victorian healthcare facilities; the benchmark being less than two per 10,000 occupied bed days.

CLABSI decline

We saw a sustained reduction in Central Line-Associated Bloodstream infections (CLABSIs) in our ICU, thanks to improved processes for insertion and care of central venous catheters. In the ICU, rates of infection are continuously monitored against the statewide target of zero. Despite an increasingly complex patient group, we have sustained a decreased rate of CLABSI.

Hand hygiene

We have again improved hand hygiene compliance this year. With a government target set at 80 per cent, we achieved 79.2 per cent compliance in the first audit period, 81.3 per cent in the second period and 81.8 per cent for period three. This year's activities included:

- the launch of a promotional hand hygiene music DVD
- increased number of auditors at ward level
- 'how to give feedback' sessions for ward auditors
- increased product availability within Psychiatry.

Immunisations

Influenza vaccination

The 2016 influenza campaign, which ended in August, saw 84 per cent of staff vaccinated, exceeding DHHS's target of 75 per cent. As of 30 June, and part-way through the 2017 campaign, 76 per cent of staff have been vaccinated.

Vaccine preventable diseases

Our staff immunisation clinic provides a comprehensive service for protection against vaccine-preventable diseases (such as measles). Over the last year, a dedicated program for existing staff has enabled vaccination uptake to be enhanced through a mobile vaccination service.

Emerging diseases

In recent years, Carbapenemase-producing enterobacteriaceae (CPE) – bacteria that are resistant to first-line antibiotics have emerged in many Australian hospitals, following increased numbers of cases internationally. We have seen increasing numbers of patients with CPE over the past 18 months. This has led to enhanced monitoring, cleaning and prevention strategies being employed.

We are fully compliant with DHHS guidelines for reducing infection risk. Proactive screening of patients who have spent time in an overseas hospital in the last year or are contacts of a known case are performed throughout the organisation. Enhanced measures, such as screening outpatients prior to planned hospitalisation, is currently being trialled to streamline patient care.

Antimicrobial stewardship

Sepsis continued to be the focus of this program for the last 18 months. The aim is to optimise antimicrobial prescribing, which means ensuring patients with infection get the right antibiotic at the right dose and for the right amount of time. This gives patients with infections the best chance to improve and reduces the risks of antibiotic resistance. Our focus on sepsis is ensuring that some of the sickest patients receive their antibiotics as soon as possible when they need it most.

Blood management

We used over 24,000 fresh blood products during the last year and our wastage for all products has remained below or at target.

Initiatives to improve the patients' own blood reserves and limit unnecessary transfusions have seen an increase in single unit transfusions, where patients with low blood count receive one bag of blood and are reassessed to see if they need further blood, rather than routinely giving two bags of blood. This, along with other practice changes, has resulted in a reduction in transfusion rate for some surgical groups.

Advance Care Planning

For the first time, we were able to measure the number of patients being admitted to our hospitals who have Advance Care Plans (ACP) on file, outlining their wishes for end of life care. Across our hospitals, 4 per cent of patients had these plans. In light of low numbers we continue to:

- work with the community on raising awareness of Advance Care Planning
- educate our clinicians so they can encourage their patients to talk about what is important to them and document their wishes in an advance care plan.

The introduction of an electronic ACP referral has increased the ease of referring patients to the ACP service. In 2016–17, we saw a 15 per cent increase in the number of referrals compared to the previous year. Inpatient wards and outpatient clinics were the two referral groups that showed the greatest improvements in referrals rates in the last year.

Falls in hospital

This year, while the total number of falls decreased by 6.6 per cent, falls with serious injury rose.

Alfred Health	Apr 2015 – Mar 2016	Apr 2016 – Mar 2017
Actual falls	2082	1952
Actual serious injury (ISR1 & 2)	17	30

We have noted a progressive decrease in the total number of patient falls over the past two years. Falls with serious injury occurred in our General Medicine Unit where delirium and behaviours of concern are a factor. At Caulfield Hospital, a number of patient falls were reported in the community service setting and transitional care.

With 77 per cent of all falls unwitnessed, we have implemented a '*Call, don't fall*' campaign as a prompt to patients to use call bells. We are also auditing call bell answering times.

Pressure injuries

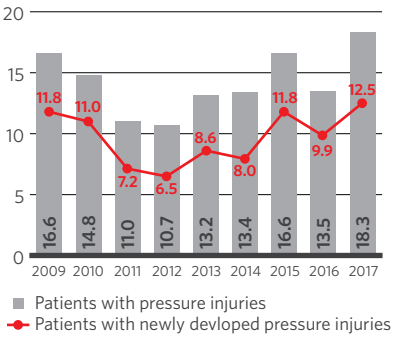
Managing hospital acquired pressure injuries has been challenging this year (June 1 2016–31 June 2017), with 99 serious pressure injuries acquired or worsened while in care, compared to 105 in 2015–16.

The Pressure Injury Prevention Committee and the Falls Prevention Committee recently combined to focus their efforts, leadership and drive improvement strategies, which included:

- establishment of a local working group in Operating Suites to improve pressure injury prevention awareness
- targeted work in high pressure injury risk areas, like ICU
- more communication during bedside handover to maximise opportunities for patients to be involved in care plans to minimise falls and pressure risks.

Pressure Injury Point Prevalence Survey 2009 to 2017

Over the last 12 months, we have seen an increase in overall pressure injuries and also a rise in hospital acquired injuries.



Quality indicators *(continued)*

Medication safety

We have introduced two innovative, Australia-first medication safety programs targeting the management of analgesics and anticoagulants – two high-risk medication groups. The aim is to improve patient outcomes, reduce adverse events and ensure appropriate medication use.

Analgesic stewardship

A recent audit of 502 patients showed 44 per cent were already taking analgesics before admission, which increased to 83 per cent after admission. One in five patients were already taking opioids before coming to hospital, but this increased to one in three inpatients. The program aims to promote optimal and safe use of these and all analgesics, which are commonly used in hospital to treat pain and are widely available.

Anticoagulation stewardship

Every year, about 200 patients are admitted with significant anticoagulant-related bleeding. Anticoagulants ('blood thinners') are used to treat and prevent potentially life-threatening clotting disorders, but also increase the risk of bleeding. A point prevalence audit showed that over 70 per cent of inpatients are prescribed an anticoagulant for clot prevention or treatment. This program was established to promote safe use of anticoagulant medications and to encourage best practice. We are working to improve patient outcomes, such as preventing in-hospital deep vein thrombosis, further education for staff and follow-up of outpatients prescribed anticoagulants.

Mental health scorecard

Adult inpatients

	Target	2016–17 actuals
Seclusion rate	Less than 15	14
Physical restraints	No set target	2.9
Mechanical restraint	No set target	1.7

Aged Psychiatry inpatients

	Target	2016–17 actuals
Seclusion rate	Less than 15	2
Physical restraints	No set target	2
Mechanical restraint	No set target	0

* *Data is calculated on the average monthly rate per 1000 bed days.*

A new program managing Behaviours of Concern has reduced seclusion rates – see page 18.

Activity

Admitted Patients	Acute	Subacute	Mental Health	Other	Total
Separations					
Same Day	64,137	12	14	0	64,163
Multi Day	42,567	3,687	1,506	0	47,760
Total Separations	**106,704**	**3,699**	**1,520**	**0**	**111,923**
Emergency	47,127	25	1,077	0	48,229
Elective	59,577	3,674	443	0	63,694
Total separations	**106,704**	**3,699**	**1,520**	**0**	**111,923**
Other					
Total bed days	**286,702**	**90,251**	**24,715**	**0**	**401,668**
Total WIES	**111,853**	**0**	**0**	**0**	**111,853**
Major trauma admissions	**0**	**0**	**0**	**0**	**1,498**

Non-Admitted Patients	Alfred	Caulfield	Sandringham	Other	Total
Emergency Department presentations	65,058	0	34,040	0	99,098
Specialist outpatient appointments	137,386	4,521	11,793	0	153,700
Allied Health outpatient appointments	36,279	0	1,640	0	37,919
Diagnostic outpatient events	0	0	0	0	0
Radiotherapy – occasions of service	32,279	0	0	23,814	56,093
Other services – occasions of service	0	0	0	0	0
Total occasions of service	**271,002**	**4,521**	**47,473**	**23,814**	**346,810**

Report of Operations Responsible Body Declaration

In accordance with the *Financial Management Act 1994*, I am pleased to present the Report of Operations for Alfred Health for the year ending 30 June 2017.

Michael Gorton
Chair
Board of Directors

22 August 2017

Performance

Strategic performance

Accountability for Alfred Health's operational performance is set by the Minister for Health through the Statement of Priorities (SOP) agreement.

DHHS action	Alfred Health deliverable	Progress as at 30 June 2017	Status
Quality and safety			
Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	Develop and implement an action plan to ensure Alfred Health services are consistent with both the national consensus statement on end of life care and the Victorian end of life and palliative care framework.	Gap analysis completed against national consensus statement and end of life framework and action plan developed. Priority areas of patient goals of care and care plan and education actioned. Draft patient goals of care template to be piloted 2017–18 and eLearning package on medical staff education about end of life conversations to be launched in August 2017.	COMPLETED
Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection.	Audit Advance Care Planning at a unit and organisational level with the goal of ensuring: ▪ 100% of patients who have an ACP have this considered as part of clinical decision making ▪ 100% of patients who have an encounter with Alfred Health, and where it is deemed clinically appropriate, are given the opportunity to have an advance care plan developed.	Established data set through VINAH and VAED to allow capability to measure/report performance, pending results from DHHS. Advanced Care Planning education is continuing across the organisation with increased number of ACP documents scanned onto patients' files and increased electronic referrals to ACP.	GOOD PROGRESS
Progress implementation of a whole-of-hospital model for responding to family violence.	Adopt the '*Strengthening hospitals response to Family Violence*' framework to the Alfred Health environment and implement this to support the guideline and policy developed in 2015–16.	Governance arrangements for organisation oversight for vulnerable people established, including consumer, Victoria Police and specialist services representation. Implementation plan for the guideline and policy developed and underway. Education and staff training commenced in Alfred ED with regular reporting to DHHS and the Royal Women's Strengthening Hospital Response to Family Violence Steering Committee.	COMPLETED
Use patient feedback, including the Victorian Healthcare Experience Survey, to drive improved health outcomes and experiences through a strong focus on person and family-centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Plan, deliver and evaluate services through the regular analysis and actioning of themes from integrated patient feedback including VHES, PES and complaints and compliments, as part of the revised 2016–20 Patients Come First strategy and plan.	Common themes from VHES and PES confirmed. Patient Comes First (PCF) scorecard developed and reviewed by PCF committee and Community Advisory Committee (CAC). Feedback action plan developed and implemented through PCF Committee.	GOOD PROGRESS
Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Reduce the use of restrictive practices across Alfred Health with particular focus on improving practices to minimise behavioural challenges associated with patients with acquired brain injuries, suffering delirium and alcohol and drug issues. Improvement strategies to include early identification, improved consultation and supervision, incident auditing, research and monitoring and feedback.	Reducing Restrictive Intervention Committee established, leading a review of current practice and performance. Preventative model of early escalation to senior clinicians was implemented in Alfred Psychiatry resulting in a significant reduction in seclusion rate to average 7 per 1000 bed days (below state target of 15 per 1000 bed days).	COMPLETED
Alfred Health Strategic Plan flagship project	Improve clinical information capture and management and patient care through continued implementation of the electronic-Timely Quality Care (eTQC) project; including mapping current-state and desired end-state clinical workflows; finalise implementation of Emergency Department Information System, implement computerised physician order entry for pathology to deliver and successfully undertake a major Millennium upgrade to support further implementation of the Electronic Medical Record (EMR).	Emergency Department system implementation underway, aligned to department redevelopment. Cerner Millennium platform upgrade to support EMR completed and pathology e-ordering roll-out completed for all Alfred Health sites. Mapping of clinical pathways and workflow continuing to progress.	COMPLETED
Alfred Health Strategic Plan flagship project	Maintain Alfred Health's role as Victoria's leading major trauma centre and major specialist service provider through continued planning for the provision of the St Kilda Wing that will provide state-of-the-art operating theatres, intensive care, pathology facilities and contemporary wards for decant and expansion.	St Kilda Wing proposal submitted to fund enabling works and business case, however no capital investment in 2017–18 budget allocated. Framework for stakeholder engagement strategy to ensure support developed. Revised Alfred Health Service Plan commissioned to provide updated Master Plan and St Kilda Wing Feasibility Study.	COMPLETED

DHHS action	Alfred Health deliverable	Progress as at 30 June 2017	Status
Access and timeliness			
Ensure the implementation of a range of strategies in specialist clinics to: (1) optimise referral management processes and improve patient flow to ensure patients are seen in turn and within time; and (2) ensure Victorian Integrated Non-admitted Health (VINAH) data accurately reflects the status of waiting patients.	Implement a major outpatient improvement project across Alfred Health to improve patient flow and develop a VINAH data quality framework to ensure potential data issues are managed appropriately and implement a reconciliation process to validate submitted data against internal information.	Multi-year, major outpatient improvement project underway including pilot program with GPs to implement eReferral. Regular submission of VINAH data to DHHS, including both state and MBS funded clinics, SACS, and HARP. Internal audit on data integrity completed and further improvements being implemented.	COMPLETED
Ensure the implementation of a range of strategies (including processes and service models) to improve patient flow, transfer times and efficiency in the Emergency Department, with particular focus on patients did not wait for treatment and/or patients that re-presented within 48 hours.	Expand admission beds and continue to implement Timely Quality Care principles to ensure Alfred Health Emergency Departments have better 'did not wait' and '48 hour re-presentations rates' than the state benchmarks.	Full commissioning of Ward 3 West completed and reconfiguration of bed stock across admission/flex and multiday beds has seen an improved performance in the overall emergency access performance. Did Not Wait performance 2.4% against state average of 4.7%; 24-hour re-presentation rate for AH is 3.8% against target of 6%. Emergency and Trauma Centre Redevelopment Project remains on track and within budget for completion in December 2017.	COMPLETED
Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Implement and evaluate the pilot Healthlinks model of care to improve health and reduce hospital admission; and implement and evaluate new clinical structure in the HARP programs to reduce clinical and functional deterioration through a more flexible and client-centred approach to care in the community.	Healthlinks model for patients with pulmonary disease and heart failure implemented. HARP structure review completed and new model implemented to deliver the Healthlinks Program. Agreed Healthlinks funding model for 2017–18 to be confirmed with DHHS.	GOOD PROGRESS
Increase the proportion of patients (locally and across the state) who receive treatment within clinically recommended time for surgery and implement ongoing processes to ensure patients are treated in turn and within clinically recommended timeframes.	Continue to expand surgical access through commissioning of new Alfred Centre procedure room and continue to provide all elective and emergency surgery within clinically recommended times.	Alfred Centre Procedure Room 3 commissioned and operational. Theatre schedule reviewed and additional lists commenced to manage emergency demand. Provided support to other health services to support statewide elective surgery performance.	COMPLETED
Develop and implement a strategy to ensure the preparedness of the organisation for the NDIS and HACC transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Ensure adequate processes (including creation of a project role) are in place to manage NDIS eligible patients admitted to state-wide services from regions which have transitioned to NDIS; and undertake work with VHA and DHHS to identify requirements as a potential provider and support the organisations' interface with NDIS. Ensure organisational readiness for changes to HACC services through new HACC transition working group and up-skill staff to ensure adequate resourcing and referral processes are in place.	Alfred Health NDIS Impact Statement developed to determine impacts and opportunities. NDIS Steering Committee established addressing key areas impacted and identify viable service provision opportunities.	COMPLETED
Health services develop and implement strategies within their organisation to ensure identification of potential organ and tissue donors and partner with DonateLife Victoria to ensure that all possible donations are achieved.	Maintain Alfred Health's position as Victoria's leading site for organ and tissue donation through continued implementation of the Organ and Tissue Donation Guidelines and associated strategies (including training and use of trained requestors, staff education, potential donor audits) overseen by the Organ and Tissue Donation Advisory Committee and further development of innovations to increase donor pool.	In 2016, the Alfred prepared 42 donors, 41 of whom proceeded to donation. The Alfred facilitates approximately 30% of Victoria's actual organ donors. All organ donation guidelines, including Donation after Cardiac Death (DCD) have been updated. DCD and the implementation and commissioning of the Ex-Vivo lung procurement equipment in 2017–18 is likely to further increase the donor pool.	COMPLETED

Performance *(continued)*

DHHS action	Alfred Health deliverable	Progress as at 30 June 2017	Status
Supporting healthy populations			
Support shared population health and wellbeing planning at a local level – aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	Work with Local Governments, Primary Care Partnerships, the South East Melbourne Primary Health Network and local agencies on catchment planning processes including needs identification, priority setting and collaborative responses to shared priorities.	Continue to progress catchment planning processes with SEM PHN with active representation from Alfred Health to support improved collaboration on common priorities. Further stakeholder planning scheduled to occur in July 2017. NW PHN and SEM PHN consulted for Alfred Health Service Plan 2017.	COMPLETED
Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	Continue primary prevention strategies in the areas of healthy food, and physical activity within the Alfred Health setting and through a leadership approach with all Victorian health services. Develop a strategy to systematically identify and respond to modifiable risk factors, including social isolation and psychological distress, for all people who access our services. Investigate models and implement a suitable approach to supporting the reduction of suicide to individuals in our community not otherwise known to Alfred Health.	AH won VicHealth award 2016 – 'Encouraging physical activity'. First Victorian health service to exceed DHHS *Healthy Choices* target. Continued collaboration with DHHS to support all Vic health services in prevention. Suicide Prevention initial scoping undertaken, informed by evidence review and gap analysis. Stakeholder consultation currently underway to confirm proposed actions for implementation in 2017–18. Continued to progress access to health and fitness services for Alfred Health staff, increased access to sit to stand meeting facilities, access to bike servicing in Active Travel zone and engaged a health and fitness provider.	COMPLETED
Develop and implement strategies that encourage a culturally diverse environment such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Increase access to culturally sensitive training and education and engage key stakeholder organisations in the community as partners to improve health outcomes and wellbeing for culturally diverse patients and communities and promote cultural sensitivity practices, as part of the 2016–20 Patients Come First Strategy and plan.	Needs analysis completed and review of existing programs underway. Steering Committee established to determine education collaboration and opportunities to improve interpreter utilisation and other CALD needs.	COMPLETED
Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	Establish a project officer to assist with the Aboriginal employment plan and to increase culturally sensitive staff training and education, as part of the revised 2016–20 Patients Come First Strategy and plan and the Alfred Health Aboriginal Reconciliation Action Plan (RAP), to improve health outcomes, safety and wellbeing for Aboriginal patients and communities.	Alfred Health Aboriginal employment plan developed and Reconciliation Action Plan launched during 2017 NAIDOC/Reconciliation Week.	COMPLETED
Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for mental health and active input into consultations on the design, service and infrastructure plan for Victoria's clinical mental health system.	Participate in service planning including engagement with consumer and carer groups and with DHHS to improve mental health services in south east Melbourne.	In partnership with DHHS, Mental Health Service Plan Report drafted pending approval from Alfred Health Executive and Alfred Health Board.	COMPLETED
Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals and communities.	Undertake a gap analysis against the Rainbow Tick Standards, ensure LGBTI representation on the PCF committee and collaborate with Transgender Victoria to provide education to staff, as part of the revised 2016–20 Patients Come First Strategy and plan to improve health outcomes and wellbeing for LGBTI patients and communities.	Rainbow tick audit completed, gaps incorporated into PCF action plan. Alfred Health leading coordination of a LGBTIQ health sector conference to occur in late 2017; funded by DHHS. Communication strategies to increase inclusivity developed and uploaded to new Alfred TV at the bedside.	COMPLETED
Further engagement with relevant academic institutions and other partners to increase participation in clinical trials.	Develop business cases with academic partners including Monash University to establish phase one clinical trials.	Scoping exercise to understand opportunities to build research partnerships completed. Monash Partners received medical research funding through a Commonwealth Grant.	COMPLETED

DHHS action	Alfred Health deliverable	Progress as at 30 June 2017	Status
Governance and leadership			
Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes, leadership are in place to support the provision of safe, quality, accountable and person-centred healthcare. It is an expectation that health services are implemented to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Undertake a gap analysis of the Alfred Health Clinical Governance Framework against the Victorian Framework and update, implement and evaluate Alfred Health framework as required.	DHHS Clinical Governance Framework only released in June 2017, subsequent to the release of the Duckett Report and the establishment of Safer Care Victoria. Initial gap analysis reveals existing Alfred Health framework is largely consistent and can align accordingly.	GOOD PROGRESS
Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Continue implementation of the Unacceptable Behaviour in the Workplace Policy and Guideline to prevent and eliminate bullying, stalking, harassment and all forms of violence at Alfred Health and develop further initiatives including the flagship Respect project, development of the Occupational Health and Safety and Wellbeing framework and use of Rapid Improvement Workshops.	Occupational Violence Strategy being implemented and embedding respectful behaviours. Key initiatives include: ▪ Expanded policies, including escalation and reporting processes. ▪ Over 1000 frontline staff receiving OV training, including staff in high risk areas. ▪ Embed respectful behaviours, including a Memorandum of Understanding with Royal Australasian College of Surgeons. ▪ Communication campaign to integrate respectful behaviours, including at time of corporate orientation. ▪ Increased access to personal duress systems for high risk areas. ▪ Review of Behaviours of Care models across Alfred Health.	COMPLETED
Board and senior management ensure that an organisational-wide occupational health and safety risk management approach is in place which includes: a focus on prevention and the strategies used to manage risks, including the regular review of these controls; and strategies to improve reporting of OHS incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Develop and implement the Alfred Health Strategic Plan flagship project on respect and quality improvement and in particular development and innovation of the Alfred Health Occupational Health and Safety and Wellbeing framework.	Framework for OHSW agreed and action plan currently being implemented through Executive Committee chaired by CEO. Multiple projects to improve staff safety and wellbeing underway including manual handling in ICU; Treat App (digital mindfulness program); and improving manager understanding of roles and responsibilities.	COMPLETED
Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person-centred care.	Create a skilled, engaged and compassionate workforce through systematic workforce planning and professional development program in priority areas. ▪ Aware program for aggression management. ▪ QI/Change management through Quality Academy Implementation of HRIS to assist in workforce planning strategies.	Aware program rolled out across organisation with over 1,000 staff receiving training in 2016–17. Co-location of quality improvement support services, including redesign and clinical governance to occur in August 2017. Local level quality improvement model and methodology currently being piloted across inpatient wards. Phase 1 HRIS project completed, including payroll systems and online recruitment. Online leave system to be launched July 2018.	GOOD PROGRESS

Performance *(continued)*

DHHS action	Alfred Health deliverable	Progress as at 30 June 2017	Status
Governance and leadership (continued)			
Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	Develop and implement the Alfred Health Strategic Plan flagship project on respect and quality improvement leading to open communication and staff engagement; Alfred Health Quality Academy in place (standardised and integrated QI and change management systems and process), 50% of teams have completed their Respect Projects, informed by PMS and other survey data. Continue to develop consumer and community engagement strategies including a range of feedback mechanisms, advisory groups and consultation strategies.	People Matter Survey completed in May 2017, demonstrated consistently high results for staff satisfaction, and efforts to improve how we communicate, implement and manage change has seen positive results. Continued to develop and expand consumer and community engagement strategies though a range of mechanisms including: Cystic Fibrosis Advisory Group, HIV Services Advisory Group and consumer participation in leadership forums.	GOOD PROGRESS
Ensure that the Victorian Child Safe standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse to children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Develop a child safe strategy at Alfred Health to embed an organisational culture of child safety. The strategy will address the Victorian Government's seven child safe standards and will include assisting staff, patients, carers and our broader community to: prevent child abuse, encourage reporting of any abuse that does occur and improve responses to allegations of child abuse. The following principles will be included in meeting each standard; promoting the cultural safety of Aboriginal children, promoting the cultural safety of children from culturally and/or linguistically diverse background and promoting the safety of children with a disability.	Gap analysis conducted to seven child safe standards; organisational work plan developed and under implementation. Working with Children Policy agreed, staff questionnaire completed by all areas working with children and results to be collated.	COMPLETED
Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	95% of staff with patient contact in high risk areas to be assessed for vaccination status/immunity and offered vaccination where appropriate (High risk defined as ED, ICU, 5E, 3CTC, 7E, dialysis). 85% of new staff with patient contact to be assessed for vaccination status/immunity and offered vaccination where appropriate. 75% of staff with patient contact in non-high risk areas to be assessed for vaccination status/immunity and offered vaccination where appropriate.	Influenza campaign 2016 achieved 84% staff vaccinated. Vaccination plan for 2017 developed and implemented with targeted campaign for high and medium risk areas achieving improved organisation-wide uptake. This resulted in follow-up on 100% of staff with outstanding or incomplete vaccinations.	COMPLETED
Financial sustainability			
Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Continue to improve cash management practices to build on gains made in available cash by: ▪ Improved monitoring and planning of capital expenditure in line with the Asset Management Framework guidelines. ▪ Continued improvement in working capital management especially a further reduction in debtor days following investment in the new billing system. ▪ Continued improvement in current asset ratio and days available cash measures towards the state-wide benchmarks.	Asset Management Framework compliance work plan has been achieved and the project is on track to meet full compliance in 2017–18 as required under the Standing Directions. Patient debtor days have reduced during 2016–17, remaining below the DHHS benchmark. Cash management remains a key priority while still funding an ambitious capital program and this is managed within the funding received from all government and non-government sources while still improving the current asset ratio.	GOOD PROGRESS
Actively contribute to the development of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	The Alfred Health Environmental Management Plan includes an active program to promote and manage sustainable work practices and reduce waste. Environmental performance will continue to be publically reported annually.	Environment Management Plan developed, including establishment of governance arrangements. Waste management and recycling best practice initiatives being implemented in recent capital work design across The Alfred site.	COMPLETED

Part B: Performance Priorities

Quality and safety

Accreditation	Target	2016–17 actuals
Compliance with NSQHS Standards accreditation	Full compliance	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Achieved

Infection prevention and control	Target	2016–17 actuals
Compliance with cleaning standards	Full compliance	Achieved
Very high risk (Category A)	90%	Achieved
High risk (Category B)	85%	Achieved
Moderate risk (Category C)	85%	Achieved
Compliance with the Hand Hygiene Australia program	80%	81%
Percentage of healthcare workers immunised for influenza	75%	84%

Patient experience	Target	2016–17 actuals
Victorian Healthcare Experience Survey – data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	94.8%
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	94.2%
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	92.1%
Victorian Healthcare Experience Survey – discharge care Quarter 1	75% very positive response	84%
Victorian Healthcare Experience Survey – discharge care Quarter 2	75% very positive response	86.9%
Victorian Healthcare Experience Survey – discharge care Quarter 3	75% very positive response	82.9%

Healthcare associated infections	Target	2016–17 actuals
Number of patients with surgical site infection	No outliers	Not achieved
ICU central line associated blood stream infection	No outliers	Not achieved
SAB rate per occupied bed days	< 2/10,000	0.97/10,000

Mental health	Target	2016–17 actuals
Percentage of adult inpatients who are readmitted within 28 days of discharge	14%	15%
Rate of seclusion events relating to an acute admission – composite seclusion rate	≤ 15/1,000	11/1,000
Rate of seclusion events relating to an adult acute admission	≤ 15/1,000	13/1,000
Rate of seclusion events relating to an aged acute admission	≤ 15/1,000	2/1,000
Rate of seclusion events relating to a child and adolescent acute admission	≤ 15/1,000	N/A*
Percentage of adults patients who have post-discharge follow-up within seven days	75%	86%
Percentage of aged patients who have post-discharge follow-up within seven days	75%	92%
Percentage of child and adolescent patients who have post-discharge follow-up within seven days	75%	92%

** This KPI is not applicable as there are no Child and Adolescent acute mental health beds at Alfred Health*

Continuing care	Target	2016–17 actuals
Functional independence gain from admission to discharge, relative to length of stay	>0.39 (GEM)	0.73
	>0.645 (Rehab)	0.7

Governance and leadership

	Target	2016–17 actuals
People Matter survey – percentage of staff with a positive response to safety culture questions	80%	91%

Performance *(continued)*

Part B: Performance Priorities (continued)

Access and timeliness

	Target	The Alfred actuals	Sandringham Hospital actuals
Percentage of ambulance patients transferred within 40 minutes	90%	85%	89%
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	78%	78%
Percentage of emergency patients with a length of stay less than four hours	81%	78%	82%
Number of patients with length of stay in the Emergency Department greater than 24 hours	0	0	0

Elective Surgery	Target	Actuals 2016-17
Percentage of Urgency Category 1 elective patients treated within 30 days	100%	100%
Percentage of urgency category 1, 2 and 3 elective patients admitted within clinically recommended timeframes	94%	97%
20% longest waiting Category 2 and 3 removals from the elective surgery waiting list	100%	98.7%
Number of patients on the elective surgery waiting list	2,000*	1,871
Number of Hospital Initiated Postponements per 100 scheduled admissions	8	4
Number of patients admitted from the elective surgery waiting list – annual total	11,500	11,619

** as at 30 June 2017*

Specialist clinics	Target	Actuals 2016-17
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	92.7%
Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%	93.4%

Finance

	Target	2016-17 actuals
Operating result ($m)	$0	$0.20M
Trade creditors	60 days	46 days
Patient fee debtors	60 days	49 days
Public & private WIES performance to date	100%	104%
Adjusted Current Asset Ratio	0.7	0.62
Number of days with available cash	14	0.90

Asset management		
Basic asset management plan	Full compliance	Achieved

Part C: Activity and funding

	2016–17 activity achievement
Acute Admitted	
WIES DVA	917
WIES Private	15,643
WIES Public	88,878
WIES TAC	6,415
Acute non-admitted	
Radiotherapy WAUs DVA	1,755
Radiotherapy WAUs Public	82,003
Home Renal Dialysis	113
Home Enteral Nutrition	904
Aged Care	
HACC	15,254
Subacute & Non-acute Admitted	
Transition Care – Bed days	23,836
Transition Care – Home day	5,926
Subacute WIES – GEM Private	608
Subacute WIES – GEM Public	2,024
Subacute WIES – Rehabilitation Private	435
Subacute WIES – Rehabilitation Public	1,316
Subacute WIES – DVA	85
Subacute Non-Admitted	
Health Independence Program – Public	97,830
Mental Health and Drug Services	
Mental Health Ambulatory	66,462
Mental Health Residential	5,980
Mental Health Subacute	2,821
Mental Health Inpatient – Bed days	24,763
Primary Health	
Community Health/Primary Care Programs	18,869
Other	
NFC – Paediatric Lung Transplantation	2
Health Workforce	219

Performance *(continued)*

Financial summary 2016–17

The operating result for 2016–17 was a $0.2 million surplus. The result is in line with the operating result target in the Statement of Priorities.

Revenue increased by $83.2 million, largely due to government grants and pharmaceutical revenue from activity growth throughout the health service.

The comprehensive result was a loss of $0.3 million, compared to a profit of $13.5 million in the previous year. This was largely due to an asset revaluation of $26.4 million in 2016–17 compared to a $36.0 million revaluation in the previous year.

During the year Alfred Health continued to find financial savings and efficiency improvements while providing excellent patient care. The operating surplus is a result of the organisation continuing its commitment to achieving savings targets through efficiency programs and close monitoring of the costs of growing activity.

	2016-17 $M	2015-16 $M	2014-15 $M	2013-14 $M	2012-13 $M
Total Revenue	1,145.5	1,062.3	975.3	915.7	894.5
Total Expenses	1,145.3	1,058.0	975.4	915.4	891.6
Operating Result*	**0.2**	**4.3**	**(0.1)**	**0.3**	**2.9**
Capital and Specific Items	(24.6)	(24.1)	(30.8)	(25.1)	(25.3)
Other Economic Flows	(4.1)	(4.5)	0.3	(0.1)	(2.8)
Net Result for the Year	**(28.5)**	**(24.3)**	**(30.6)**	**(24.9)**	**(25.2)**
Other	28.2	37.8	2.3	286.7	7.9
Comprehensive Result	**(0.3)**	**13.5**	**(28.3)**	**261.8**	**(17.3)**
Retained Surplus/Deficit	(250.5)	(228.1)	(186.5)	(159.4)	(141.5)
Total Assets	1,096.9	1,085.1	1,056.8	1,086.2	808.2
Total Liabilities	306.2	294.1	279.4	265.1	248.9
Net Assets	790.7	791.0	777.4	821.1	559.3

* *The operating result is the result for which the hospital is monitored in its Statement of Priorities also referred to the Net result before capital and specific items. The prior year operating result comparatives have been restated to reflect the presentation of Other Economic Flows.*

** *Other includes Asset revaluation and Investment revaluation.*

Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2016-17 is $34.5m (excluding GST) with the details shown below.

($ million)

Business As Usual (BAU) ICT expenditure	Non-Business As Usual (non-BAU) ICT expenditure	Operational expenditure	Captial expenditure	Year
$27.0m	$7.5m	$4.1m	$3.4m	30-Jun-17

Research through partnership

This year's achievements included progression on landmark peanut vaccine trials, a new blood cancer research centre and 'study of the year' award.

Major research highlights

Across our health network, clinical research is undertaken in a range of important areas, bringing major benefits to our patients.

Here were some of the highlights:

World-first: peanut allergy treatment

Human clinical trials of a world-first peanut allergy treatment began in June. Researchers are focusing on the molecular parts of the potent nut allergen that are needed to build tolerance, while removing the risk of a severe reaction.

The technology, which is being developed by Australian biotechnology company Aravax, is underpinned by more than 15 years of research led by respiratory physician Professor Robyn O'Hehir and her team at The Alfred and Monash University.

The treatment uses new technology that resets the immune system so that it tolerates peanut without causing any allergic reactions. The research has been supported by the Australian Food Allergy Foundation, Gandel Philanthropy, the Alfred Hospital Trust, and the National Health and Medical Research Council.

Prep X expansion

This year The Alfred's ground-breaking study providing people at risk of HIV with access to the life-changing medication Pre-exposure prophylaxis (PrEP) expanded.

PrEP is a life changing HIV prevention medication for people at risk of HIV infection. More than 2600 at-risk Victorians are now accessing the drug through the Victorian-first PrEPX study, run by The Alfred in collaboration with community groups, clinics and GPs.

The study was expanded into rural and regional sites providing access to 150 places in the study in early 2017. New sites opened at Ballarat, Shepparton, Bendigo, Mildura and Sale, Geelong and Wodonga.

Most recently, the study was expanded into South Australia thanks to a new partnership with South Australian Health and Medical Research Institute (SAHMRI) and SA Health.

The study also received a $100,000 funding boost from the Victorian AIDS Council (VAC) during the year, allowing an extra 600 people to take part in the study, which had an extensive waitlist. The study is sponsored by the Victorian Government, VAC and Alfred Health.

Image (right): Alfred Health ensures research and clinical care work hand in hand, for the benefits of our patients.

Research through partnership *(continued)*

New blood cancer research centre

The Alfred and Monash University are set to establish Australia's first dedicated blood cancer research centre, thanks to a $1.2 million grant from the Australian Cancer Research Foundation (ACRF).

The ACRF Blood Cancer Therapeutics Centre, based at The Alfred, will be home to the latest technology available in blood cancer research and will enable researchers to dramatically improve outcomes for patients with blood cancer.

The new centre will enable researchers to find out more about these cancers, discover more effective therapies, track patient treatment responses up to 1000 times more closely, and improve therapies to get better outcomes overall for patients.

The Blood Cancer Therapeutics Centre will collect and analyse samples from across the country. It is one of only four projects nationally to receive an ACRF grant this year.

Tony Charlton Chair Oncology

In honour of Tony Charlton, who spent more than 20 years supporting the hospital, The Alfred established its first ever Chair of Oncology.

The role seeks to foster the translation, acceleration and transfer of research findings into clinical practice, making a positive difference to the health, wellbeing and quality of life for thousands of Victorians fighting cancer.

Inaugural Tony Charlton Chair – Professor John Zalcberg OAM – is a researcher and gastrointestinal oncology clinician. He currently holds the position of Head, Cancer Research Program in the School of Public Health and Preventive Medicine within the Faculty of Medicine, Nursing and Health Sciences at Monash University.

Research awards

Australian Trial of the Year

The Alfred's Director of Anaesthesia and Perioperative Medicine, Professor Paul Myles, and his team were awarded Australian Trial of the Year for their worldwide study exploring the risks associated with aspirin and Tranexamic acid (TXA).

The award – part of the Clinical Trials 2017 – recognises remarkable Australians who undertake ground-breaking clinical trials. The study, led by The Alfred and Monash University, shows that TXA can nearly halve the number of people who suffer complications with bleeding following open heart and other major surgery.

Innovative research award

Associate Professor Julian Elliott, an HIV physician at The Alfred and a researcher at Monash University and Cochrane Australia, has received the prestigious Commonwealth Health Minister's Award for Excellence in Health and Medical Research. This annual award recognises the top-ranked Career Development Fellowship (CDF) applicant through the National Health and Medical Research Council (NHMRC).

Using this funding, A/Prof Elliott and his team will be able to continue their innovative work developing new systems to analyse and simplify medical research. This includes online platforms, artificial intelligence and the 'citizen science' website – where members of the public help process research articles. A/Prof Elliott's work focuses on making sure the findings of research translate into action and improved health, using new technologies and ways of collaborating to make that easier.

AMREP

Alfred Health is a collaborative partner in the Alfred Medical Research and Education Precinct (AMREP) with Monash University, Baker Heart and Diabetes Institute, Burnet Institute, La Trobe University and Deakin University. Each year, the AMREP Council monitors a selection of research outputs: external research funding, peer reviewed publications, and completed and passed masters and doctoral degrees.

In 2016, AMREP researchers secured more than $100 million in external research funding, of which just over half was from the National Health and Medical Research Council (NHMRC). During the year, 237 students completed their masters and doctoral degrees.

In 2016, AMREP had a total of 1,972 publications including refereed journal articles, book chapters and books.

Academic Health Science Centre update

The Monash Partners Academic Health Science Centre, of which Alfred Health is a lead partner, continued to work towards enhancing the health of our community. The Federal Government has committed more than $2 million to Monash Partners to support high impact research projects that deliver direct clinical benefit and better health outcomes. Monash Partners will also lead the development of a national data strategy through the national alliance of Academic Health Science Centres. During the year Monash Partners:

- developed a model to streamline research ethics and governance review
- established and delivered a large-scale clinical research training program
- established data executive and jointly agreed data integration priorities
- led engagement with government that delivered $2.2M in funding for new high impact health innovation projects
- engaged broadly to enhance and integrate research, education and clinical care.

NHMRC funding

Alfred Health researchers were lead investigators of several new NHMRC grants commencing in 2017.

Centres of Research Excellence:

Professor Peter Cameron: Centre of Research Excellence in pre-hospital emergency care. 2016–2021: $2,499,625

Project Grants

- **Professor Stephen Bernard:** Targeted therapeutic mild hypercapnia after resuscitated cardiac arrest: a phase III multi-centre randomised controlled trial (The TAME Cardiac Arrest Trial). 2017–2021: $2,069,878
- **Dr Eric Chow:** A randomised controlled trial of daily antibacterial mouthwash to reduce pharyngeal gonorrhoea among men who have sex with men (MSM). 2017–2019: $376,730
- **Professor Jamie Cooper:** The prophylactic hypothermia to lessen traumatic brain injury –randomised controlled trial: Continuation of funding request. 2017–2018: $266,321
- **Dr Carol Hodgson:** Treatment of invasively ventilated adults with early activity and mobilisation. 2017–2021: $1,467,137
- **Professor Jayashri Kulkarni:** A randomised controlled trial of NMDA antagonist, memantine, for the treatment of borderline personality disorder. 2017–2019: $993,067
- **Professor Robert Medcalf:** The effect of anti-fibrinolytic drugs on blood-brain barrier integrity and the immune response in traumatic brain injury. 2017–2020: $870,476
- **Dr Trisha Peel:** The Arthroplasty Surgical Antibiotic Prophylaxis (ASAP) Study. 2017–2021: $3,473,554
- **Professor Anton Peleg:** Systems-level characterisation and therapeutic targeting of small RNAs in Acinetobacter baumannii disease. 2017–2020: $581,990

- **Associate Professor Jake Shortt:** Molecular & translational characterisation of IMiD-mediated BET-protein degradation in multiple myeloma. 2017–2019: $551,344
- **Associate Professor Andrew Wei:** Toward effective targeted therapies for Acute Myeloid Leukaemia (AML). 2017–2019: $551,344

Translational Research Projects

- **Dr Carol Hodgson:** Early identification of disability to inform better care and outcomes in high risk patients. 2017: $97,000.

Practitioner Fellowships

- **Professor Anton Peleg** (2017–2021)

Career Development Fellowships

- **Dr Julian Elliott** (2017–2020)

Early Career Fellowships

- **Dr Narelle Cox** (2017–2020)
- **Dr Stuart Marshall** (2017–2020)
- **Associate Professor Andrew Udy** (2017–2020)

Research Poster Display and Research Day

The 2016 Alfred Week Research Poster Display in October showcased 162 research posters from across AMREP, with prizes awarded to those judged to be the best in their category.

Research Day featured a keynote address by Professor Joseph Trapani, Executive Director Cancer Research and Head of Cancer Immunology Program, Peter MacCallum Cancer Centre, titled *The long awaited advent of cancer immunotherapy – a fourth pillar of therapy for cancer.*

Presentation of the AMREP Research Prizes followed. These prizes are awarded annually for the highest impact original clinical and basic research articles published by AMREP researchers in the previous year.

Projects and infrastructure

Redeveloping our cardiac ward and The Alfred's Emergency and Trauma Centre were key projects this year, as were some important developments in IT infrastructure. With limited remaining clinical space at The Alfred, planning began to move Executive and administrative staff to create extra patient treatment areas.

3 West ward redevelopment

During the year, the 3 West ward redevelopment was completed. This included the refurbishment of the ward and new infrastructure. The 22-bed cardiac ward now has:

- four higher-end single rooms with ensuites
- a new Cardiac Day Procedure Unit (DPU) facility with eight beds and four chairs
- a new waiting area
- training room and shared staff room.

The refurbished facility, which has been well received by patients and staff, was funded by The Alfred Foundation's partnership with the community and donor contributions.

Special Care Nursery

Sandringham Hospital's Special Care Nursery has been fully redeveloped, following funding from DHHS. The new facility provides for an eight-bed (Level 4 facility), with a contemporary, relaxing environment, with facilities for families to help with parenting and the transition to home. It also includes facilities for teaching, including video conferencing and use of the electronic medical record at the bedside. The new facility will be fully operational from July 2017 and is a welcome addition to the Women's at Sandringham Maternity Service.

Emergency and Trauma Centre redevelopment

This year the Emergency Department Redevelopment Project has seen the completion of external works, which includes a new ambulance entry and egress and a public entry for vehicles and pedestrians. Internally, construction of the new public entry and waiting area is almost complete, as is the provision of a dedicated Behaviour of Concern (BOC) area. Work this year has also included:

- the construction of accommodation for a second MRI
- commencement of demolition and infrastructure works around the department.

This project, which is due for completion at the end of 2017, has been made possible due to the significant support of the Eva and Les Erdi Humanitarian Charitable Foundation.

Infrastructure and maintenance works

Description	2013 $'000	2014 $'000	2015 $'000	2016 $'000	2017 $'000
Plant & non-medical Equipment	1,361	1,832	1,598	2,018	2,325
Buildings	2,437	2,320	3,475	4,368	6,039
Grand Total	**3,798**	**4,152**	**5,073**	**6,386**	**8,364**

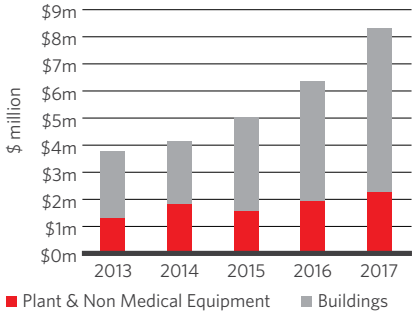
Site infrastructure and facilities upgrades continued as a major focus and included:

- Fire services upgrade works are due to be completed by late-2017
- The upgrade to lifts continues with funding to replace the Centre Block lifts. These works are due for completion by the end of 2017.
- Improvements to the functionality and safety of the helipad.
- A 'rolling stock' upgrade to bathrooms and amenities including:
  - the Aged Care building – Caulfield Hospital
  - mental health facilities – inpatient and community based
  - main ward areas.

Some of our ageing buildings, particularly at Caulfield Hospital and The Alfred, regularly require maintenance. Caulfield Hospital's rehabilitation wards in the 'Breezeway' receive the most patient and family complaints regarding poor infrastructure.

Over recent years, the increasing maintenance and repair costs relating to infrastructure and buildings highlight our ageing infrastructure.

Building and infrastructure maintenance costs



In June 2017, the Victorian Government announced funding through the Engineering Infrastructure Replacement Program, with $9.4 million for Alfred Health to replace the sewerage and stormwater system.

Capital projects all focus on improving facilities for our patients and their families and carers.

Planning for new ward

With The Alfred facing issues of capacity, planning has commenced for creating a new ward on the fifth floor of The Alfred's main ward block. This new ward will allow the early recovery of trauma patients. The current clinics, clinical research and sleep studies for respiratory medicine will move to alternative areas.

The assessment of functional needs for this project has been completed and two new locations are required to support our respiratory service and maintain high-quality clinical care:

- East Block, second floor, for clinical services, research areas and offices
- The Alfred Centre, ground floor, for a new purpose built sleep laboratory.

These proposed new locations will offer better facilities, proximity to clinical areas and improved separation of patients with differing infection risks. It is anticipated that services will be relocated in early 2018.

Projects and infrastructure *(continued)*

Investment in IT infrastructure

New projects that improve our clinical care are a focus over the next five years:

eTQC connected care

- **Electronic medical record:** The eTQC (electronic Total Quality Care) program is a five-year program (2016–2021) to transition our current hybrid (electronic and paper-based) clinical information system to an integrated electronic medical information system, digitising our health system. The eTQC program will:
  - introduce or expand the use of digital clinical documentation across the organisation
  - support patient engagement in their clinical care
  - introduce system work flows and standardised order sets for standardised clinical pathways, and interdisciplinary plans of care
  - introduce electronic medication management
  - increase data quality and accessibility.

  The first phase of eTQC will go live in late 2018, with the implementation of comprehensive clinical documentation, medication management and clinical decision support tools across inpatient areas. The initial phase will also see the introduction of a patient portal, further supporting engagement of patients and their families' involvement in their healthcare.

iPM Patient Administration System

- **iPM project:** We replaced three separate Patient Administration Systems with one single shared service (iPM) in June 2016. The successful implementation resulted in:
  - removal of duplicate entries
  - introduction of a single Alfred Health-wide identifying number (UR), rather than separate numbers for each hospital campus
  - improved accuracy of statutory reports, such as the Victorian Admitted Episodes Dataset (VAED).

High value equipment and infrastructure funding

In 2016–17 Alfred Health was allocated $7.8 million in funding from DHHS' High Value State-wide Replacement and Violence Prevention Funds.

The funded projects were:

	$'000
Medical equipment	
Angiography Unit – Bi Plane	$1,600
MRI 1.5T	$600
Echocardiography systems (2)	$660
Bio-chemical analysers (2)	$700
Infrastructure works	
Chillers replacement	$500
Building controls systems	$500
Fire ring main works	$1,000
Hydraulic services upgrade	$1,300
Violence prevention	
Entry /arrival to Mental Health Inpatient Unit	$385
Duress alarm system – community staff	$60
Main Ward Block – entry management	$500

Building projects status

Alfred Health obtains building permits for new projects, where required, as well as certificates of occupancy or certificates of final inspection for all completed projects.

Projects completed (*with certificates of final completion*):

The Alfred –	Main Ward Block level 3 West
The Alfred –	Medical Record refurbishment
The Alfred –	Renal office refurbishment
The Alfred –	MWB stairwell refurbishment
The Alfred –	Philip Block capping replacement
The Alfred –	Philip Block – electrical upgrade
The Alfred –	Helipad upgrade
The Alfred –	Procedure room / theatre works
Caulfield –	Baringa bathroom upgrade
Sandringham –	Special Care Nursery

Projects with building permits under construction:

The Alfred –	Interim fire upgrade works
The Alfred –	Lift upgrades projects (Centre block)
The Alfred –	Emergency Department redevelopment
The Alfred –	Pathology core laboratory works

In line with the *Building Act 1993*, Alfred Health used registered building practitioners on all building projects, with maintenance of their registered status for the duration of the works a condition of their contract. We maintain all buildings in a safe and serviceable condition, with routine inspections and ensure that we undertake scheduled maintenance programs. We also inspected all buildings' essential services for compliance, as required by legislation.

Community and environment

Engaging our volunteers through new programs and training, ongoing initiatives to improve health and a renewed focus on environmental sustainability ensured strong relationships with our community continued.

Health promotion and prevention

Healthy Choices

Ongoing work with retailers has ensured we have maintained our healthy food targets, with all our retail outlets providing more than 50 per cent of foods and drinks that are rated 'green' or most healthy, and no more than 20 per cent that are rated 'red' or least healthy. To further our work in Healthy Choices, we took an innovative approach and examined how traffic light labelling and clever 'nudge' lines impacted purchases of foods. Results found a significant shift in consumer purchasing towards healthier 'green' food choices (26 per cent increase) and away from 'red' choices (17 per cent decrease), while maintaining financial viability for the retailer. This labelling has now been expanded to Caulfield and Sandringham Hospitals and has gained significant interest from other organisations.

P.A.R.T.Y program boost

The Alfred's highly successful P.A.R.T.Y (Prevent Alcohol and Risk-related Trauma in Youth) Program will be extended until 2019, thanks to a Victorian Government funding boost. P.A.R.T.Y graphically demonstrates the consequences of risky behaviour, including drug and alcohol use, by showing secondary school students the costs first-hand. Each year, more than 200 schools across the state take part in the program, which enables students to tour the Emergency Department, ICU, trauma and burns wards. Since the program began in 2009, around 5800 students from 148 schools across Victoria have taken part. The Alfred also has an outreach component, where teams travel to regional Victoria to educate youth in other areas.

Community engagement

100 years of care

This year Caulfield Hospital marked its centenary – 100 years since first being opened to care for thousands of First World War soldiers in 1917.

Caulfield Hospital was first established as the Number 11 Australian General Hospital to care for and rehabilitate more than 18,000 soldiers and nurses returning from the First World War. An Anzac Day event at the hospital celebrated this history and included participation from the City of Glen Eira, Member for Caulfield, the Grimwade Centre for Cultural Materials Conservation at University of Melbourne and a large gathering of past and present staff and patients.

Local recognition

Two members of the Sandringham Hospital Day Procedure Centre Capital Appeal Steering Committee were awarded Australia Day and Queen's Birthday honours respectively. Mrs Janet Spooner DGSJ was awarded a Medal of the Order of Australia (OAM) on Australia Day for service to the community through charitable organisations. Mr Alistair Murray was appointed as a Member of the Order of Australia (AM) for significant service to sailing, as a supporter of young sports people, and to the marine manufacturing and export industry.

Image (right): We work to keep our patients happy and comfortable, but we're also involved in helping our community stay healthy and out of hospital too.

Community and environment *(continued)*

Alfred Health volunteers

Alfred Health Volunteers

524
volunteers across our organisation

256
at The Alfred

138
at Caulfield Hospital

130
at Sandringham Hospital

This year an extra 95 new volunteers have entered The Alfred and Caulfield hospitals and 31 at Sandringham Hospital.

Volunteer training

An orientation day attracted 52 people this year. Four information sessions were held for 70 people and 66 of those applied to volunteer at our hospitals. Other training was held for:

- volunteer consumers
- specialised emergency and trauma volunteers
- wayfinding app volunteer user testing
- hand foot massage training.

Emergency and Heart volunteers

Extra volunteers were placed into our Emergency & Trauma Centre at The Alfred, in anticipation of the improvements that will be occurring there as a result of the redevelopment. Volunteers were also involved in the Heart Centre letter scanning project, helping patients operate the new system which allows them to check in on arrival.

Patient Pals

The Patient Pal program is a new volunteer program in Sandringham Hospital's Ward F2 (Medical Ward). The program is designed to give support to our elderly and dementia patients at meal times via verbal cueing and encouragement to eat and drink. These volunteers also read to patients, play games and give hand rubs, as part of a wellbeing effort. Many of these patients suffer from loneliness and boredom, but daily visits from volunteers has made a positive difference.

Gifts and donations

The Alfred Foundation

The Alfred Foundation raised more than $12 million for The Alfred in 2016–17.

Through remarkable community support, The Alfred Foundation was able to continue to positively impact the lives of the hospital's patients and their families. This generous support came from individuals, community groups, estates, corporate partners, trusts and foundations, and media organisations.

The Foundation's major fundraising activities were focused on supporting The Alfred's Trauma Service expansion.

Significant support was received from:

- Estate of Anthony Doble
- Eva & Les Erdi Humanitarian Charitable Foundation
- Estate of Colin Frank Such
- Elgin and Leslie Charles Gordon
- Mr Michel Thévenot
- The Margaret Pratt Foundation
- Merrin Foundation
- Bulla Dairy Foods
- Estate of Dudley Barton Adams
- Fox Family Foundation
- AAMI
- Dry July Foundation
- Rotary Club of Greater Dandenong
- Gandel Philanthropy
- The Pratt Foundation
- The Muriel May & Les Talbot Batten Foundation
- Estate of Elizabeth Bodnar
- Estate of Yolantha Reisner

Trauma Service expansion

This project will see the hospital redevelop the fifth floor of the Main Ward Block into a specialised trauma inpatient ward – the hospital's first, purpose-built facility dedicated to the early recovery of trauma inpatients.

Women@The Alfred

Since 2001, Women@The Alfred has championed men's health, raising millions of dollars for The Alfred. In 2016–17, the group's dedicated support for the hospital continued with the 13th Annual Chairman's Lunch. The event, which raised funds for the purchase of new, state-of-the-art medical equipment, brought together over 600 of Melbourne's most influential leaders in business, health, sport and the media.

Community fundraising

The Alfred continued to receive support from individuals and groups organising community fundraising events in support of the hospital.

For the fourth consecutive year, The Alfred was named as a beneficiary of Dry July, the national fundraiser which aims to raise funds for adults living with cancer. The event continued to draw increased support, and funds raised were used to improve areas used by cancer patients and their families.

Alfred staff and supporters once again took part in Run Melbourne. The event provides the Foundation with an opportunity to connect with our fundraisers and the community. Funds from the 2016 event went towards supporting The Helen Macpherson Smith Burns Unit at The Alfred.

Father's Day Appeal

In the 16 years since its inception, The Alfred Father's Day Appeal has raised millions of dollars to improve the care that the hospital offers to men, their families and the entire community. With Bulla Family Dairy coming on board as a major sponsor, this year's Appeal encouraged men to become 'Healthy Heroes' and take responsibility for both their mental and physical health.

The annual festivities kicked off with long-time supporter 3AW's traditional broadcast from inside the hospital. As part of the live broadcast, 3AW radio personalities were joined on air by a number of The Alfred's leading clinicians as well as a host of current and former patients. The annual *Healthy Men* publication this year focused on educating men about mental health. Funds raised from the appeal went towards the Cardiac Day Procedure Unit redevelopment.

Life Support Committee

This committee continued to help the hospital minimise the devastating impact of trauma on the Victorian community. Over the past year, the committee hosted successful fundraising events, including a jazz function and, for the fourth consecutive year, a marquee at the Portsea Polo.

In 2016–17, The Alfred Foundation Board comprised:

- Sir Rod Eddington AO (Chairman)
- Mr Ian Cootes AM (Deputy Chairman)
- Mr Peter Barnett
- Mr Ravi Bhatia
- Mr Anthony Charles
- Mr Didier Elzinga
- Mr Peter Fox AM
- Mr Michael Kiely
- Mr Eddie McGuire AM
- Ms Angela Mihelcic (Director, The Alfred Foundation)
- Mr Chris Nolan (Chairman, Father's Day Appeal)
- Mr Tony Phillips
- Mr George Richards
- Mr Rob Sayer
- Mr Paul Sheahan AM
- Mrs Carolyn Stubbs OAM (Chairman, Women@theAlfred)
- Professor Andrew Way (Chief Executive, Alfred Health)
- Mr Alan Williams
- Sir Donald Trescowthick AC KBE (Patron)

Caulfield Hospital Fundraising

Pin & Win

Alfred Health was the preferred charity for the Melbourne Racing Club for the 2016 Pin and Win promotion. The popular pins were sold by many volunteers at the Caulfield Cup Carnival and other MRC racing events including those at Mornington from September to December 2016. The Pin and Win promotion was supported by a number of businesses who donated the prizes, sold the pins and also provided volunteers. Racing identity Matt Cumani was the event ambassador.

Auxiliary support

The onsite Helmsmen Auxiliary Kiosk once again provided the hospital with an annual donation of over $56,000. Since its formation in 1979, the volunteers who run the kiosk have raised more than $1.1 million for hospital equipment and programs. This year's donation was used to purchase equipment for the Aged Care Wards, Baringa Aged Psychiatry and inpatient rehabilitation wards and included pressure relief mattresses, vital signs machines, patient hoist, shower chairs and a bladder scanner.

Significant support was received from:

- Estate of John Alexander Earle
- Helmsmen Auxiliary Kiosk
- Mrs Pamela Durra
- Mr Wilfrid Omer-Cooper
- The Estate of Henry Herbert Yoffa
- Queenscliff Football & Netball Club

Sandringham Hospital Fundraising

Day Procedure Centre Capital Appeal

Many local organisations and residents have supported the appeal to raise funds to build the same-day surgical procedure centre. This has included a significant contribution by the Sandringham Community Bank, after which the centre will be named. With State Government funding awarded to support the construction, more than $2.3 million has been secured towards the $2.5 million target.

Community support

Sandringham Hospital received generous support from individuals, community groups, businesses and trusts and foundations this year.

Major fundraising events held in support of the hospital included the Black Rock Sports Auxiliary Annual Charity Golf Day at Royal Melbourne Golf Club, the Sandringham Hospital Staff 24-hour Walk, Oaks Day lunches at Sandringham Yacht Club and Royal Brighton Yacht Club, the inaugural *A Lunch by the Bay* fundraising luncheon and the Brighton Golf Club Ladies Charity Day.

Community support enabled the purchase of new medical equipment including a defibrillator and crash cart to care for critically ill patients, patient monitors to provide a live reflection of a patient's vital signs following surgery, new beds, pressure relieving mattresses and an isolette to provide a controlled environment for babies receiving care in the Special Care Nursery.

Significant support was received from:

- Sandringham Community Bank Branch of Bendigo Bank
- Black Rock Sports Auxiliary
- Brighton Golf Club Ladies Charity Day
- Collier Charitable Fund
- F & M Hofmann
- In memory of Mr Raymond Woff
- J & Hope Knell Trust Fund
- Lions Club of Beaumaris
- Lions Club of Moorabbin
- Moorabbin Airport and the Goodman Foundation
- Rotary Club of Bentleigh Moorabbin Central
- Rotary Club of Hampton
- Royal Brighton Yacht Club
- Sandringham Hospital Kiosk Auxiliary
- Sandringham Yacht Club
- Sandringham Hospital Staff 24-hour Walk
- The Gary Thomson Endowment

Community and environment *(continued)*

Environmental sustainability

Environmental performance reporting

The environmental data management system (EDMS) monitors our environmental performance in:

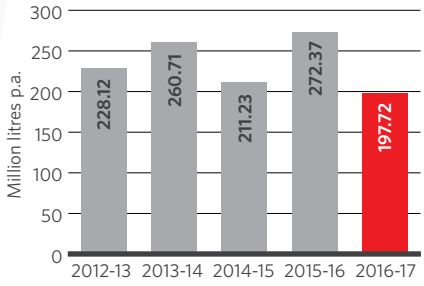
- energy and water consumption, and carbon emissions
- environmental impacts
- site contribution – expenditure and environmental impacts for the largest sites in the organisation.

It is expected the EDMS will be expanded in 2017–18 to include waste, paper and transport impacts.

Water consumption

Water consumption for 2016–17 totals 198 ML, this has decreased by 74 ML (-29 per cent expenditure) when compared to the reporting year 2015–16, due to infrastructure improvements to the condensate (steam) plant.

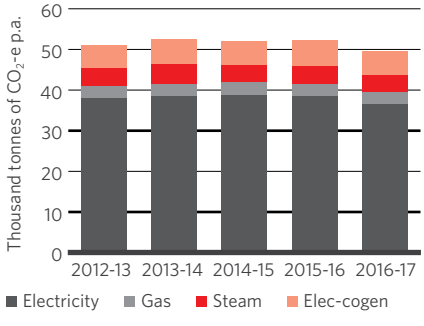
Alfred Health total water consumption



Impacts and emissions

Environmental impacts and associated carbon emissions at Alfred Health have remained relatively consistent over the last five financial years, with electricity (including Cogen), gas and steam producing 49.53 thousand tonnes of CO_2e in 2016–17 and 52.18 thousand tonnes CO_2e in 2015–16.

Alfred Health total carbon emissions (electricity, cogen, gas, steam)



Expenditure versus environmental impacts

Costs associated with electricity (including Cogen), gas, steam and water for 2016–17 decreased by 6 per cent from the previous financial year. This is due to the decrease in water consumption.

Alfred Health total expenditure (electricity, cogen, gas, steam, water) 2015–16 and 2016–17 (excluding waste)

Expenditure	2015–16 ($'000)	2016–17 ($'000)	Change from previous year
Electricity	$5,027	$4,972	-1.1%
Natural Gas	$429	$457	6.4%
Potable Water	$1,324	$937	-29.2%
Steam	$760	$714	-6.1%
Total	**$7,540**	**$7,080**	**-6.1%**

Environmental and sustainability highlights

A new position – the Environmental and Sustainability Officer – commenced in February 2017, with the job to develop and implement Alfred Health's Environmental Management Plan (2017–2021). The Plan's objective is to establish ways in which environmental impacts associated with organisational operations can be minimised.

Environmental improvement activities

During the year, operational improvement activities included:

- **KIMGUARD recycling program:** This program was expanded from The Alfred to include Sandringham and Caulfield Hospitals. The program recycles uncontaminated KIMGUARD sterile wraps. In 2016–17 over 7000 kg of waste has been diverted from landfill. The wraps are recycled and made into decking and benches. An expansion of this recycling initiative is being considered to other soft plastic waste generated by the organisation.
- **PVC recycling program:** Introduced at our three hospital sites this year, this program aims to collect high-quality, used PVC medical products for recycling into useful new products, like children's playmats, garden hose and playgrounds. On average The Alfred uses over 10,111.0 kg of PVC annually. By participating in the recycling program, it is estimated that our PVC waste costs have reduced more than 50 per cent. In addition, we are reducing our carbon footprint by preventing high quality PVC from going to landfill.
- **Waste management:** We have rolled out waste management and recycling best practice activities into existing clinical and non-clinical areas across The Alfred, to include Emergency, Medical Day Unit (Alfred Centre), Cardiac Cath Lab, 7 West, Theatre and Intensive Care Units and 553 St Kilda Road tenanted site. Staff now have the option to segregate waste and increase recycling, where possible.
- **Organics food waste reduction:** This trial program began in The Alfred's main kitchen and included the installation of 'ORCA', a bio-degradable food waste machine. During the six-month trial, more than 20 tonnes of food waste was diverted from landfill. A permanent solution is now being investigated for implementation across all Alfred Health kitchens.
- **Lift replacement:** By replacing lifts across multiple sites, we have reduced our electricity costs in running lifts by 40 per cent. Lifts, as a standing infrastructure item, are major energy consumers.
- **Pneumatic controls systems:** We are upgrading these systems within the East Block, Philip Block and Main Ward Block. The new control technology will significantly improve the efficiency of mechanical infrastructure, in particular air conditioning and heating systems.
- **LED lighting:** All redeveloped and refurbished areas are replaced with LED lights as a standard action.
- **Condensate heat exchangers:** By replacing these heat exchangers at The Alfred, we have made significant energy and water savings, with an estimated reduction of 900,000 litres of water per week.

Governance

Being responsive and making good, transparent decisions are key principles of Alfred Health's governance process.

Alfred Health's Board is accountable to the Minister for Health. Its role is to exercise good governance in achieving the objectives, as outlined in Alfred Health's Strategic Plan 2016–20 and the annual Statement of Priorities.

The Board comprises up to nine independent non-executive directors who are elected for a period of up to three years and can be re-elected to serve for up to nine years. The Board had eight directors for the 2016–2017 year.

During the 2016–17 year the Board was assisted by two Advisory Committee Members. These individuals provided their expertise and advice to the committees in their deliberations. Associate Professor Jill Sewell served on the Quality Committee. Ms Hannah Crawford was appointed to assist the Finance and Audit Committees and served from January to June 2017.

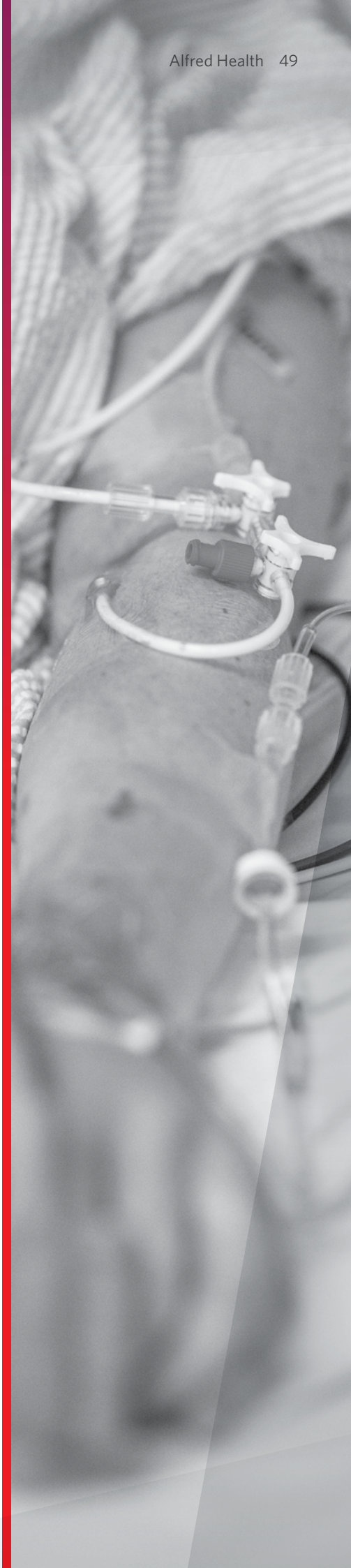
Objectives, functions, power and duties

The core objective of the service is to provide public health services in accordance with the principles established as guidelines for the delivery of public hospital services in Victoria under section 17AA of the *Health Services Act 1988* (Vic) ('the Act').

The other objectives of the service as a public health service are to:

1. provide high-quality health services to the community, which aim to meet community needs effectively and efficiently;
2. integrate care as needed across service boundaries in order to achieve continuity of care and promote the most appropriate level of care to meet individual needs;
3. ensure that health services are aimed at improvements in individual health outcomes and population health status by allocating resources according to best-practice healthcare approaches;
4. ensure that the service strives to continuously improve quality and foster innovation;
5. support a broad range of high-quality health research to contribute to new knowledge and to take advantage of knowledge gained elsewhere;
6. operate in a business like manner, which maximises efficiency, effectiveness and cost-effectiveness and ensures the service's financial viability;
7. ensure that mechanisms are available to inform consumers and protect their rights and to facilitate consultation with the community;
8. operate a public health service as authorised by or under the Act; and
9. carry out any other activities that may be conveniently carried out in connection with the operation of a public health service or calculated to make more efficient any of the service's assets or activities.

The powers and duties of Alfred Health are as prescribed by the Act.



Governance *(continued)*

Board of Directors
as at 30 June 2017

Ms Helen Shardey
BComm TSTC MAICD

Chairperson

Chair: Remuneration Committee
Member: Finance, Occupational Health, Safety & Welfare and Quality Committees

Ms Shardey was a Member of the Victorian Parliament for 14 years until her retirement in 2010, including five years as the Shadow Minister for Health, and at various times she also served as the Shadow Minister for Aged Care; Community Services; Housing; and Multicultural Affairs. Ms Shardey has an in-depth understanding of the health portfolio, a strong understanding of the structure and governance of the health system, both State and Federal, and expertise in strategy and policy development with a focus on health and social policy. She has previously worked as a corporate consultant, senior policy adviser (Federal Parliament), medical practice manager and secondary teacher, and has been appointed Ambassador at Large for the Jewish National Fund of Australia and is President of the National Jewish Fund Victoria. She is a member of the Australian Institute of Company Directors and a past board member of the Victorian Reproductive Treatment Authority.

Mr Julian Gardner
AM BA LLB FIPAA

Deputy Chair of the Board

Chair: Quality Committee
Member: Primary Care & Population Health Advisory Committee

Mr Gardner is a lawyer whose consultancy has included law reform, advance care planning and public administration. He is the Chair of the Board of Mind Australia Ltd, an NGO providing community mental health services and a member of the Ministerial Advisory Panel on Voluntary Assisted Dying.

He has previously held positions as Victoria's Public Advocate, President of the Mental Health Review Board, National Convenor of the Social Security Appeals Tribunal, Chairperson of the WorkCare Appeals Board, Vice-Chair of the Australian Press Council and Director of the Victorian Legal Aid Commission.

He is a Fellow of the Institute of Public Administration Australia (Victoria) and a Fellow of International House, University of Melbourne where he was the Council Chair.

Ms Kaye McNaught
BA (PSYCH,CRIM) LLB (MELB)

Chair: Occupational Health, Safety & Welfare Committee
Member: Audit Committee

Ms McNaught has over 20 years' experience working in the public health system.

Between 1985 and 1995 she was employed at the Royal Children's Hospital Melbourne as the HIV/AIDS and Haemophilia Clinical Nurse Consultant and Counsellor. This statewide service was provided to families, individuals and staff. During this time Ms McNaught was a member of various committees, some of which included the National AIDS Counsellor Association, Paediatric AIDS Task Force, the AIDS Education Strategy Committee, the RCH Infection Control Committee and the AIDS Health Department task force education program. From 1993 until 1995 she was a member of the Board of Management of the Mordialloc-Cheltenham Community Hospital. Since 2001, Ms McNaught has been a barrister at the Victorian Bar and currently is a member of the Victorian Bar Health and Wellbeing Committee.

Ms Sara Duncan
BSCBEng(Biomed) GCertArts(Sociology)

Chair: Audit Committee
Acting Chair: Finance Committee
Member: Occupational Health, Safety & Welfare and Remuneration Committees

Ms Duncan is a policy and strategy professional with a background in biomedical engineering. She has extensive experience across the health, community and disability service sectors having held positions with the Victorian Healthcare Association, Australian Red Cross, Victorian Government and the Women's and Children's Hospital in Adelaide. She is committed to evidence informed policy as a driver to systematically improve service delivery; she is also a strong advocate for the role of consumers in shaping services. Ms Duncan is an independent consultant, community member of the Mental Health Tribunal, was previously a member of the Ministerial Advisory Committee for Senior Victorians and previously National President of Better Hearing Australia.

Dr Benjamin Goodfellow
FRANZCP MBBS MPM CAPC

Chair: Primary Care & Population Health Advisory Committee
Member: Quality Committee

Dr Goodfellow is a child and adolescent psychiatrist in public and private practice with a fellowship in infant mental health from the Royal Children's Hospital. Among his public health roles he is the consultant for the infant psychiatry program and paediatric consultation-liaison service at Geelong University Hospital, as well as a standing member of the High-risk Infant Panel at DHS–Child Protection Geelong. Dr Goodfellow has a background in health systems development and public policy with a focus on clinical standards and productivity, particularly at the interface of health services with government and NGOs.

He is a senior lecturer at Deakin University, an editor of the Australian Association of Infant Mental Health newsletter and has served as the registrar representative on the Faculty of Child and Adolescent Psychiatry within the Royal Australian and New Zealand College of Psychiatrists.

Ms Miriam Suss OAM
BA MSW

Chair: Community Advisory Committee
Member: Primary Care & Population Health Advisory and Quality Committees

Ms Suss is a social worker by profession who has served as the Director of Social Work and Community Development Services at Jewish Care, was the Executive Director of the Jewish Community Council of Victoria, the Ethnic Communities' Council of Victoria, and has held the position of General Manager Development, Communications and Marketing at Jewish

Care. She recently retired as General Manager of the Caulfield Hebrew Congregation. Ms Suss is currently the Deputy Chair of Multicultural Arts Victoria, and is Deputy Chair of the Victorian Interpreter and Translation Service, a Victorian Government business enterprise.

Ms Melanie Eagle

BA BSW LLB Post Graduate Diploma of International Development GAICD

Member: Finance, Remuneration and Primary Care & Population Health Advisory Committees

Ms Melanie Eagle has qualifications in Arts, Social Work, the Law, and is a graduate of the Australian Institute of Company Directors. She is the Chief Executive Officer at Hepatitis Victoria – the peak organisation providing advocacy, awareness raising, information, support and health promotion for people living with or affected by viral hepatitis. Her professional work has included the public sector (city strategic planning, social policy, women's policy, law reform, and equal opportunity); the private sector (a solicitor); and the union movement. She has been the Mayor and a Councillor of the City of St Kilda and on the Boards of a wide range of organisations including Hanover Welfare, Prahran Mission and St Kilda Skillshare. She is a Director of the Inner South Community Health Centre, a committee member of the Chronic Illness Alliance of Victoria and a Patron of the Epilepsy Foundation.

Mr David Shaw

LLB

Member: Community Advisory and Occupational Health, Safety & Welfare Committees

Mr Shaw has been a partner of law firm, Holding Redlich, since 1989. He has a wealth of experience in complex disputes involving employment law, discrimination, administrative decisions and the rules of organisations. These disputes often play out in the Federal and State Courts and Tribunals, Royal Commissions and investigations by integrity agencies.

In the course of his practice Mr Shaw acts for individuals, companies, unions, not-for-profit bodies and government agencies. He has had an extensive pro bono practice, most often acting for Indigenous people, Indigenous groups and refugees.

In the health sector, Mr Shaw has acted for a major health industry union and its members, medical practitioners and health professionals. This has involved disputes over the control of the union, disputes over employment conditions, investigations involving the conduct and performance of health professionals, disputes over specialist accreditation and a complex whistleblowing complaint involving a health authority's response to alleged negligence by a surgeon.

Mr Shaw is a previous Board Member of the Falls Creek Alpine Resort Management Board.

Mr Shaw has been recognised in *Best Lawyers* as a leading lawyer in the practice area of Labour and employment from 2012 to 2016.

Board changes

- Ms Helen Shardey and Ms Sara Duncan finished their board terms on 30 June 2017.
- Dr Benjamin Goodfellow and Ms Kaye McNaught were re-appointed as board members for new three-year terms from 1 July 2017.
- Mr David Shaw, who was appointed to the Board in August 2016, resigned his position, with effect from 30 June 2017.

New appointments included:

- Mr Michael Gorton, who was appointed Board Chair effective as of 1 July 2017.
- Dr Victoria Atkinson, who was appointed to the Board 1 July 2017.

Board committees

The Alfred Health Board established a number of committees and advisory committees in accordance with sections 65S and 65ZA of the Act and Government Sector Remuneration Panel (GSERP) Policy.

Audit Committee

The Audit Committee assists the Board to fulfil its statutory and fiduciary duties relating to the financial management of Alfred Health with respect to internal controls, accounting and reporting practices. It aims to ensure that those duties are carried out in accordance with the Act, the Financial Management Compliance Framework, the Risk Management Framework and any other relevant legislation. This committee is responsible for overseeing the internal audit function and developing and reviewing the Alfred Health Internal Audit Plan. Also, it is responsible for:

- overseeing the maintenance of an effective system of internal monitoring and control of data integrity risk management;
- reviewing the implications of external audit findings for internal controls; and
- reviewing the annual accounts for recommendation to the Board.

Community Advisory Committee

The Community Advisory Committee (CAC) provides advice to the Board on consumer, carer and community participation and other Alfred Health community initiatives. It advises on priority areas and issues requiring consumer and carer participation. This includes matters of community interest and concern to culturally, religiously and linguistically diverse (CALD) communities. It is a forum through which members of the community can work in partnership with Alfred Health as consumer representatives to improve patient experiences.

Finance Committee

The Finance Committee assists the Board to fulfil its financial responsibilities. This includes reporting to the Board on Alfred Health's financial position and the appropriateness of the financial information prepared by management, receiving and reviewing the annual budget and key budget strategies, and overseeing and supervising the management and implementation of actions to address financial management risks. In addition, the committee considers and recommends to the Board financial commitments that require approval.

Primary Care & Population Health Advisory Committee

The Primary Care & Population Health Advisory Committee assists the Board in ensuring that:

- the health services provided meet the needs of our communities
- the views of users and providers are taken into account; and
- arrangements are put in place with other relevant agencies and service providers to enable effective and efficient service delivery and continuity of care.

Governance *(continued)*

Occupational Health, Safety & Welfare Committee

This new Committee held its first meeting on 16 February 2017. The Occupational Health, Safety & Welfare (OHS&W) Committee has been established to assist the Board in ensuring that:

- effective and accountable systems are in place to monitor and improve the OHS&W of staff;
- any systemic problems identified with the OHS&W of staff services are addressed; and
- continuous improvement and innovation are fostered within Alfred Health.

Quality Committee

The Quality Committee was established to ensure that effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services. This involves making certain that:

- any systemic problems identified with the quality and effectiveness of health services are addressed
- continuous improvement and innovation are fostered within Alfred Health.

Remuneration Committee

The Remuneration Committee provides advice to the Board on executive remuneration matters and monitors the implementation of an executive remuneration policy that is consistent with the business objectives and human resources needs of Alfred Health, GSERP policies, and prevailing legislation.

Committee Membership *as at 30 June 2017*

Audit Committee

- Ms Sara Duncan (Chair)
- Ms Kaye McNaught
- Ms Helen Shardey (in attendance)
- Ms Hannah Crawford (Advisory Member – January to June 2017)

Finance Committee

- Ms Sara Duncan (Acting Chair)
- Ms Helen Shardey
- Ms Melanie Eagle
- Prof. Andrew Way
- Ms Hannah Crawford (Advisory Member – January to June 2017)

Community Advisory Committee

- Ms Miriam Suss (Chair)
- Mr David Shaw
- Ms Natalie Ross
- Ms Estie Teller
- Mr Barry Westhorpe
- Ms Mary Close
- Mr John Hawker
- Mr Stuart Martin
- Ms Carol Gordon
- Mr David Mills
- Mr Chris Karagiannis
- Ms Kay Currie

Primary Care & Population Health Advisory Committee

- Dr Benjamin Goodfellow (Chair)
- Mr Julian Gardner AM
- Ms Miriam Suss OAM
- Ms Melanie Eagle
- Prof. Andrew Way
- Ms Kirstan Corben
- Associate Professor Peter Hunter
- Associate Professor Simon Stafrace

Occupational Health, Safety & Welfare Committee

- Ms Kaye McNaught (Chair)
- Ms Sara Duncan
- Mr David Shaw
- Ms Helen Shardey

Quality Committee

- Mr Julian Gardner AM (Chair)
- Ms Helen Shardey
- Dr Benjamin Goodfellow
- Ms Miriam Suss
- Associate Professor Jill Sewell (Advisory Member)

Remuneration Committee

- Ms Helen Shardey (Chair)
- Ms Sara Duncan
- Ms Melanie Eagle

Risk management

Alfred Health has an integrated clinical and enterprise risk register which currently consists of 31 open risks as at 30 June 2017. High and extreme risk issues are addressed by specific committees including falls prevention, pressure injuries, medication safety and behaviours of concern. This ensures focus and coordination of effort on the important issues for Alfred Health. The incident reporting system, Riskman, is an integral component of Alfred Health's risk management system. Alfred Health provides regular training and information for staff on the use of Riskman throughout the year. Riskman data is routinely analysed for trends and reported to various committees including to the Executive Committee, the Quality Committee and the Audit Committee. In the event a serious incident occurs, staff undertake formal reviews to identify opportunities to improve the systems of care. Grand Rounds, newsletters and clinical alerts are used to provide feedback to staff on the outcomes of the review and any related system changes to be implemented.

Senior officers

Chief Executive

Professor Andrew Way
RN BSc (Hons) MBA FAICD FACHSM

Professor Way has served as Alfred Health's Chief Executive since 2009. His focus is on improving access, ensuring high quality, safe services with low mortality, within a strong financial framework and a research-supportive environment. Alfred Health is now seen as a leader in these areas.

Prof. Way led the development of Victoria's first Academic Health Science Centre – Monash Partners, now an accredited NHMRC Advanced Health and Research Translation Centre. He was appointed as an Adjunct Clinical Professor in the School of Public Health and Preventative Medicine, Faculty of Medicine Nursing and Health Sciences, Monash University in 2015.

Prof. Way is also a Director of other health-related organisations and is a member of several government and other advisory groups. Prior to his relocation to Melbourne in 2009, Andrew had an extensive career in the NHS in the UK, latterly as CEO of the Royal Free Hampstead NHS Trust.

Chief Operating Officer

Dr Tim Sinclair
DBA

Dr Sinclair was appointed as Chief Operating Officer in January 2017. He is responsible for the management and performance of Alfred Health's clinical operations.

Previously, Dr Sinclair spent five years as the General Manager of Concord Hospital in Sydney, a 750-bed tertiary hospital affiliated with the University of Sydney. He has also acted as the Director of Operations for the Sydney Local Health District and worked in several other senior health positions in New South Wales over the past decade.

Dr Sinclair has a background in Health Information Management and has a Masters in Health Services Management and a Doctorate in Business Administration.

Executive Director, Medical Services & Chief Medical Officer

Dr Lee Hamley
MBBS MBA FRACMA

As Executive Director Medical Services and Chief Medical Officer, Dr Hamley reports to the Chief Executive.

She is responsible for clinical governance, risk management and patient safety, the development of the clinical workforce across Alfred Health, professional medical issues, investigative services (pathology, radiology and nuclear medicine) and pharmacy.

Dr Hamley chairs the Alfred Health Infection Control Committee, Medical Appointments Committee and Credentialing Committee.

Dr Hamley's external appointments include being a Member of the Postgraduate Medical Council of Victoria, Accreditation Sub-Committee and Chair of the Melbourne Metropolitan Medical Executives Committee.

Executive Director, Nursing Services & Chief Nursing Officer

Ms Janet Weir-Phyland
RN BScN MBA

Ms Weir-Phyland provides professional leadership to Alfred Health's nursing workforce.

Her role ensures the delivery of a competent, professional and capable workforce able to meet the ongoing challenges of providing services in a wide variety of settings, including the community.

Ms Weir-Phyland has a track record of implementing clinical and quality care initiatives, developing nursing workforce strategies, and has a particular interest in interdisciplinary practice development.

The position is also accountable for site coordination of Sandringham Hospital and Caulfield Hospital.

Executive Director, Strategy & Planning

Mr Paul Butler

Mr Butler is responsible for ensuring Alfred Health has a clear future direction through our Strategic Plan. The plan, with its defined goals and objectives, supports the health and wellbeing of all Victorians and builds capability as a quaternary teaching hospital and international health and medical research centre.

Mr Butler has responsibility for Alfred Health's capital and infrastructure, service planning and outpatients functions. These functions are central to providing clinical and other corporate programs with a safe, efficient and effective operating environment.

Mr Butler has had an extensive career in the Victorian public health system, including executive and senior management roles in the Victorian Department of Health (now Health and Human Services) in regional and program management, and in disability services. His interests include health system and service planning and management and, particularly, the intersection of primary health care and acute hospital services. Mr Butler has been a board director on a variety of non-government organisations in the health and human services fields.

Director, Research

Professor Stephen Jane
MBBS PhD FRACP FRCPA FAHMS

Prof. Jane is responsible to the Chief Executive for the strategic direction and governance of research at Alfred Health. An experienced haematologist, Prof. Jane has a strong interest in translational research and, through his role, is a key player in Alfred Health's efforts to establish an Academic Health Science Centre (AHSC).

He joined Alfred Health in 2011, following 10 years as head of one of the country's foremost bone marrow research laboratories at Royal Melbourne Hospital – a group of researchers he has brought with him to The Alfred.

Governance *(continued)*

Executive Director, Finance

Mr Peter Joyce
BCom CPA

As Executive Director Finance and CFO, Mr Joyce is responsible for all finance and procurement functions.

This includes financial accounting, management accounting and analysis, Clinical Performance Unit, payroll services, supply and internal and external financial reporting.

Mr Joyce has a long and diverse career as a senior financial executive and general manager as well as a number of years as a small business owner. He has worked in Europe, Asia and Australia in consumer products, financial services and IT and has a significant background in process improvement and organisational change. He has had major involvement for a long period of time in mergers and acquisitions, including the integration of new businesses into existing structures especially related to systems, processes and human resources.

Mr Joyce has spent the last five years at Alfred Health and before that spent over a decade as a consultant, small business owner in the IT industry and also as CFO of a company providing services in the financial products industry.

Executive Director, People & Culture

Ms Chris McLoughlin
BSW

As Executive Director, People and Culture at Alfred Health, Ms McLoughlin's role focuses on building organisational capability.

The Human Resources team is highly customer focused and seeks to ensure all new starters have an effective orientation, that current staff are well supported and developed with an emphasis on all staff receiving regular feedback, and that the OHS unit ensures that safety is a high priority for all.

In the Organisational Development Unit and the Centre for Health Innovation these specialist teams design and develop systems, processes, teams, education and development programs and support innovation. Ms McLoughlin's department works to embed the purpose and beliefs of Alfred Health in the daily work of the health service. Well-supported and capable staff provide great care and service for our patients, community and customers.

In 2013 Ms McLoughlin successfully completed the executive link program which is sponsored and run by DHHS. She is currently on the Board of the Victorian Hospitals' Industrial Association (VHIA).

Executive Director, Information Development

Ms Ann Larkins
MBT, CCRN

As Executive Director of Information Development, Ms Larkins is responsible for supporting the organisation through significant technological change. This includes making strategic use of data and systems so that clinical care at the bedside is performed with all the information required for excellence in care.

The Information Development team covers all aspects of IT Infrastructure, Projects, Applications Development, Health Information Services, Security, Privacy and the development of the Electronic Medical Record, which is a strategic focus for the organisation in the coming years.

Ms Larkins has a long history of critical care clinical practice and management roles in health, hospitality management in NSW and QLD, and more recently was the Chief Knowledge and Information Officer/CIO at Victoria's largest regional health service.

She has a strong interest in data and the use of predicative analytics to support clinical decision making and is a Fellow at Deakin University's Centre for Pattern Recognition and Data Analytics (PRaDA).

General Counsel

Mr David Ruschena
PhD LLB (Hons)/BSc (Hons)

Responsible for providing legal advice across Alfred Health.

Mr Ruschena was appointed as General Counsel in August 2015.

Alfred Health Organisational Structure June 2017

Key

CFO	Chief Financial Officer
CPO	Chief Purchasing Officer
ED	Executive Director
PD	Program Director
DoN	Director of Nursing
AH	Alfred Hospital
CH	Caulfield Hospital
SH	Sandringham Hospital

HSEC Member

Governance *(continued)*

Legislation change – patient rights

Alfred Health is preparing for the introduction of the Medical Treatment Planning and Decisions Act, which commences operation on 12 March 2018. It makes a series of significant changes to the law governing delivery of medical treatment, with the intention of ensuring that people receive medical treatment that is consistent with their preferences and values.

Under the new legislation, Victorians will be able to create legally binding advance care directives. Advance care directives are documents that record a person's preferences and values in relation to medical treatment. Under the new legislation, such directives may take one (or both) of two forms. These are:

- instructional directives, which provide directives about the specific treatment, or sorts of treatments, that the person accepts or refuses; and
- values directives, which describe the person's views and values that medical treatment decision makers and health practitioners must give effect to.

The Act repeals and replaces the Medical Treatment Act, although it will recognize Refusal of Treatment Certificates that have already been executed. Victorians will also be able to appoint Medical Treatment Decision Makers (who will make decisions on behalf of a person when they no longer have decision making capacity) and Support Persons (who will assist a person to make decisions for themselves, by collecting and interpreting information or assisting the person to communicate their decisions).

Medical Treatment Decision Makers will replace attorneys holding an Enduring Power of Attorney (Medical Treatment) and 'persons responsible'. Other Enduring Powers of Attorney, for financial or personal/lifestyle matters, will continue to be the appropriate documentation for a person to grant authority to make future decisions.

General Information

Directions of the Minister for Finance

All the information described in the directions of the Minister for Finance is available to the relevant Minister, Members of Parliament or the public on request.

Competitive neutrality

Alfred Health continues to comply with government policy on competitive neutrality.

Alignment with public administration values

Alfred Health assists staff to identify desired behaviours and ensures that policy and practice are underpinned by core public sector values through its Code of Conduct and Financial Code of Practice. These are approved by the Board of Directors and are consistent with the Public Sector Code of Conduct for Victorian Public Sector Employees issued by the Public Sector Standards Commissioner. Principles of equal opportunity and fair and reasonable treatment of others are included in the Code of Conduct and the range of policies and guidelines. This includes a policy and guideline on conflicts of interest. We ensure that policy and practice are consistent with the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

The Freedom of Information Act 1982

Freedom of Information decisions 2016–17

Applications Received	2,468
Applications granted (full)	2,160
Applications granted (part)	14
Access denied	12
No documents	30
Other	115
Not finalised	137

Not finalised 2015-16	217
Access granted in full	181
Access granted in part	0
Access denied	0
Other	36

Protected Disclosure Act 2012 (Vic)

Alfred Health complies with its obligations under the *Protected Disclosure Act 2012* (Vic). In particular, procedures for the protection of persons from detrimental action can be found in the Alfred Health policy on Protected Disclosure which is located on our website: **www.alfredhealth.org.au**. Hard copies are available from the office of the Alfred Health Legal Counsel.

Complaints about misconduct or corruption involving public health services in Victoria can be made by individuals directly to the Independent Broad-based Anti-corruption Commission (IBAC) on 1300 735 135 or via their website at **www.ibac.vic.gov.au**.

DataVic access

In August 2012, the Victorian Government released the DataVic Access Policy, which enables the sharing of Government data at no, or minimal, cost to users. Government data from all agencies will be progressively supplied in a machine-readable format that will minimise access costs and maximise use and reuse.

Consultancy costs

Consultant	Purpose of Consultancy	Total Approved Project Fee (excl GST)	Expenditure (excl GST)	Future Approved Expenditure
Bureau Veritas	Asbestos Audit	85,544	85,544	0
Civilised Pty Ltd	Patient Stories Video Production	10,000	10,000	0
Dandolopartners	AMREP Strategic Review	24,813	24,813	0
Immediacy	Staff Video Production	28,310	28,310	0
LEHR Consultation	Alfred Health Infrastructure condition assessment	77,000	77,000	0
Lisa Delaney Consulting	Psychiatry Service Plan Development	147,400	65,500	81,900
PWC	Consulting on Tender – Radiotherapy	22,935	22,935	0
Roadhouse Digital Pty Ltd	Alfred Ethics – ERA Version 1	25,000	25,000	0

There were no consultancies under $10,000.

Additional information

In compliance with the requirements of FRD 22G Standard Disclosures in the Report of Operations, details in respect of the items listed below have been retained by Alfred Health and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

a. A statement of pecuniary interest has been completed;

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

c. Details of publications produced by the Department about the activities of the Health Service and where they can be obtained;

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

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

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

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

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

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

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

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

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

Attestation on Data Integrity

I, Andrew Way, certify that Alfred Health has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. Alfred Health has critically reviewed these controls and processes during the year.

Professor Andrew Way
Chief Executive

Melbourne
22 August 2017

Attestation for Risk Management Framework & Processes

I, Andrew Way, certify that Alfred Health has complied with the Ministerial Standing Direction 3.7.1 – Risk Management Framework and Processes. Alfred Health's Audit Committee verifies this.

Professor Andrew Way
Chief Executive

Melbourne
22 August 2017

Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

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

Professor Andrew Way
Chief Executive

Melbourne
22 August 2017

Disclosure index

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

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FRD 22H	Application and operation of *Freedom of Information Act 1982*	56
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	44
FRD 22H	Details of consultancies over $10,000	57
FRD 22H	Details of consultancies under $10,000	None
FRD 22H	Employment and conduct principles	56
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FRD 25C	Victorian Industry Participation Policy disclosures	None
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Financial Statements
Year ended 30 June 2017

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

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

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

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

We authorise the attached financial statements for issue on 22 August 2017.

Mr Michael Gorton
Board Chairman

Melbourne
22 August 2017

Mr Andrew Way
Accountable Officer

Melbourne
22 August 2017

Mr Peter Joyce
Chief Finance & Accounting Officer

Melbourne
22 August 2017

Audit Report

Independent Auditor's Report

VAGO
Victorian Auditor-General's Office

To the Board of Alfred Health

Opinion

I have audited the consolidated financial report of Alfred Health (the health service) and its controlled entity (together the consolidated entity), which comprises the:

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

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

Basis for Opinion

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

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

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

Board's responsibilities for the financial report

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

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
25 August 2017

Charlotte Jeffries
as delegate for the Auditor-General of Victoria

Comprehensive Operating Statement

for the Financial Year Ended 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Revenue from operating activities	2.1	1,141,548	1,058,303	1,141,548	1,058,303
Revenue from non-operating activities	2.1	3,980	4,048	4,810	4,955
Employee expenses	3.1	(738,403)	(684,384)	(738,403)	(684,384)
Non salary labour costs	3.1	(16,675)	(12,780)	(16,675)	(12,780)
Supplies and consumables	3.1	(261,135)	(245,202)	(261,135)	(245,202)
Other expenses	3.1	(127,990)	(114,370)	(128,819)	(115,100)
Finance Costs-Self Funded Activity	3.3	(1,122)	(1,290)	(1,122)	(1,290)
Net Result Before Capital & Specific Items		**203**	**4,325**	**204**	**4,502**
Capital purpose income	2.1	43,569	42,442	44,336	42,442
Other capital expenses	3.1	(129)	(139)	(872)	(1,089)
Depreciation and amortisation	4.4	(67,897)	(66,088)	(67,897)	(66,088)
Finance costs	3.3	(138)	(337)	(138)	(337)
Net Result After Capital & Specific Items		**(24,392)**	**(19,797)**	**(24,367)**	**(20,570)**
Other economic flows included in net result					
Net gain/(loss) on non-financial assets	7.2	(1)	(147)	(1)	(147)
Net gain/(loss) on financial instruments		(4,773)	(4,074)	(4,030)	(3,124)
Revaluation of Long Service Leave		649	(324)	649	(324)
Total other economic flows included in net result		**(4,125)**	**(4,545)**	**(3,382)**	**(3,595)**
NET RESULT FOR THE YEAR		**(28,517)**	**(24,342)**	**(27,749)**	**(24,165)**
Other Comprehensive Income					
Items that will not be reclassified to net result					
Changes in Physical Asset Revaluation Surplus		26,423	35,997	26,423	35,997
Items that may be reclassified subsequently to net result					
Changes to financial assets available-for-sale revaluation surplus		1,844	1,867	2,042	547
Total Other Comprehensive Income	**8.1**	**28,267**	**37,864**	**28,465**	**36,544**
COMPREHENSIVE RESULT		**(250)**	**13,522**	**716**	**12,379**

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

Balance Sheet

as at 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Current Assets					
Cash and cash equivalents	6.2	36,529	28,005	36,767	28,647
Receivables	5.1	51,191	50,094	51,369	50,299
Inventories	5.2	9,495	9,547	9,495	9,547
Prepayments and Other assets	5.4	2,898	2,705	2,898	2,705
Total Current Assets		**100,113**	**90,351**	**100,529**	**91,198**
Non-Current Assets					
Receivables	5.1	10,242	7,839	10,242	7,839
Investments and other financial assets	4.1	43,788	41,619	58,173	54,606
Property, plant & equipment	4.3	930,075	941,425	930,075	941,425
Intangible assets	4.5	12,686	3,912	12,686	3,912
Total Non-Current Assets		**996,791**	**994,795**	**1,011,176**	**1,007,782**
TOTAL ASSETS		**1,096,904**	**1,085,146**	**1,111,705**	**1,098,980**
Current Liabilities					
Payables	5.5	76,680	77,884	76,794	77,997
Interest bearing liabilities	6.1	3,999	3,908	3,999	3,908
Provisions	3.4	174,246	157,436	174,246	157,436
Other current liabilities	5.3	71	69	71	69
Total Current Liabilities		**254,996**	**239,297**	**255,110**	**239,410**
Non-Current Liabilities					
Interest bearing liabilities	6.1	20,613	24,515	20,613	24,515
Provisions	3.4	30,573	30,362	30,573	30,362
Total Non-Current Liabilities		**51,186**	**54,877**	**51,186**	**54,877**
TOTAL LIABILITIES		**306,182**	**294,174**	**306,296**	**294,287**
NET ASSETS		**790,722**	**790,972**	**805,409**	**804,693**
EQUITY					
Property, plant & equipment revaluation surplus	8.1	573,721	547,298	573,721	547,298
Financial assets available for sale revaluation surplus	8.1	22,745	20,901	23,279	21,237
General purpose surplus	8.1	70,991	76,057	70,991	76,057
Restricted specific purpose surplus	8.1	49,661	50,700	63,521	63,793
Contributed capital	8.1	324,134	324,134	324,134	324,134
Accumulated deficits	8.1	(250,530)	(228,118)	(250,237)	(227,826)
TOTAL EQUITY		**790,722**	**790,972**	**805,409**	**804,693**
Commitments	6.3				
Contingent assets and contingent liabilities	7.3				

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

Statement of Changes in Equity

for the Financial Year Ended 30 June 2017

Consolidated	Note	Property, Plant & Equipment Revaluation Surplus $'000	Financial Assets Available for Sale Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 30 June 2015		**511,301**	**20,690**	**57,409**	**66,571**	**324,134**	**(187,792)**	**792,313**
Net result for the year		-	-	-	-	-	(24,165)	(24,165)
Other comprehensive income for the year		35,997	547	-	-	-	-	36,544
Transfer from accumulated surplus		-	-	18,648	(2,778)	-	(15,870)	-
Balance at 30 June 2016		**547,298**	**21,237**	**76,057**	**63,793**	**324,134**	**(227,826)**	**804,693**
Net result for the year		-	-	-	-	-	(27,749)	(27,749)
Other comprehensive income for the year		26,423	2,042	-	-	-	-	28,465
Transfer from accumulated surplus		-	-	(5,066)	(272)	-	5,338	-
Balance at 30 June 2017		**573,721**	**23,279**	**70,991**	**63,521**	**324,134**	**(250,237)**	**805,409**

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

Statement of Changes in Equity

for the Financial Year Ended 30 June 2017

Parent	Property, Plant & Equipment Revaluation Surplus $'000	Financial Assets Available for Sale Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 30 June 2015	**511,301**	**19,033**	**57,409**	**52,032**	**324,134**	**(186,461)**	**777,448**
Net result for the year	-	-	-	-	-	(24,342)	(24,342)
Other comprehensive income for the year	35,997	1,868	-	-	-	-	37,864
Transfer from accumulated surplus	-	-	18,648	(1,332)	-	(17,316)	-
Balance at 30 June 2016	**547,298**	**20,901**	**76,057**	**50,700**	**324,134**	**(228,118)**	**790,972**
Net result for the year	-	-	-	-	-	(28,517)	(28,517)
Other comprehensive income for the year	26,423	1,844	-	-	-	-	28,267
Transfer from accumulated surplus	-	-	(5,066)	(1,039)	-	6,105	-
Balance at 30 June 2017	**573,721**	**22,745**	**70,991**	**49,661**	**324,134**	**(250,530)**	**790,722**

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

Cash Flow Statement

for the Financial Year Ended 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating grants from government		953,165	877,711	953,165	877,711
Capital grants from government		31,390	20,396	31,390	20,396
Patient and resident fees received		44,282	43,371	44,282	43,371
Private practice fees received		61,743	58,504	61,743	58,504
Donations and bequests received		12,487	15,968	12,487	15,968
GST received from / (paid to) ATO		33,519	30,128	33,519	30,128
Interest received		1,059	1,284	1,059	1,284
Other capital receipts		4,059	3,763	4,059	3,763
Other receipts		71,378	61,178	71,655	61,441
Total Receipts		**1,213,082**	**1,112,303**	**1,213,359**	**1,112,566**
Employee expenses paid		(721,165)	(688,741)	(721,165)	(688,741)
Non salary labour costs		(16,675)	(12,780)	(16,675)	(12,780)
Payments for supplies and consumables		(424,838)	(369,046)	(425,597)	(370,679)
Finance costs		(1,296)	(1,290)	(1,296)	(1,290)
Total Payments		**(1,163,974)**	**(1,071,857)**	**(1,164,733)**	**(1,073,490)**
NET CASH FLOW FROM OPERATING ACTIVITIES	**8.2**	**49,108**	**40,446**	**48,626**	**39,076**
CASH FLOWS FROM INVESTING ACTIVITIES					
Purchase of non-financial assets		(38,934)	(36,588)	(38,934)	(36,588)
Proceeds from sale of non-financial assets		52	29	52	29
Proceeds from sale of investments		2,072	6,505	2,151	8,312
NET CASH USED IN INVESTING ACTIVITIES		**(36,810)**	**(30,054)**	**(36,731)**	**(28,247)**
CASH FLOWS FROM FINANCING ACTIVITIES					
Repayment of borrowings		(3,777)	(1,281)	(3,777)	(1,281)
NET CASH USED IN FINANCING ACTIVITIES		**(3,777)**	**(1,281)**	**(3,777)**	**(1,281)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**8,521**	**9,111**	**8,118**	**9,548**
Cash and cash equivalents at beginning of financial year		**27,937**	**18,826**	**28,578**	**19,030**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	**6.2**	**36,458**	**27,937**	**36,696**	**28,578**

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

Notes to the Financial Statements

30 June 2017

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Basis of presentation

Notes to the Financial Statements (continued)

30 June 2017

Basis of presentation

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

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

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

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

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

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

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

Note 1 – Summary of Significant Accounting Policies

These annual financial statements represent the audited general purpose financial statements for Alfred Health and the Consolidated Entity for the period ended 30 June 2017. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act 1994* and applicable Australian Accounting Standards (AASs), which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB101 *Presentation of Financial Statements*.

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

Alfred Health is a not-for-profit entity and therefore applies the additional AUS paragraphs applicable to 'not-for-profit' Health Services under the AASs.

The annual financial statements were authorised for issue by the Board of Alfred Health on [DATE].

(b) Reporting Entity

The financial statements include all the controlled activities of Alfred Health. Its principal address is:

55 Commercial Road
Melbourne
Victoria 3004

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

Objectives and funding

Alfred Health's overall objective is to provide public health services in accordance with the principles established as guidelines for the delivery of public hospital services in Victoria under section 17AA of the *Health Services Act 1988 (Vic)*, as well as improve the quality of life to Victorians.

Alfred Health is predominantly funded by accrual based grant funding for the provision of outputs.

(c) Basis of accounting preparation and measurement

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

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

The going concern basis was used to prepare the financial statements. Alfred Health contemplates the continuity of normal trading operations and the realisation of assets and settlement of liabilities in the ordinary course of business. The Department of Health & Human Services (DHHS) has confirmed in writing its intention to continue to provide financial support to Alfred Health up until 30 September 2018.

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

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

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

- Non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are reassessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- Available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income – items that may be reclassified subsequent to net result); and
- The fair value of assets other than land is generally based on their depreciated replacement value.

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

(d) Principles of Consolidation

These statements are presented on a consolidated basis in accordance with AASB 10 *Consolidated Financial Statements*:

- The consolidated financial statements of Alfred Health include all reporting entities controlled by Alfred Health as at 30 June 2017, and the consolidated financial statements exclude bodies of Alfred Health that are not controlled by Alfred Health, and therefore are not consolidated.

Notes to the Financial Statements (continued)

30 June 2017

Note 1 – Summary of Significant Accounting Policies (continued)

- Control exists when Alfred Health has the power to govern the financial and operating policies of a Health Service so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable are taken into account. The consolidated financial statements include the audited financial statements of the controlled entities listed in Note 8.9.

Where control of an entity is obtained during the financial period, its results are included in the comprehensive operating statement from the date on which control commenced. Where control ceases during a financial period, the entity's results are included for that part of the period in which control existed. Where dissimilar accounting policies are adopted by entities and their effect is considered material, adjustments are made to ensure consistent policies are adopted in these financial statements.

Entities consolidated into Alfred Health reporting entity include:

Alfred Hospital Whole Time Medical Specialists' Private Practice Trust.

Intersegment Transactions

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

Note 2 – Funding delivery of our services

The hospital's overall objective is to deliver programs and services that support and enhance the wellbeing of all Victorians.

To enable the hospital to fulfil its objective it receives income based on parliamentary appropriations. The hospital also receives income from the supply of services.

Structure

2.1 Analysis of revenue by source

Note 2.1 – Analysis of Revenue by Source

Consolidated	Admitted Patients 2017 $'000	Non-Admitted 2017 $'000	EDs 2017 $'000	Mental Health 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Government Grant	639,111	66,247	28,727	56,753	8,711	10,576	142,807	952,932
Indirect contributions by Department of Health and Human Services	3,158	-	-	-	-	-	-	3,158
Patient & Resident Fees	42,862	-	-	154	97	445	-	43,558
Commercial Activities	-	-	-	-	-	-	11,191	11,191
Recoupment from Private Practice for Use of Hospital Facilities	18,319	-	1,150	123	17	-	37,882	57,491
Other Revenue from Operating Activities	4,847	-	429	10,633	-	3	57,306	73,218
Total Revenue from Operating Activities	**708,297**	**66,247**	**30,306**	**67,663**	**8,825**	**11,024**	**249,186**	**1,141,548**
Interest	-	-	-	-	-	-	4,286	4,286
Other Revenue from Non-Operating Activities	-	-	-	-	-	-	524	524
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**-**	**-**	**4,810**	**4,810**
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	44,336	44,336
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**-**	**44,336**	**44,336**
TOTAL REVENUE	**708,297**	**66,247**	**30,306**	**67,663**	**8,825**	**11,024**	**298,332**	**1,190,694**

Notes to the Financial Statements (continued)

30 June 2017

Note 2.1 – Analysis of Revenue by Source (continued)

Consolidated	Admitted Patients 2016 $'000	Non-Admitted 2016 $'000	EDs 2016 $'000	Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Government Grant	598,285	65,543	30,934	51,713	8,476	9,679	125,598	890,228
Indirect contributions by Department of Health and Human Services	1,694	-	-	-	-	-	-	1,694
Patient & Resident Fees	42,145	-	-	283	72	329	-	42,829
Commercial Activities	-	-	-	-	-	-	11,355	11,355
Recoupment from Private Practice for Use of Hospital Facilities	16,362	-	1,190	113	74	-	30,365	48,104
Other Revenue from Operating Activities	5,010	84	196	9,369	2	2	49,430	64,093
Total Revenue from Operating Activities	**663,496**	**65,627**	**32,320**	**61,478**	**8,624**	**10,010**	**216,748**	**1,058,303**
Interest	-	-	-	-	-	-	4,270	4,270
Other Revenue from Non-Operating Activities							685	685
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**-**	**-**	**4,955**	**4,955**
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	42,442	42,442
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**-**	**42,442**	**42,442**
TOTAL REVENUE	**663,496**	**65,627**	**32,320**	**61,478**	**8,624**	**10,010**	**264,146**	**1,105,700**

Department of Health & Human Services makes certain payments on behalf of the Health Service.

These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2.1 – Analysis of Revenue by Source (continued)

Income from Transactions

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

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

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

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

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

Indirect Contributions from The Department of Health & Human Services

- Insurance is recognised as revenue following advice from The Department of Health & Human Services.
- Long Service Leave (LSL) Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the 'Metropolitan Health and Aged Care Services Division Hospital Circular 04/2017'.

Patient and Resident Fees

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

Private Practice Fees

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

Revenue from Commercial Activities

Revenue from commercial activities is recognised at the time the invoices are raised.

Donations and Other Bequests

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

Dividend Revenue

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

Interest Revenue

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

Sale of Investments

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

Category Groups

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

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

Mental Health Services (Mental Health) comprises all specialised mental health services providing a range of inpatient, community based residential, rehabilitation and ambulatory services that treat and support people with a mental illness and their families and carers. These services aim to identify mental illness early, and seek to reduce its impact through providing timely acute care services and appropriate longer-term accommodation and support for those living with a mental illness.

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

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

Aged Care comprises a range of in home, specialist geriatric, residential care and community-based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.

Primary, Community and Dental Health comprises a range of home-based, community-based, community, primary health and dental services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health services.

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

Notes to the Financial Statements (continued)

30 June 2017

Note 3 – The Cost of delivering services

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

Structure

Note 3.1 – Analysis of Expenses by Source

Consolidated	Admitted Patients 2017 $'000	Non-Admitted 2017 $'000	EDs 2017 $'000	Mental Health 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Employee Expenses	372,116	12,339	50,454	57,655	5,787	3,219	236,833	738,403
Other Operating Expenses								
Non Salary Labour Costs	12,135	36	808	1,441	2	-	2,253	16,675
Supplies and Consumables	139,573	44,014	3,338	682	2,346	85	71,097	261,135
Domestic services and supplies	5,802	85	944	258	17	5	25,005	32,116
Other Expenses	22,130	1,869	683	6,395	1,928	-	63,698	96,703
Medical Support Costs	250,724	26,735	26,294	28,422	3,859	1,558	(337,592)	-
Finance Costs-Self Funded Activity (refer note 3.3)	-	-	-	-	-	-	1,122	1,122
Total Expenditure from Operating Activities	**802,480**	**85,078**	**82,521**	**94,853**	**13,939**	**4,867**	**62,416**	**1,146,154**
Depreciation & Amortisation (refer note 4.4)	-	-	-	-	-	-	67,897	67,897
Finance Costs (refer note 3.3)	-	-	-	-	-	-	138	138
Other Non-Operating Expenses								
Expenditure for Capital Purposes	-	-	-	-	-	-	872	872
Total other expenses	**-**	**-**	**-**	**-**	**-**	**-**	**68,907**	**68,907**
Total Expenses	**802,480**	**85,078**	**82,521**	**94,853**	**13,939**	**4,867**	**131,323**	**1,215,061**

Note 3.1 – Analysis of Expenses by Source (continued)

Consolidated	Admitted Patients 2016 $'000	Non-Admitted 2016 $'000	EDs 2016 $'000	Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Employee Expenses	350,750	12,115	45,058	50,135	5,192	2,982	218,153	684,384
Other Operating Expenses								
Non Salary Labour Costs	8,239	30	686	1,521	3	-	2,301	12,780
Supplies and Consumables	129,350	44,808	3,202	564	2,182	40	65,056	245,202
Domestic services and supplies	5,561	73	737	250	-	5	23,333	29,959
Other Expenses	19,377	2,870	735	6,046	1,446	-	54,668	85,141
Medical Support Costs	229,511	26,500	23,087	24,383	3,428	1,407	(308,315)	-
Finance Costs-Self Funded Activity (refer note 3.3)	-	-	-	-	-	-	1,290	1,290
Total Expenditure from Operating Activities	**742,788**	**86,396**	**73,505**	**82,899**	**12,250**	**4,434**	**56,486**	**1,058,756**
Depreciation & Amortisation (refer note 4.4)	-	-	-	-	-	-	66,088	66,088
Finance Costs (refer note 3.3)	-	-	-	-	-	-	337	337
Other Non-Operating Expenses								
Expenditure for Capital Purposes	-	-	-	-	-	-	1,089	1,089
Total other expenses	**-**	**-**	**-**	**-**	**-**	**-**	**67,514**	**67,514**
Total Expenses	**742,788**	**86,396**	**73,505**	**82,899**	**12,250**	**4,434**	**124,000**	**1,126,270**

Expense Recognition

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

Cost of Goods Sold

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

Employee expenses

Employee expenses include:

- Wages and salaries;
- Annual leave, Sick leave, Long service leave;
- Workcover; and
- Superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Grants and other transfers

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

Other operating expenses

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

Supplies and consumables

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

Bad and doubtful debts

Refer to Note 4.1 Investments and other financial assets.

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

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

Notes to the Financial Statements (continued)

30 June 2017

Note 3.1 – Analysis of Expenses by Source (continued)

Borrowing costs of qualifying assets

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

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

Net gain/(loss) on non-financial assets

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

Revaluation gains/(losses) of non-financial physical assets

Refer to Note 4.3 Property, plant and equipment.

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

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

Net gain/(loss) on financial instruments

Net gain/(loss) on financial instruments includes:

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

Impairment of non-financial assets

Intangible assets with indefinite useful lives (and intangible assets not available for use) are tested annually for impairment and whenever there is an indication that the asset may be impaired. Refer to Note 7.2 Net gain/(loss) on disposal of non-financial assets.

Revaluations of financial instrument at fair value

Refer to Note 7.1 Financial instruments.

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

Refer to Note 1(d) Principles of consolidation.

Other gains/(losses) from other economic flows

Other gains/(losses) include:

- the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and
- transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

Category Groups

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

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

Mental Health Services (Mental Health) comprises all specialised mental health services providing a range of inpatient, community-based residential, rehabilitation and ambulatory services that treat and support people with a mental illness and their families and carers. These services aim to identify mental illness early, and seek to reduce its impact through providing timely acute care services and appropriate longer-term accommodation and support for those living with a mental illness.

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

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

Aged Care comprises a range of in home, specialist geriatric, residential care and community-based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.

Primary, Community and Dental Health comprises a range of home-based, community-based, community, primary health and dental services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health services.

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

Note 3.2 – Analysis of Expense and Revenue by Internally Managed and Restricted Specific Purpose Funds

	Expense		Revenue	
	Consol'd 2017 $'000	Consol'd 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Commercial Activities				
Private Practice and Other Patient Activities	4,255	5,372	6,175	6,460
Car Park	3,150	2,997	9,993	9,835
Property Expense/Revenue	152	89	212	164
Other Activities				
Fundraising and Community Support	2,953	2,820	12,594	15,883
Research and Scholarship	25,563	21,483	24,375	22,228
Other	11,043	10,052	16,455	19,186
TOTAL	**47,116**	**42,813**	**69,804**	**73,756**

Note 3.3 – Finance Costs

	Consol'd 2017 $'000	Consol'd 2016 $'000
Finance Costs - Self Funded Activity	1,122	1,290
	1,122	1,290
Interest on Long-Term Borrowings (Note 6.1)	138	337
TOTAL FINANCE COSTS	**1,260**	**1,627**

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

Finance costs include:

- interest on bank overdrafts and short-term and long-term borrowings;
- amortisation of discounts or premiums relating to borrowings;
- amortisation of ancillary costs incurred in connection with the arrangement of borrowings; and
- finance charges in respect of finance leases recognised in accordance with AASB 117 *Leases*.

Notes to the Financial Statements (continued)

30 June 2017

Note 3.4 – Employee Benefits in the Balance Sheet

	Consol'd 2017 $'000	Consol'd 2016 $'000
Current Provisions		
Employee Benefits (Note 3.4)		
Annual Leave (Note 3.4)		
- Unconditional and expected to be settled within 12 months (i)	58,944	53,135
Long Service Leave (Note 3.4)		
- Unconditional and expected to be settled within 12 months (i)	84,907	77,619
Other	14,429	13,315
	158,280	144,069
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months (i)	15,966	13,367
Total Current Provisions	174,246	157,436
Non-Current Provisions		
Employee Benefits (ii)	27,679	27,529
Provisions related to Employee Benefit On-Costs	2,894	2,833
Total Non-Current Provisions	**30,573**	**30,362**
TOTAL PROVISIONS	**204,819**	**187,798**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Unconditional LSL Entitlements	93,786	85,607
Annual Leave Entitlements	64,522	58,514
Accrued Wages and Salaries	13,897	11,424
Accrued Days Off	2,041	1,891
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements (ii)	30,573	30,362
Total Employee Benefits and Related On-Costs	**204,819**	**187,798**
(b) Movement in Provisions		
Movement in Long Service Leave:		
Balance at start of year	**115,969**	**109,133**
Provision made during the year	18,003	16,027
Settlement made during the year	(9,612)	(9,191)
Balance at end of year	**124,360**	**115,969**

(i) Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by employees, not including on-costs.

(ii) The amounts disclosed are discounted to present values.

Note 3.4 – Employee Benefits in the Balance Sheet (continued)

Provisions

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

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

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

Employee Benefits

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

Wages and Salaries, Annual Leave, and Accrued Days Off

Liabilities for wages and salaries, including non-monetary benefits, annual leave and accrued days off are all recognised in the provision for employee benefits as 'current liabilities', because the Health Service does not have an unconditional right to defer settlements of those liabilities.

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

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

Long Service Leave

The liability for long service leave (LSL) is recognised in the provision for employee benefits.

Current Liability – unconditional (LSL) is disclosed in the notes to the financial statements as a current liability even where Alfred Health does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- Undiscounted value – the component that Alfred Health expects to wholly settle within 12 months; and
- Present value – the component that Alfred Health does not expect to wholly settle within 12 months.

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

Any gain or loss following revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in estimations e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as an other economic flow.

Termination Benefits

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

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

On-costs related to employee expenses

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

Notes to the Financial Statements (continued)

30 June 2017

Note 3.5 – Superannuation

	Paid Contribution for the year		Contribution outstanding at	
	Consol'd 2017 $'000	Consol'd 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
(i) Defined benefit plans:				
Health Super	784	792	61	78
Defined contribution plans:				
First State	30,320	29,836	2,459	3,149
Vic Super	133	138	10	14
Hesta	19,675	17,549	1,603	1,780
Other	6,353	5,327	1,995	1,413
TOTAL SUPERANNUATION	**57,265**	**53,642**	**6,128**	**6,434**

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

Defined contribution superannuation plans

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

Defined benefit superannuation plans

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

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

The name and details of the major employee superannuation funds and contributions made by Alfred Health are disclosed in Note 3.5: Superannuation.

Superannuation liabilities

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

Note 4 – Key Assets to Support Service Delivery

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

Structure

Note 4.1 – Investments and Other Financial Assets

	Consolidated Specific Purpose Fund	
Non-Current Assets Available for sale	**2017 $'000**	**2016 $'000**
Managed Investment Schemes	58,173	54,606
TOTAL NON-CURRENT	**58,173**	**54,606**
Represented by:		
Investments Held in Trust	58,173	54,606
TOTAL	**58,173**	**54,606**

(a) Ageing and analysis of investments and other financial assets

Refer to Note 7.1(c) Financial Instruments for the ageing analysis investments and other financial assets.

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

Refer to Note 7.1(c) Financial Instruments for the nature and extent of credit risk arising from investments and other financial assets.

These investments are exempt from complying with Standing Direction 3.7.2.3, as granted by the Victorian Treasurer on 16 May 2017.

Notes to the Financial Statements (continued)

30 June 2017

Note 4.1 – Investments and Other Financial Assets (continued)

Investments and Other Financial Assets

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

Investments are classified in the following categories:

- Loans and Receivables; and
- Available-for-Sale financial assets.

These assets currently include Alfred Health's trustee investments, the income of which Alfred Health is wholly entitled to and, on a consolidated basis, the Alfred Hospital Whole Time Medical Specialists' Private Practice Trust Fund.

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

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

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

Impairment of Financial Assets

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

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

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

In order to determine an appropriate fair value as at 30 June 2017 for its portfolio of financial assets, Alfred Health obtained a valuation based on the best available advice using market values through reputable financial institutions. This value was compared against the valuation methodologies provided by the issuer as at 30 June 2016. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

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

Doubtful Debts

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

Note 4.2 – Interests in subsidiary and unconsolidated structured entities

The Whole Time Medical Specialists' Private Practice Scheme and Trust Fund is a charitable trust set up principally for the benefit of Alfred Health.

AASB10 *Consolidated Financial Statements* is applied in the preparation of consolidated financial statements for a group of entities under the control of the parent.

AASB 10 requires the satisfaction of all of the following three criteria for control to exist over an entity for financial reporting purposes:

(a) The investor has power over the investee;

(b) The investor has exposure, or rights to variable returns from its involvement with the investee; and

(c) The investor has the ability to use its power over the investee to affect the amount of investor's returns.

In the case of the Trust, Alfred Health has the powers noted above due to its ability to appoint and remove the majority of the trustees.

Control was deemed to have occurred on 31 May 2009, when Alfred Health appointed the trustees. At that time, the Trust had net assets of $13.197m and under AASB 3 *Business Combinations*, this amount was recognised in Alfred Health's revenue.

At 30 June 2017, the Trust had net assets of $14.686m (2016: $13.721m) which have been included in the financial statements of the consolidated entity.

Note 4.3 – Property, Plant and Equipment

a) Gross carrying amount and accumulated depreciation

	Consol'd 2017 $'000	Consol'd 2016 $'000
Land		
Crown Land at Fair Value	237,347	210,924
Total Land	**237,347**	**210,924**
Buildings		
Buildings Under Construction at cost	1,049	5,352
Buildings at Fair Value	740,886	732,538
Less Accumulated Depreciation	(141,153)	(93,606)
Total Buildings	**600,782**	**644,284**
Leasehold Improvements at fair value		
Leasehold Improvements	4,385	4,385
Less Accumulated Amortisation	(1,236)	(1,106)
Total Leasehold Improvements	**3,149**	**3,279**
Plant & Equipment, Furniture & Fittings at Fair Value		
Medical Equipment	147,025	133,931
Less Accumulated Depreciation	(106,227)	(96,341)
Total Medical Equipment	40,798	37,590
Computers & Communication Equipment	52,351	51,718
Less Accumulated Depreciation	(47,597)	(45,580)
Total Computers & Communication Equipment	4,754	6,138
Furniture & Fittings	7,234	7,237
Less Accumulated Depreciation	(6,124)	(5,823)
Total Furniture & Fittings	1,110	1,414
Other Equipment	65,769	52,907
Less Accumulated Depreciation	(37,061)	(33,817)
Total Other Equipment	28,708	19,090
Plant & Equipment – Work in Progress	13,427	18,706
Total Plant & Equipment and Furniture & Fittings	**88,797**	**82,938**
Motor Vehicles		
Motor Vehicles at Fair Value	60	60
Less Accumulated Depreciation	(60)	(60)
Total Motor Vehicles	**-**	**-**
TOTAL	**930,075**	**941,425**

Notes to the Financial Statements (continued)

30 June 2017

Note 4.3 – Property, Plant and Equipment (continued)

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

Consolidated	Land $'000	Buildings $'000	Leasehold Improve-ments $'000	Medical Equipment $'000	Computers $'000	Furniture & Fittings $'000	Other Plant & Equipment $'000	Motor Vehicles $'000	Totals $'000
Balance at 1 July 2015	**174,927**	**684,615**	**3,410**	**40,301**	**4,125**	**1,750**	**24,871**	**-**	**933,999**
Net additions and transfers between classes	-	6,704	-	8,265	3,954	-	16,620	-	35,543
Disposals (WDV)	-	-	-	(176)	-	-	-	-	(176)
Revaluation Increments	35,997	-	-	-	-	-	-	-	35,997
Depreciation (note 4.4)	-	(47,034)	(131)	(10,800)	(1,943)	(336)	(3,694)	-	(63,938)
Balance at 1 July 2016	**210,924**	**644,285**	**3,279**	**37,589**	**6,138**	**1,413**	**37,797**	**-**	**941,425**
Net additions and transfers between classes	-	4,045	-	13,331	638	-	7,721	-	25,735
Disposals (WDV)	-	-	-	(37)	-	-	(15)	-	(52)
Revaluation Increments	26,423	-	-	-	-	-	-	-	26,423
Depreciation (note 4.4)	-	(47,548)	(130)	(10,085)	(2,022)	(303)	(3,368)	-	(63,456)
Balance at 30 June 2017	**237,347**	**600,782**	**3,149**	**40,798**	**4,754**	**1,110**	**42,135**	**-**	**930,075**

Land and buildings carried at valuation: An independent valuation of Alfred Health's land and buildings was performed by the Valuer-General Victoria to determine the fair value of the land and buildings. The valuation, which conforms to Australian Valuations Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation is 30 June 2014.

In accordance with FRD 103F Alfred Health performed an annual fair value assessment of all non-financial physical assets taking into account all fair value indicators, which includes VGV land and building indices. Based on the managerial valuation Alfred Health has revalued land by $26,423k in the financial year. The next scheduled full revaluation will be conducted in 2019.

Note 4.3 – Property, Plant and Equipment (continued)

c) Fair Value Measurement Hierarchy for Assets as at 30 June 2017

	Carrying Amount As At 30 June 2017 $'000	Level 1 $'000	Level 2 $'000	Level 3 $'000
Land at Fair Value				
Non-Specialised Land	-	-	-	-
Specialised Land	237,347	-	-	237,347
Total Land at Fair Value	**237,347**	**-**	**-**	**237,347**
Buildings at Fair Value				
Non-Specialised Buildings	-	-	-	-
Specialised Buildings	600,782	-	-	600,782
Total Buildings at Fair Value	**600,782**	**-**	**-**	**600,782**
Leasehold Improvements at Fair Value				
Leasehold Improvements	3,149	-	-	3,149
Total Leasehold Improvements Fair Value	**3,149**	**-**	**-**	**3,149**
Plant & Equipment, Furniture & Fittings at Fair Value				
Medical Equipment	40,798	-	-	40,798
Computers & Communication Equipment	4,754	-	-	4,754
Furniture & Fittings	1,110	-	-	1,110
Other Equipment	28,708	-	-	28,708
Plant & Equipment – Work in Progress	13,427	-	-	13,427
Total Plant & Equipment and Furniture & Fittings Fair Value	**88,797**	**-**	**-**	**88,797**
TOTAL ASSETS AT FAIR VALUE	**930,075**	**-**	**-**	**930,075**

There have been no transfers between levels during the period.

Notes to the Financial Statements (continued)

30 June 2017

Note 4.3 – Property, Plant and Equipment (continued)

c) Fair Value Measurement Hierarchy for Assets as at 30 June 2016

	Carrying Amount As At 30 June 2016 $'000	Level 1 $'000	Level 2 $'000	Level 3 $'000
Land at Fair Value				
Non-Specialised Land	-	-	-	-
Specialised Land	210,924	-	-	210,924
Total Land at Fair Value	**210,924**	**-**	**-**	**210,924**
Buildings at Fair Value				
Non-Specialised Buildings	-	-	-	-
Specialised Buildings	644,284	-	-	644,284
Total Buildings at Fair Value	**644,284**	**-**	**-**	**644,284**
Leasehold Improvements at Fair Value				
Leasehold Improvements	3,279	-	-	3,279
Total Leasehold Improvements Fair Value	**3,279**	**-**	**-**	**3,279**
Plant & Equipment, Furniture & Fittings at Fair Value				
Medical Equipment	37,590	-	-	37,590
Computers & Communication Equipment	6,138	-	-	6,138
Furniture & Fittings	1,414	-	-	1,414
Other Equipment	19,090	-	-	19,090
Plant & Equipment – Work in Progress	18,706	-	-	18,706
Total Plant & Equipment and Furniture & Fittings Fair Value	**82,938**	**-**	**-**	**82,938**
TOTAL ASSETS AT FAIR VALUE	**941,425**	**-**	**-**	**941,425**

There have been no transfers between levels during the period.

Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision, and future periods if the revision affects both current and future periods. Judgements made by management in the application of AASs that have significant effects on the financial statements and estimates relate to:

- the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.1 Financial Instruments);
- superannuation expense (refer to Note 3.5 Superannuation);
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.4 Employee benefits in the balance sheet); and
- equities and management investment schemes classified at level 3 of the fair value hierarchy

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

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

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

Note 4.3 – Property, Plant and Equipment (continued)

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

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

The Valuer-General Victoria (VGV) is Alfred Health's independent valuation agency. Alfred Health, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether a revaluation is required.

Fair value measurement

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

The fair value measurement is based on the following assumptions:

- that the transaction to sell the asset or transfer the liability takes place either in the principal market (or the most advantageous market, in the absence of the principal market), either of which must be accessible to Alfred Health at the measurement date;
- that Alfred Health uses the same valuation assumptions that market participants would use when pricing the asset or liability, assuming that market participants act in their economic best interest.

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

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

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

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

In accordance with paragraph AASB 13.29, Alfred Health can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset. Therefore, an assessment of the HBU will be required when the indicators are triggered within a reporting period, which suggest the market participants would have perceived an alternative use of an asset that can generate maximum value. Once identified, Alfred Health is required to engage with VGV or other independent valuers for formal HBU assessment.

These indicators, as a minimum, include:

External factors:

- Changed acts, regulations, local law or such instrument which affects or may affect the use or development of the asset;
- Changes in planning scheme, including zones, reservations, overlays that would affect or remove the restrictions imposed on the asset's use from its past use;
- Evidence that suggest the current use of an asset is no longer core to requirements to deliver Alfred Health's service obligation;
- Evidence that suggests that the asset might be sold or demolished at reaching the late stage of an asset's life cycle.

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

Valuation hierarchy

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

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

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

Notes to the Financial Statements (continued)

30 June 2017

Note 4.3 – Property, Plant and Equipment (continued)

d) Reconciliation of Level 3 Fair Value

30 June 2017	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant & Equipment, Furniture & Fittings $'000	Motor Vehicles $'000	Totals $'000
Opening Balance	**210,924**	**644,284**	**3,279**	**82,938**	**-**	**941,425**
Purchases / (Sales)	-	4,046	-	21,690	-	25,736
Transfers in / (out) of Level 3	-	-	-	-	-	-
Gains or losses recognised in net result	-	-	-	(52)	-	(52)
- Depreciation	-	(47,548)	(130)	(15,778)	-	(63,456)
Subtotal	**210,924**	**600,782**	**3,149**	**88,797**	**-**	**903,652**
Items recognised in other comprehensive income						
- Revaluation	26,423	-	-	-	-	26,423
Subtotal	**26,423**	**-**	**-**	**-**	**-**	**26,423**
Closing Balance	**237,347**	**600,782**	**3,149**	**88,797**	**-**	**930,075**

There have been no transfers between levels during the period.

30 June 2016	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant & Equipment, Furniture & Fittings $'000	Motor Vehicles $'000	Totals $'000
Opening Balance	**174,927**	**684,615**	**3,410**	**71,047**	**-**	**933,999**
Purchases / (Sales)	-	6,704	-	28,839		35,543
Transfers in / (out) of Level 3	-	-	-	-	-	-
Gains or losses recognised in net result	-	-	-	(176)	-	(176)
- Depreciation	-	(47,034)	(131)	(16,773)	-	(63,938)
Subtotal	**174,927**	**644,284**	**3,279**	**82,938**	**-**	**905,428**
Items recognised in other comprehensive income						
- Revaluation	35,997	-	-	-	-	35,997
Subtotal	**35,997**	**-**	**-**	**-**	**-**	**35,997**
Closing Balance	**210,924**	**644,284**	**3,279**	**82,938**	**-**	**941,425**

Note 4.3 – Property, Plant and Equipment (continued)

Identifying unobservable inputs (level 3) fair value measurements

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

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

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

Alfred Health shall develop unobservable inputs using the best information available in the circumstances, which might include Alfred Health's own data. In developing unobservable inputs, Alfred Health may begin with its own data, but it shall adjust this data if reasonably available information indicates that other market participants would use different data or there is something particular to Alfred Health that is not available to other market participants. Alfred Health need not undertake exhaustive efforts to obtain information about other market participant assumptions. However, Alfred Health shall take into account all information about market participant assumptions that is reasonably available. Unobservable inputs developed in the manner described above are considered market participant assumptions and meet the object of a fair value measurement.

Specialised land and specialised buildings

The market approach is also used for specialised land and specialised buildings although it is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued. Specialised assets contain significant, unobservable adjustments; therefore these assets are classified as Level 3 under the market based direct comparison approach.

The CSO adjustment is a reflection of the valuer's assessment of the impact of restrictions associated with an asset to the extent that it is also equally applicable to market participants. This approach is in line with the highest and best use consideration required for fair value measurement, and takes into account the use of the asset that is physically possible, legally permissible and financially feasible. As adjustments of CSO are considered as significant unobservable inputs, specialised land would be classified as Level 3 assets.

For the health services, the depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

An independent valuation of the Health Service's specialised land and specialised buildings was performed by independent valuers Opteon as agent for the Valuer-General Victoria and Value it Property Valuers to determining the fair value of the land. The valuation was performed using the market approach adjusted for CSO. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

In accordance with FRD 103F Alfred Health performed an annual fair value assessment of all non-financial physical assets taking into account all fair value indicators, which includes VGV land and building indices. Based on the managerial valuation Alfred Health has revalued land by $26,423k in the financial year. The next scheduled full revaluation will be conducted in 2019.

Plant and Equipment and Furniture and Fittings

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

Motor Vehicles

Alfred Health 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 Alfred Health who set relevant depreciation rates during use to reflect the consumption of the vehicles. As a result, the fair value of vehicles does not differ materially from the carrying value (depreciated cost).

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

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

Notes to the Financial Statements (continued)

30 June 2017

Note 4.3 – Property, Plant and Equipment (continued)

e) Description of Significant Unobservable Inputs to Level 3 Valuations

	Valuation Technique	Significant Unobservable Inputs
Specialised Land	Market Approach	Community Service Obligation (CSO) adjustment
Specialised Buildings	Depreciated Replacement Cost	Useful life of specialised buildings
Leasehold Improvements	Depreciated Replacement Cost	Useful life of leasehold improvements
Plant and Equipment, Furniture & Fittings	Depreciated Replacement Cost	Useful life of plant, equipment, furniture & fittings
Motor Vehicles	Depreciated Replacement Cost	Useful life of motor vehicles

Refer to Note 7.4 for guidance on fair value measurement indicative expectations.

Property, plant and equipment

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 4.3 Property, plant and equipment.

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

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

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

Leasehold improvements are capitalised as an asset and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the improvements.

Revaluations of Non-Current Physical Assets

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

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

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

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

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

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

Note 4.4 – Depreciation and Amortisation

	Consol'd 2017 $'000	Consol'd 2016 $'000
Depreciation		
Buildings	47,548	47,034
Medical	10,085	10,800
IT Infrastructure and Equipment	2,022	1,943
Furniture and Fittings	303	336
Other Plant and Equipment	3,368	3,694
Motor Vehicles	-	-
TOTAL DEPRECIATION	**63,326**	**63,807**
Amortisation		
Leasehold Improvements	130	131
Computer Software	4,441	2,150
TOTAL AMORTISATION	**4,571**	**2,281**
TOTAL DEPRECIATION AND AMORTISATION	**67,897**	**66,088**

Depreciation

Depreciation is provided on property, plant and equipment, including freehold buildings, but excluding land and investment properties. Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

Depreciation is generally calculated on a straight-line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health & Human Services. Assets with a cost in excess of $2,500 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2016/17	2015/16
Buildings	25 – 56 years	25 – 56 years
Plant & Equipment	10 – 20 years	10 – 20 years
Medical Equipment	8 – 10 years	8 – 10 years
Computers	3 years	3 years
Furniture and Fittings	10 – 15 years	10 – 15 years
Motor Vehicles	8 years	8 years
Intangible Assets	3 – 4 years	3 – 4 years
Leasehold Improvements	40 years	40 years

Notes to the Financial Statements (continued)

30 June 2017

Note 4.5 – Intangible Assets

	Consol'd 2017 $'000	Consol'd 2016 $'000
Computer Software at cost	31,160	17,946
Less Accumulated Amortisation	(18,474)	(14,034)
TOTAL	**12,686**	**3,912**

Reconciliations of the carrying amounts of intangible assets at the beginning and end of the previous and current financial years are set out below.

	Computer Software $'000
Balance at 1 July 2015	**4,989**
Additions	1,073
Amortisation (Note 4.4)	(2,150)
Balance at 1 July 2016	**3,912**
Additions	13,215
Amortisation (Note 4.4)	(4,441)
Balance at 30 June 2017	**12,686**

Intangible Assets

Intangible assets represent identifiable non-monetary assets without physical substance such as patents, trademarks, and computer software and development costs (where applicable). Intangible assets are initially recognised at cost. Subsequently, intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses. Costs incurred subsequent to initial acquisition are capitalised when it is expected that additional future economic benefits will flow to Alfred Health.

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

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

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

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

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

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

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

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

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

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

Amortisation

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

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

Alfred Health does not have any intangible assets with indefinite useful lives. Any excess of the carrying amount over the recoverable amount is recognised as an impairment loss. Intangible assets with finite lives are amortised over a 3 to 4 year period.

Note 5 – Key Assets and Liabilities

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

Structure

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

Note 5.1 – Receivables

	Consol'd 2017 $'000	Consol'd 2016 $'000
Current		
Contractual		
Inter Hospital Debtors	1,594	2,453
Trade Debtors	4,885	5,908
Patient Fees Receivable	16,473	12,156
Accrued Revenue – Other	19,336	21,897
Less Allowance for Doubtful Debts (a)		
Trade Debtors	(188)	(400)
Patient Fees	(3,542)	(3,314)
Subtotal	**38,558**	**38,700**
Statutory		
GST Receivable	3,279	2,682
Accrued Revenue - Department of Health and Human Services	9,532	8,917
TOTAL CURRENT RECEIVABLES	**51,369**	**50,299**
Non-Current		
Statutory		
Long Service Leave – Department of Health and Human Services	10,242	7,839
TOTAL NON-CURRENT RECEIVABLES	**10,242**	**7,839**
TOTAL RECEIVABLES	**61,611**	**58,138**
(a) Movement in the Allowance for Doubtful Debts		
Balance at beginning of year	(3,713)	(3,715)
Amounts written off/(on) during the year	4,756	3,554
Increase in allowance recognised in net result	(4,773)	(3,552)
BALANCE AT END OF YEAR	**(3,730)**	**(3,713)**

(b) Ageing analysis of receivables

Please refer to Note 7.1(c) Financial instruments for the ageing analysis of contractual receivables.

(c) Nature and extent of risk arising from receivables

Please refer to Note 7.1(c) Financial instruments for the nature and extent of credit risk arising from contractual receivables.

Notes to the Financial Statements (continued)

30 June 2017

Note 5.1 – Receivables (continued)

Receivables consist of:

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

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

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

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

Note 5.2 – Inventories

	Consol'd 2017 $'000	Consol'd 2016 $'000
Pharmaceuticals		
At cost	6,355	6,295
Medical and Surgical Lines		
At cost	1,368	1,429
Radiology Stores		
At cost	432	305
Theatre Stores		
At cost	1,340	1,518
TOTAL INVENTORIES	**9,495**	**9,547**

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

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

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

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

Functional obsolescence occurs when an item no longer functions the way it did when it was first acquired.

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

Note 5.3 – Other Liabilities

	Consol'd 2017 $'000	Consol'd 2016 $'000
Current		
Patient Monies held in Trust	71	69
TOTAL	**71**	**69**
Total Monies held in Trust		
Represented by the following assets:		
Cash Assets (Note 6.2)	71	69

Note 5.4 – Prepayments and Other Assets

	Consol'd 2017 $'000	Consol'd 2016 $'000
Current		
Prepayments	2,898	2,705
TOTAL	**2,898**	**2,705**

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

Note 5.5 – Payables

	Consol'd 2017 $'000	Consol'd 2016 $'000
Current		
Contractual		
Trade Creditors (i)	31,506	29,128
Accrued Expenses	30,698	35,467
Salary Packaging	7,168	5,768
Superannuation	6,128	6,434
	75,500	76,797
Statutory		
Department of Health and Human Services (ii)	1,294	1,200
	1,294	1,200
TOTAL	**76,794**	**77,997**

(i) The average credit period is 46 days (2016: 42 days). No interest is charged on payables.

(ii) Terms and conditions of amounts payable to The Department of Health & Human Services vary according to the particular agreement with the Department.

(a) Maturity analysis of payables – Please refer to Note 7.1(d) for the ageing of contractual payables.

(b) Nature and extent of risk arising from payables – Please refer to Note 7.1(d) Financial instruments for the nature and extent of risk arising from contractual payables.

Notes to the Financial Statements (continued)

30 June 2017

Payables consist of:

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

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

Note 6 – How we Finance our Operations

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

This section includes disclosures of balances that are financial instruments (such as borrowings and cash balances).

Note: 7.1 provides additional, specific financial instrument disclosures.

Structure

6.1 Borrowings

6.2 Cash and cash equivalents

6.3 Commitments

Note 6.1 – Borrowings

	Consol'd 2017 $'000	Consol'd 2016 $'000
Current		
Australian Dollar Borrowings		
- Department of Health and Human Services	2,500	2,500
- Treasury Corporation Victoria Loan	1,499	1,408
Total Current	**3,999**	**3,908**
Non-Current		
Australian Dollar Borrowings		
- Department of Health and Human Services	4,796	7,159
- Treasury Corporation Victoria Loan	15,817	17,356
Total Non-Current	**20,613**	**24,515**
TOTAL	**24,612**	**28,423**

Terms and conditions of Borrowings

Treasury Corporation Victoria

a) Repayments for the Multi Storey Car Park are quarterly with the final instalment due on 22 March 2024. The principal outstanding for this loan at 30 June 2017 is $4.5m.

b) Average interest rate applied during 2016/17 was 6.33% (2015/16: 6.39%). Interest rate is fixed for the life of the loans.

c) Repayments for the Alfred Centre Car Park are quarterly starting September 2007 and with the final instalment due on 15 June 2027. The principal outstanding for this loan at 30 June 2017 is $12.8m.

d) Repayment of these loans has been guaranteed in writing by the Treasurer.

Department of Health & Human Services

e) Department of Health & Human Services has provided an interest free loan to Alfred Health for the amount of $10m. Repayments for the DHHS loan are annually starting 30 June 2017 and with the final instalment due on 30 June 2020. The outstanding amount for this loan at 30 June 2017 is $7.5m.

	2017 $'000	2016 $'000
Amount of Borrowing Costs Recognised as Expense (Refer to Note 3.3)	**1,260**	**1,627**

(a) Maturity analysis of Borrowings – refer to Note 7.1 Financial instruments for the maturity analysis of Borrowings.

(b) Nature and extent of risk arising from Borrowings – refer to Note 7.1 Financial instruments for the nature and extent of risk arising from Borrowings.

(c) Defaults and breaches – there were no defaults and breaches of any loan during the current and prior year.

All borrowings are initially recognised at fair value of consideration received, less directly attributable transaction costs. The measurement basis subsequent to initial recognition is at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowing using the effective interest method.

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

Notes to the Financial Statements (continued)

30 June 2017

Note 6.1 – Borrowings (continued)

a) Operating Leases

	Consol'd 2017 $'000	Consol'd 2016 $'000
Non-Cancellable Operating Leases Payables		
Not later than one year	5,558	3,577
Later than one year but not later than five years	7,605	9,080
Later than five years	71	83
Total Operating Leases Commitments	**13,234**	**12,740**

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

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

Operating Leases

Entity as Lessee

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

Lease Incentives

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

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

Leasehold Improvements

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

Note 6.2 – Cash and Cash Equivalents

For the purposes of the cash flow statement, cash assets include cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

	Consol'd 2017 $'000	Consol'd 2016 $'000
Cash on Hand	44	44
Cash at Bank	36,723	28,603
TOTAL CASH AND CASH EQUIVALENTS	**36,767**	**28,647**
Represented by		
Cash held for:		
Health Service Operations	2,799	11,366
Pre-funded Capital Projects	31,048	15,762
Employee Salary Packaging	2,849	1,450
Total	**36,696**	**28,578**
Monies held in Trust on behalf of patients*	71	69
Total	**71**	**69**
TOTAL CASH AND CASH EQUIVALENTS	**36,767**	**28,647**

Alfred Health has an unused overdraft facility of $1,808,000 with Westpac Banking Corporation.

* Not available for cash flow statement presentation purposes as the cash is not available to be used for day–to-day operating activities of Alfred Health.

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

For cash flow statement presentation purposes, cash and cash equivalents include bank overdrafts, which are included as liabilities on the balance sheet.

Notes to the Financial Statements (continued)

30 June 2017

Note 6.3 – Commitments

	Consol'd 2017 $'000	Consol'd 2016 $'000
Capital Expenditure Commitments:		
Payable:		
Building Works	8,661	3,078
Plant & Equipment		
- Medical Equipment	1,981	10,899
- Computer Equipment	804	1,593
Total Capital Expenditure Commitments	**11,446**	**15,570**
Capital Expenditure Commitments:		
Not later than one year	11,446	15,570
Later than one year but not later than five years	-	-
Total Capital Expenditure Commitments	**11,446**	**15,570**
Other Expenditure Commitments		
Payable:		
Supplies and Consumables		
- Medical	8,688	3,539
- Other	74,230	24,893
Maintenance Contracts		
- Medical	29,457	15,581
- Information Technology	32,513	37,112
Total Other Expenditure Commitments	**144,888**	**81,125**
Other Expenditure Commitments:		
Not later than one year	49,440	43,866
Later than one year but not later than five years	91,878	37,024
Later than 5 years	3,570	235
Total Other Expenditure Commitments	**144,888**	**81,125**
Operating Leases Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating leases		
- Property	11,132	10,702
- Medical Equipment	197	230
- Motor Vehicle	1,905	1,808
Total Operating Leases Commitments	**13,234**	**12,740**
Operating Leases Commitments Payable as Follows:		
Non-Cancellable		
Not later than one year	5,558	3,577
Later than one year but not later than five years	7,605	9,080
Later than 5 years	71	83
Total Operating Leases Commitments	**13,234**	**12,740**
Total Commitments for Expenditure (inclusive of GST)	**169,568**	**109,435**
Less GST recoverable from the Australian Tax Office	**(15,415)**	**(9,949)**
Total Commitments for Expenditure (exclusive of GST)	**154,153**	**99,486**

(i) Other Supplies and Consumables commitments are inclusive of the contract to provide non-clinical support services.

Note 6.3 – Commitments (continued)

Alfred Health has operating lease arrangements for motor vehicles, office and medical equipment and property (including a car park). There are no contingent rental payments. Payments are determined within the terms of agreement and do not contain purchase options. There are no significant restrictions imposed by the lease agreements such as additional debt or further financing.

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

Note 7 – Risks, contingencies & valuation uncertainties

Introduction

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

Structure

7.1 Financial instruments

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

7.3 Contingent assets and contingent liabilities

7.4 Fair value determination

Note 7.1 – Financial Instruments

Financial Risk Management Objectives and Policies

Alfred Health's principal financial instruments comprise of:

- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Investment in Equities and Managed Investment Schemes
- Payables
- Borrowings

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

Alfred Health's main financial risks include credit risk, liquidity risk and market risk. Alfred Health manages these financial risks in accordance with its financial risk management policy.

Alfred Health uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the finance committee of Alfred Health.

The main purpose in holding financial instruments is to prudentially manage Alfred Health's financial risks within the government policy parameters.

Categorisation of financial instruments

Details of each category of financial instrument, in accordance with AASB 139, is disclosed either on the face of the balance sheet or in these notes.

Notes to the Financial Statements (continued)

30 June 2017

Note 7.1 – Financial Instruments (continued)

	Contractual Financial Assets – Available for Sale 2017 $'000	Contractual Financial Assets – Loans and Receivables 2017 $'000	Contractual Financial Liabilities at Amortised Cost 2017 $'000	Total 2017 $'000
Financial Assets				
Cash and Cash equivalents	-	36,767	-	36,767
Receivables	-	42,288	-	42,288
Other Financial Assets	58,173	-	-	58,173
Total Financial Assets (i)	**58,173**	**79,055**	**-**	**137,228**
Financial Liabilities				
Payables	-	-	75,500	75,500
Borrowings	-	-	24,612	24,612
Other Liabilities	-	-	71	71
Total Financial Liabilities (ii)	**-**	**-**	**100,183**	**100,183**

	Contractual Financial Assets – Available for Sale 2016 $'000	Contractual Financial Assets – Loans and Receivables 2016 $'000	Contractual Financial Liabilities at Amortised Cost 2016 $'000	Total 2016 $'000
Financial Assets				
Cash and Cash equivalents	-	28,647	-	28,647
Receivables	-	42,413	-	42,413
Other Financial Assets	54,606	-	-	54,606
Total Financial Assets (i)	**54,606**	**71,060**	**-**	**125,666**
Financial Liabilities				
Payables	-	-	76,798	76,798
Borrowings	-	-	28,423	28,423
Other Liabilities	-	-	69	69
Total Financial Liabilities (ii)	**-**	**-**	**105,290**	**105,290**

(i) The total amount of financial assets disclosed here excludes statutory receivables (i.e. amounts owing from Victorian State Government and GST input tax credit recoverable).

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

Note 7.1 – Financial Instruments (continued)

(b) Net holding gain/(loss) on financial instrument by category

	Net Holding gain/(loss) 2017 $'000	Net Holding gain/(loss) 2016 $'000
Financial Assets		
Cash and Cash equivalents	4,286	4,270
Available for Sale Investments	2,042	547
Total Financial Assets	**6,328**	**4,817**
Financial Liabilities		
Borrowings	(1,260)	(1,627)
Total Financial Liabilities	**(1,260)**	**(1,627)**

(i) For cash and cash equivalents, loans or receivables and available-for-sale financial assets, the net gain or loss is calculated by taking the movement in the fair value asset, interest revenue, plus or minus foreign exchange gains or losses arising from revaluation of the financial assets, and minus any impairment recognised in the net result.

(ii) For financial liabilities measured at amortised cost, the net gain or loss is calculated by taking the interest expense, plus or minus foreign exchange gains or losses from revaluation of the financial liabilities measured at amortised cost.

(c) Credit Risk

Credit risk arises from the contractual financial assets of Alfred Health, which comprise cash and deposits, non-statutory receivables and available for sale contractual financial assets. Alfred Health's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to Alfred Health. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with Alfred Health's contractual financial assets is minimal because the main debtor is the Victorian Government. It is Alfred Health's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

In addition, Alfred Health does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash assets, which are mainly cash at bank. As with the policy for Debtors, Alfred Health's policy is to only deal with banks with high credit ratings.

Provision for impairment for contractual financial assets is recognised when there is objective evidence that the Health Service will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, debts which are more than 60 days overdue, and changes in debtor credit ratings.

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Alfred Health's maximum exposure to credit risk without taking account of the value of any collateral obtained.

Notes to the Financial Statements (continued)

30 June 2017

Note 7.1 – Financial Instruments (continued)

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

	Financial institutions (AA credit rating) $'000	Government agencies (AA credit rating) $'000	Government agencies (BBB credit rating) $'000	Other (min BBB credit rating) $'000	Total $'000
2017					
Financial Assets					
Cash and Cash Equivalents	36,767	-	-	-	36,767
Trade debtors	-	4,885	-	-	4,885
Other receivables	-	1,594	-	35,809	37,403
Other Financial Assets (i)	58,173	-	-	-	58,173
Total Financial Assets	**94,940**	**6,479**	**-**	**35,809**	**137,228**
2016					
Financial Assets					
Cash and Cash Equivalents	28,647	-	-	-	28,647
Trade debtors	-	5,907	-	-	5,907
Other receivables	-	2,453	-	34,053	36,506
Other Financial Assets (i)	54,606	-	-	-	54,606
Total Financial Assets	**83,253**	**8,360**	**-**	**34,053**	**125,666**

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

Ageing analysis of financial asset as at 30 June

			Past due but not impaired				
	Consol'd Carrying Amount $'000	Not Past Due and Not Impaired $'000	Less than 1 Month $'000	1 - 3 Month $'000	3 Months - 1 Year $'000	1 - 5 Years $'000	Impaired Financial Assets $'000
2017							
Financial Assets							
Cash and Cash Equivalents	36,767	36,767	-	-	-	-	-
Receivables	42,288	15,648	8,217	5,687	9,006	-	3,730
Other Financial Assets	58,173	58,173	-	-	-	-	-
Total Financial Assets	**137,228**	**110,588**	**8,217**	**5,687**	**9,006**	**-**	**3,730**
2016							
Financial Assets							
Cash and Cash Equivalents	28,647	28,647	-	-	-	-	-
Receivables	42,413	21,930	7,110	5,401	4,259	-	3,713
Other Financial Assets	54,606	54,606	-	-	-	-	-
Total Financial Assets	**125,666**	**105,183**	**7,110**	**5,401**	**4,259**	**-**	**3,713**

Note 7.1 – Financial Instruments (continued)

Contractual financial assets that are either past due or impaired

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

There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired, and they are stated at their carrying amounts as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired.

(d) Liquidity Risk

Liquidity risk is the risk that Alfred Health would be unable to meet its financial obligations as and when they fall due.

Alfred Health's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet.

Alfred Health manages its liquidity risk by a number of avenues. Cash assets are held with more than one financial institution, and a reasonable amount of cash is held at call to enable access as required.

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

Maturity analysis of financial liabilities as at 30 June

			Maturity Dates				
	Consol'd Carrying Amount $'000	Consol'd Nominal Amount $'000	Less than 1 Month $'000	1 - 3 Month $'000	3 Months - 1 Year $'000	1 - 5 Years $'000	Over 5 Years $'000
2017							
Financial Liabilities							
Payables	75,500	75,500	72,392	2,539	569	-	-
Borrowings	24,612	24,612	-	366	3,633	13,895	6,718
Other Financial Liabilities	71	71	71	-	-	-	-
Total Financial Liabilities	**100,183**	**100,183**	**72,463**	**2,905**	**4,202**	**13,895**	**6,718**
2016							
Financial Liabilities							
Payables	76,798	76,798	75,862	568	368	-	-
Borrowings	28,423	28,764	-	301	3,607	16,041	8,815
Other Financial Liabilities	69	69	69	-	-	-	-
Total Financial Liabilities	**105,290**	**105,631**	**75,931**	**869**	**3,975**	**16,041**	**8,815**

(e) Market Risk

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

Currency Risk

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

Notes to the Financial Statements (continued)

30 June 2017

Note 7.1 – Financial Instruments (continued)

Interest Rate Risk

Exposure to interest rate risk may arise primarily through Alfred Health's interest bearing liabilities and its investment of surplus cash resources. Minimisation of risk is achieved by mainly undertaking fixed rate interest bearing financial instruments and investing in short-term financial instruments.

Inflation Rate Risk

Exposure to inflation rate risk arises through Alfred Health's interest bearing liabilities and its investment of surplus cash resources. Minimisation of risk is achieved by mainly undertaking fixed rate interest bearing financial instruments and investing in short-term financial instruments.

Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

			Interest Rate Exposure		
	Weighted Average Effective Interest Rate (%)	Carrying Amount $'000	Fixed Interest Rate $'000	Variable Interest Rate $'000	Non Interest Bearing $'000
2017					
Financial Assets					
Cash and Cash Equivalents	1.75	36,767	1,621	35,102	44
Receivables:					
Trade Debtors	-	4,885	-	-	4,885
Other Receivables	-	37,403	-	-	37,403
Other Financial Assets	-	58,173	-	-	58,173
Total Financial Assets		**137,228**	**1,621**	**35,102**	**100,505**
2017					
Financial Liabilities					
Payables	-	75,500	-	-	75,500
Borrowings	6.33	24,612	24,612	-	-
Other Financial Liabilities	2.5	71	71	-	-
Total Financial Liabilities		**100,183**	**24,683**	**-**	**75,500**
2016					
Financial Assets					
Cash and Cash Equivalents	1.75	28,647	1,607	26,996	44
Receivables:					
Trade Debtors	-	5,908	-	-	5,908
Other Receivables	-	36,506	-	-	36,506
Other Financial Assets	-	54,606	-	-	54,606
Total Financial Assets		**125,666**	**1,607**	**26,996**	**97,063**
2016					
Financial Liabilities					
Payables	-	76,798	-	-	76,798
Borrowings	6.39	28,423	28,423	-	-
Other Financial Liabilities	1.75	69	69	-	-
Total Financial Liabilities		**105,290**	**28,492**	**-**	**76,798**

Note 7.1 – Financial Instruments (continued)

Sensitivity Disclosure Analysis

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

- A parallel shift of +0.5% and -0.5% in market interest rates (AUD) from year-end rates of 1.75%;
- A parallel shift of +0.5% and -0.5% in inflation rate from year-end rates of 1.0%;
- A parallel shift of +10% and -10% in prices of Australian equities.

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

		Interest Rate Risk				Other Price Risk			
		-0.50%		0.50%		-10%		10%	
	Carrying Amount $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000	Profit $'000	Equity $'000
2017									
Financial Assets									
Cash and Cash Equivalents	36,767	(184)	(184)	184	184	-	-	-	-
Receivables:									
Trade Debtors	4,885	-	-	-	-	-	-	-	-
Other Receivables	37,403	-	-	-	-	-	-	-	-
Other Financial Assets	58,173	-	-	-	-	-	(5,817)	-	5,817
Total Financial Assets	**137,228**	**(184)**	**(184)**	**184**	**184**	**-**	**(5,817)**	**-**	**5,817**
2017									
Financial Liabilities									
Payables:	75,500	-	-	-	-	-	-	-	-
Borrowings	24,612	-	-	-	-	-	-	-	-
Other Financial Liabilities	71	-	-	-	-	-	-	-	-
Total Financial Liabilities	**100,183**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
2016									
Financial Assets									
Cash and Cash Equivalents	28,647	(143)	(143)	143	143	-	-	-	-
Receivables:									
Trade Debtors	5,908	-	-	-	-	-	-	-	-
Other Receivables	36,505	-	-	-	-	-	-	-	-
Other Financial Assets	54,606	-	-	-	-	-	(5,461)	-	5,461
Total Financial Assets	**125,666**	**(143)**	**(143)**	**143**	**143**	**-**	**(5,461)**	**-**	**5,461**
2016									
Financial Liabilities									
Payables	76,798	-	-	-	-	-	-	-	-
Borrowings	28,423	-	-	-	-	-	-	-	-
Other Financial Liabilities	69	-	-	-	-	-	-	-	-
Total Financial Liabilities	**105,290**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Please note that a change in interest rates will not affect the borrowings balance above due to the interest rate in relation to these loans being fixed for the length of their term.

Notes to the Financial Statements (continued)

30 June 2017

Note 7.1 – Financial Instruments (continued)

(f) Fair Value

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

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

Alfred Health considers that the carrying amount of financial instrument assets and liabilities recorded in the financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows the fair values of most of the contractual financial assets and liabilities are the same as the carrying amounts.

Comparison between carrying amount and fair value

	Consol'd Carrying Amount 2017 $'000	Fair value 2017 $'000	Consol'd Carrying Amount 2016 $'000	Fair value 2016 $'000
Financial Assets				
Cash and Cash Equivalents	36,767	36,767	28,647	28,647
Receivables (i)				
- Trade Debtors	4,885	4,885	5,908	5,908
- Other Receivables	37,403	37,403	36,505	36,505
Other Financial Assets (i)	58,173	58,173	54,606	54,606
Total Financial Assets	**137,228**	**137,228**	**125,666**	**125,666**
Financial Liabilities				
Payables	75,500	75,500	76,798	76,798
Borrowings	24,612	24,612	28,423	28,423
Other Financial Liabilities (i)	71	71	69	69
Total Financial Assets	**100,183**	**100,183**	**105,290**	**105,290**

(i) The carrying amounts exclude statutory financial assets and liabilities (i.e. amounts owing to and from Victorian State Government and GST input tax credit and GST Payable).

Note 7.1 – Financial Instruments (continued)

Financial Assets measured at fair value

	Carrying Amount as at 30 June $'000	Fair value measurement at end of reporting period using: Level 1 $'000	Level 2 $'000	Level 3 $'000
2017				
Available for sale financial assets				
- Equities and managed funds	58,173	58,173	-	-
Total Financial Assets	**58,173**	**58,173**	**-**	**-**
2016				
Available for sale financial assets				
- Equities and managed funds	54,606	54,606	-	-
Total Financial Assets	**54,606**	**54,606**	**-**	**-**

There have been no transfers between levels during the period.

The fair value of the financial assets and liabilities is included at the amount at which the instrument could be exchanged in a current transaction between willing parties, other than in a forced or liquidation sale. The following methods and assumptions were used to estimate fair value:

Listed securities

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

Debt securities

In the absence of an active market, the fair value of Alfred Health's debt securities and government bonds are valued using observable inputs such as recently executed transaction prices in securities of the issuer or comparable issuers and yield curves. Adjustments are made to the valuations when necessary to recognise differences in the instrument's terms. To the extent that the significant inputs are observable, Alfred Health categorises these investments as Level 2.

Unlisted securities

The fair value of unlisted securities is based on the discounted cash flow method. Significant inputs in applying this technique include growth rates applied for future cash flows and discount rates utilised.

To the extent that the significant inputs are unobservable, Alfred Health categorises these investments as Level 3.

The fair value of unlisted investments is based on the discounted cash flow technique. Significant inputs in applying this technique include growth rates applied for cash flows and discount rates used.

Alfred Health does not have unlisted securities as at 30 June 2017.

Managed Investment Schemes

Investments include Alfred Health's trustee investments. The trusts receive an income from managed investment schemes. The managed investment schemes invest in listed securities and the assets are valued with reference to a quoted (unadjusted) market price from an active market. Alfred Health categorises these assets as Level 1.

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 Alfred Health's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

Where relevant, for note disclosure purposes, a distinction is made between those financial assets and financial liabilities that meet the definition of financial instruments in accordance with AASB132 and those that do not.

The following refers to financial instruments unless otherwise stated.

Note 7.1 – Financial Instruments (Continued)

Categories of non-derivative financial instruments

Loans and Receivables

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

Loans and receivables category includes cash and deposits (refer to Note 5.1 Receivables), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Notes to the Financial Statements (continued)

30 June 2017

Note 7.1 – Financial Instruments (continued)

Available-for-sale Financial Assets

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised in 'other comprehensive income' until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in the net result for the period. Fair value is determined in the manner described in Note 7.1 Financial instruments.

Financial liabilities at amortised cost

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

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

Net Gain/(Loss) on Financial Instruments

Net gain/(loss) on financial instruments includes:

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

Revaluations of Financial Instruments at Fair Value

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

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

	Consol'd 2017 $'000	Consol'd 2016 $'000
Proceeds from disposals of Plant & Equipment		
Medical Equipment	36	29
Other Equipment	15	-
Less: Written Down Value of Non-Current Assets Sold		
Medical Equipment	(37)	(176)
Other Equipment	(15)	-
NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS	**(1)**	**(147)**

Disposal of Non-Financial Assets

Any gain or loss on the sale of non-financial assets are recognised in the comprehensive operating statement. Refer to Note 1 Summary of Significant Accounting Policies.

Impairment of Non-Financial Assets

Apart from intangible assets with indefinite useful lives, all other non-financial assets are assessed annually for indications of impairment.

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

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

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

Note 7.3 – Contingent Assets and Contingent Liabilities

No contingent assets or liabilities are present for the year ending 30 June 2017.

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

Note 7.4 – Fair Value Determination

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

(i) Newly built / acquired assets could be categorised as Level 2 assets as depreciation would not be a significant unobservable input (based on the 10% materiality threshold).

Note 8 – Other Disclosures

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

Structure

Notes to the Financial Statements (continued)

30 June 2017

Note 8.1 – Equity

	Consol'd 2017 $'000	Consol'd 2016 $'000
(a) Surpluses		
(i) Property, Plant & Equipment Revaluation Surplus (1)		
Balance at the Beginning of the Reporting Period	547,298	511,301
Revaluation Increment		
Land	26,423	35,997
Balance at the End of the Reporting Period	**573,721**	**547,298**
Represented by: Land	188,083	161,660
Buildings	385,638	385,638
	573,721	547,298
(ii) Financial Assets Available-for-Sale Revaluation Surplus (2)		
Balance at the Beginning of the Reporting Period	21,237	20,690
Valuation gain/loss recognised	2,042	547
Balance at the End of the Reporting Period	**23,279**	**21,237**
(iii) General Purpose Surplus		
Balance at the Beginning of the Reporting Period	76,057	57,409
Transfers (to)/from Accumulated Deficit	(5,066)	18,648
Balance at the End of the Reporting Period	**70,991**	**76,057**
(iv) Restricted Specific Purpose Surplus		
Balance at the Beginning of the Reporting Period	63,793	66,571
Transfers (to)/from Accumulated Deficit	(272)	(2,778)
Balance at the End of the Reporting Period	**63,521**	**63,793**
Total Surpluses	**731,512**	**708,385**
(b) Contributed Capital		
Balance at the Beginning of the Reporting Period	324,134	324,134
Balance at the End of the Reporting Period	**324,134**	**324,134**
(c) Accumulated Deficit		
Balance at the Beginning of the Reporting Period	(227,826)	(187,792)
Net Result for the Year	(27,749)	(24,165)
Transfers to General Purpose Surplus	5,066	(18,648)
Transfers to Restricted Specific Purpose Surplus	272	2,778
Balance at the End of the Reporting Period	**(250,237)**	**(227,826)**
TOTAL EQUITY AT END OF FINANCIAL YEAR	**805,409**	**804,693**

(1) The Property, Plant and Equipment asset revaluation surplus arises on the revaluation of property, plant and equipment.

(2) The financial assets available-for-sale revaluation surplus arises on the revaluation of available-for-sale financial assets. Where a revalued financial asset is sold, that portion of the surplus which relates to the financial asset, and is effectively realised, is recognised in the net result. Where a revalued financial asset is impaired (to a value less than cost), that portion of the surplus which relates to that financial asset is recognised in net result.

Note 8.1 – Equity (continued)

Contributed Capital

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

Property, Plant and Equipment Revaluation Surplus

The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

Financial Asset Available-for-Sale Revaluation Surplus

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

General Purpose Surplus

General purpose surpluses represent specific purpose funds over which Alfred Health has management control as well as discretion on the ultimate usage of these funds.

Specific Restricted Purpose Surpluses

Specific restricted purpose surpluses are established where Alfred Health has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

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

	Consol'd 2017 $'000	Consol'd 2016 $'000
Net Result for the Year	**(27,749)**	**(24,165)**
Non-cash movements:		
Depreciation and Amortisation	67,897	66,088
Provision for Doubtful Debts	17	(2)
DH Loan Discount	138	337
Non-cash Investment Income	(3,789)	(3,763)
Movements Included in Investing and Financing Activities		
Net Loss from Disposal of Non-Financial Assets	1	147
Movements in Assets & Liabilities		
- Increase/(Decrease) in Employee Benefits	17,022	(4,022)
- (Decrease)/Increase in Payables	(1,220)	19,727
- (Decrease)/Increase in Other Liabilities	(76)	39
- (Increase) in Receivables	(3,473)	(12,789)
- (Increase) in Prepayments	(193)	(645)
- Decrease/(Increase) in Inventories	51	(1,876)
NET CASH INFLOWS/(OUTFLOWS) FROM OPERATING ACTIVITIES	**48,626**	**39,076**

Notes to the Financial Statements (continued)

30 June 2017

Note 8.3 – Responsible Persons Disclosures

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

Responsible Ministers

The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services

The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health

Responsible persons are as follows (all are Directors of Alfred Health and except where noted held their office for the period 1 July 2016 to 30 June 2017)

Ms Helen Shardey
BComm TSTC MAICD

Mr Julian Gardner
BA LLB FIPAA

Ms Sara Duncan
BSCBEng (Biomed), GCertArts (Sociology)

Mr Ben Goodfellow
FRANZCP, MBBS, MPM, CAPC

Ms Kaye McNaught
BA (PSYCH, CRIM), LLB (MELB)

Ms Miriam Suss OAM
BA MSW

Ms Melanie Eagle
BA BSW LLB, GAICD, GradDip (International Development)

Mr David Shaw
LLB
(Appointed 2 August 2016)

Accountable Officer

Mr Andrew Way
(Chief Executive)
RN BSc (Hons) MBA FAICD

Responsible Persons' Remuneration

The number of responsible persons are shown in their relevant income bands:

	Consolidated	
Income Band	**2017**	**2016**
$30,000 - $39,999	7	8
$70,000 - $79,999	1	1
$550,000 - $559,999	1	1
Total Number	**9**	**10**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$892,415**	**$915,188**

Note 8.4 – Executive Officer Disclosures

Remuneration of executives

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

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

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

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

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

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

Share-based payments are cash or other assets paid or payable as agreed between the health service and the employee, provided specific vesting conditions, if any, are met.

Several factors affected total remuneration payable to executives over the year. All executives received an annual bonus as per the terms of their individual employment contracts. A number of executive officers resigned or were retrenched in the past year. This has had an impact on total remuneration figures due to the inclusion of annual leave, long service leave and retrenchment payments.

Remuneration of Executive Officers (including Key Management Personnel disclosed in Note 8.5)	2017 $	2016 $
Short-term employee benefits	2,077,747	
Post-employment benefits	174,042	
Other long-term benefits	65,898	
Termination benefits	-	
Share-based payments	-	
Total Remuneration (i) (ii) (iii)	**2,317,687**	
Total Number of Executives	**9**	**7**
Total Annualised Employee Equivalent (AEE) (iv)	**7**	**7**

(i) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-2016 reporting period.

(ii) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 *Related Party Disclosures* and are also reported within the related parties (Note 8.5).

(iii) The remuneration of Executive Officers disclosed includes pro-rata remuneration of employees whilst acting in the Executive's roles.

(iv) Annualised employee equivalent is based on the time fraction worked over the reporting period.

Note 8.5 – Related Parties

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

- all key management personnel and their close family members;
- all cabinet ministers and their close family members; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

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

Significant transactions with government-related entities

Alfred Health received funding from the Department of Health and Human Services of $832.9 million (2016: $760.9 million).

Alfred Health also provided services to other government related entities that were not individually significant totaling $13.9 million (2016: $11.6 million), and received services that were not individually significant totaling $9.5 million (2016: $10.9 million).

Key management personnel (KMP) of the hospital include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the hospital. 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 Department of Parliamentary Services' Financial Report.

Compensation	2017 $'000	2016 $'000
Short-term employee benefits	2,881	
Post-employment benefits	237	
Other long-term benefits	92	
Termination benefits	-	
Share-based payments	-	
Total	**3,210**	

Transactions with key management personnel and other related parties

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

Outside of normal citizen type transactions with Alfred Health, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

Note 8.6 – Remuneration of Auditors

	Consol'd 2017 $'000	Consol'd 2016 $'000
Victorian Auditor-General's Office		
Audit of financial statements	251	246
Total Auditor Remuneration	**251**	**246**

Notes to the Financial Statements (continued)

30 June 2017

Note 8.7 – AASBs Issued that are not Yet Effective

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2017 reporting period. The Department of Treasury and Finance (DTF) assesses the impact of all these new standards and advises Alfred Health of their applicability and early adoption where applicable.

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

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on Alfred Health financial statements
AASB 9 *Financial instruments*	This standard simplifies requirements for the classification and measurement of financial assets, and a revised impairment loss model to recognise impairment earlier as opposed to the current approach that recognises impairment only when incurred.	1 Jan 2018	The preliminary assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 15 *Revenue from Contracts with Customers*	This Standard requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2018	Ongoing work is being done to monitor and assess the impact of this standard.
AASB 2016-7 *Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities*	This standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1 Jan 2019	Ongoing work is being done to monitor and assess the impact of this standard.
AASB 16 *Leases*	This Standard introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 Jan 2019	Alfred Health will assess the impact of this standard for future periods.
AASB 1058 *Income of Not-for-Profit Entities*	This Standard replaces AASB 1004 *Contributions* and establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objectives.	1 Jan 2019	Alfred Health will assess the impact of this standard for future periods.

Note 8.8 – Events Occurring after the Balance Sheet Date

No events after the Balance Sheet date which may have a material impact on these financial statements have occurred.

Note 8.9 – Controlled Entities

Name of Entity
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust

Country of Residence
Australia

Equity Holding
100%

Note 8.10 – Economic Dependency

The financial performance and position of Alfred Health has worsened since the prior year, with the health service reporting a deficit net result of $28,517,000 (2016: $24,342,000), a net current asset deficit position of $154,883,000 (2016: deficit $148,946,000), resulting in a current asset ratio of 0.39 (2016: 0.37).

As a result of the financial performance and position, Alfred Health has obtained a letter of support from the State Government and in particular, The Department of Health & Human Services (DHHS), confirming that the department will continue to provide Alfred Health adequate cash flow to meet its current and future obligations up to 30 September 2018. A letter was also obtained for the previous financial year. On that basis, the financial statements have been prepared on a going concern basis.

Note 8.11 – Alternative Presentation of Comprehensive Operating Statement

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Grants					
Operating	2.1	952,932	890,228	952,932	890,228
Capital	2.1	31,390	20,396	31,390	20,396
Interest	2.1	2,713	3,363	4,286	4,270
Sales of goods and services	2.1	115,375	103,982	115,399	103,982
Other Income	2.1	86,687	86,824	86,687	86,824
Revenue from transactions		**1,189,097**	**1,104,793**	**1,190,694**	**1,105,700**
Employee expenses	3.1	738,403	684,384	738,403	684,384
Operating Expenses					
Supplies and consumables	3.1	261,135	245,202	261,135	245,202
Non salary labour costs	3.1	16,675	12,780	16,675	12,780
Finance Costs - Self funded activities	3.3	1,122	1,290	1,122	1,290
Other	3.1	127,990	114,370	128,819	115,100
Non-Operating Expenses					
Finance costs - other	3.3	138	337	138	337
Expenditure for capital purpose	3.1	129	139	872	1,089
Depreciation and amortisation	4.4	67.897	66,088	67,897	66,088
Expenses from transactions		**1,213,489**	**1,124,590**	**1,215,061**	**1,126,270**
Net results from transactions - Total		**(24,392)**	**(19,797)**	**(24,367)**	**(20,570)**
Other economic flows included in net result					
Net gain/(loss) on non-financial assets	7.2	(1)	(147)	(1)	(147)
Net gain/(loss) on financial instruments		(4,773)	(4,074)	(4,030)	(3,124)
Revaluation of Long Service Leave		649	(324)	649	(324)
Total other economic flows included in net result		**(4,125)**	**(4,545)**	**(3,382)**	**(3,595)**
Net Result for the Year		**(28,517)**	**24,342)**	**(27,749)**	**(24,165)**
Other comprehensive income					
Items that will not be reclassified to net result					
Changes in Physical Asset Revaluation Surplus		26,423	35,997	26,423	35,997
Items that may be reclassified subsequently to net result					
Changes to financial assets available-for-sale revaluation surplus		1,844	1,867	2,042	547
Total other comprehensive income	**8.1**	**28,267**	**37,864**	**28,465**	**36,544**
COMPREHENSIVE RESULT		**(250)**	**13,522**	**716**	**12,379**

Notes to the Financial Statements (continued)

30 June 2017

Note 8.12 – Glossary of terms and style conventions

Actuarial gains or losses on superannuation defined benefit plans

Actuarial gains or losses are changes in the present value of the superannuation defined benefit liability resulting from

(a) experience adjustments (the effects of differences between the previous actuarial assumptions and what has actually occurred); and

(b) the effects of changes in actuarial assumptions.

Amortisation

Amortisation is the expense which results from the consumption, extraction or use over time of a non-produced physical or intangible asset.

Comprehensive result

The net result of all items of income and expense recognised for the period. It is the aggregate of operating result and other comprehensive income.

Commitments

Commitments include those operating, capital and other outsourcing commitments arising from non-cancellable contractual or statutory sources.

Current grants

Amounts payable or receivable for current purposes for which no economic benefits of equal value are receivable or payable in return.

Depreciation

Depreciation is an expense that arises from the consumption through wear or time of a produced physical or intangible asset. This expense reduces the 'net result for the year'.

Effective interest method

The effective interest method is used to calculate the amortised cost of a financial asset or liability and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial instrument, or, where appropriate, a shorter period.

Employee benefits expenses

Employee benefits expenses include all costs related to employment including wages and salaries, fringe benefits tax, leave entitlements, redundancy payments, defined benefits superannuation plans, and defined contribution superannuation plans.

Financial asset

A financial asset is any asset that is:

(a) cash;

(b) an equity instrument of another entity;

(c) a contractual or statutory right:

- to receive cash or another financial asset from another entity; or
- to exchange financial assets or financial liabilities with another entity under conditions that are potentially favourable to the entity; or

(d) a contract that will or may be settled in the entity's own equity instruments and is:

- a non-derivative for which the entity is or may be obliged to receive a variable number of the entity's own equity instruments; or
- a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments.

Financial instrument

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Financial assets or liabilities that are not contractual (such as statutory receivables or payables that arise as a result of statutory requirements imposed by governments) are not financial instruments.

Financial liability

A financial liability is any liability that is:

(a) A contractual obligation:

(i) to deliver cash or another financial asset to another entity; or

(ii) to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to the entity; or

(b) A contract that will or may be settled in the entity's own equity instruments and is:

(i) a non-derivative for which the entity is or may be obliged to deliver a variable number of the entity's own equity instruments; or

(ii) a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments. For this purpose the entity's own equity instruments do not include instruments that are themselves contracts for the future receipt or delivery of the entity's own equity instruments.

Financial statements

A complete set of financial statements comprises:

(a) Balance sheet as at the end of the period;

(b) Comprehensive operating statement for the period;

(c) A statement of changes in equity for the period;

(d) Cash flow statement for the period;

(e) Notes, comprising a summary of significant accounting policies and other explanatory information;

(f) Comparative information in respect of the preceding period as specified in paragraph 38 of AASB 101 *Presentation of Financial Statements*; and

(g) A statement of financial position at the beginning of the preceding period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements in accordance with paragraphs 41 of AASB 101.

Note 8.12 – Glossary of terms and style conventions (continued)

Grants and other transfers

Transactions in which one unit provides goods, services, assets (or extinguishes a liability) or labour to another unit without receiving approximately equal value in return. Grants can either be operating or capital in nature.

While grants to governments may result in the provision of some goods or services to the transferor, they do not give the transferor a claim to receive directly benefits of approximately equal value. For this reason, grants are referred to by the AASB as involuntary transfers and are termed non-reciprocal transfers. Receipt and sacrifice of approximately equal value may occur, but only by coincidence. For example, governments are not obliged to provide commensurate benefits, in the form of goods or services, to particular taxpayers in return for their taxes. Grants can be paid as general purpose grants which refer to grants that are not subject to conditions regarding their use. Alternatively, they may be paid as specific purpose grants which are paid for a particular purpose and/or have conditions attached regarding their use.

General government sector

The general government sector comprises all government departments, offices and other bodies engaged in providing services free of charge or at prices significantly below their cost of production. General government services include those which are mainly non-market in nature, those which are largely for collective consumption by the community and those which involve the transfer or redistribution of income. These services are financed mainly through taxes, or other compulsory levies and user charges.

Interest expense

Costs incurred in connection with the borrowing of funds includes interest on bank overdrafts and short-term and long-term liabilities, amortisation of discounts or premiums relating to liabilities, interest component of finance lease repayments, and the increase in financial liabilities and non-employee provisions due to the unwinding of discounts to reflect the passage of time.

Interest income

Interest income includes unwinding over time of discounts on financial assets and interest received on bank term deposits and other investments.

Liabilities

Liabilities refers to interest-bearing liabilities mainly raised from public liabilities raised through the Treasury Corporation of Victoria, finance leases and other interest-bearing arrangements. Liabilities also include non-interest bearing advances from government that are acquired for policy purposes.

Net acquisition of non-financial assets (from transactions)

Purchases (and other acquisitions) of non-financial assets less sales (or disposals) of non-financial assets less depreciation plus changes in inventories and other movements in non-financial assets. It includes only those increases or decreases in non-financial assets resulting from transactions and therefore excludes write-offs, impairment write-downs and revaluations.

Net result

Net result is a measure of financial performance of the operations for the period. It is the net result of items of income, gains and expenses (including losses) recognised for the period, excluding those that are classified as 'other comprehensive income'. Net result from transactions/net operating balance Net result from transactions or net operating balance is a key fiscal aggregate and is income from transactions minus expenses from transactions. It is a summary measure of the ongoing sustainability of operations. It excludes gains and losses resulting from changes in price levels and other changes in the volume of assets.

Net worth

Assets less liabilities, which is an economic measure of wealth.

Non-financial assets

Non-financial assets are all assets that are not 'financial assets'. It includes inventories, land, buildings, infrastructure, road networks, land under roads, plant and equipment, investment properties, cultural and heritage assets, intangible and biological assets.

Non-profit institution

A legal or social entity that is created for the purpose of producing or distributing goods and services but is not permitted to be a source of income, profit or other financial gain for the units that establish, control or finance it.

Payables

Includes short and long-term trade debt and accounts payable, grants, taxes and interest payable.

Produced assets

Produced assets include buildings, plant and equipment, inventories, cultivated assets and certain intangible assets. Intangible produced assets may include computer software, motion picture films, and research and development costs (which does not include the startup costs associated with capital projects).

Public financial corporation sector

Public financial corporations (PFCs) are bodies primarily engaged in the provision of financial intermediation services or auxiliary financial services. They are able to incur financial liabilities on their own account (e.g. taking deposits, issuing securities or providing insurance services).

Estimates are not published for the public financial corporation sector.

Public non-financial corporation sector

The public non-financial corporation (PNFC) sector comprises bodies mainly engaged in the production of goods and services (of a non-financial nature) for sale in the market place at prices that aim to recover most of the costs involved (e.g. water and port authorities). In general, PNFCs are legally distinguishable from the governments that own them.

Notes to the Financial Statements (continued)

30 June 2017

Note 8.12 – Glossary of terms and style conventions (continued)

Receivables

Includes amounts owing from government through appropriation receivable, short and long-term trade credit and accounts receivable, accrued investment income, grants, taxes and interest receivable.

Sales of goods and services

Refers to income from the direct provision of goods and services and includes fees and charges for services rendered, sales of goods and services, fees from regulatory services and work done as an agent for private enterprises. It also includes rental income under operating leases and on produced assets such as buildings and entertainment, but excludes rent income from the use of non-produced assets such as land. User charges includes sale of goods and services income.

Supplies and services

Supplies and services generally represent cost of goods sold and the day-to-day running costs, including maintenance costs, incurred in the normal operations of the Department.

Transactions

Revised Transactions are those economic flows that are considered to arise as a result of policy decisions, usually an interaction between two entities by mutual agreement. They also include flows in an entity such as depreciation where the owner is simultaneously acting as the owner of the depreciating asset and as the consumer of the service provided by the asset.

Taxation is regarded as mutually agreed interactions between the government and taxpayers. Transactions can be in kind (e.g. assets provided/given free of charge or for nominal consideration) or where the final consideration is cash.

Style conventions

Figures in the tables and in the text have been rounded. Discrepancies in tables between totals and sums of components reflect rounding. Percentage variations in all tables are based on the underlying unrounded amounts.

The notation used in the tables is as follows:

zero, or rounded to zero

(000) negative numbers

2017 - year period

2016 - prior year period


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Caulfield
HOSPITAL


Main Entrance
Sandringham
Sandringham
Hospital for life

The Alfred

55 Commercial Road, Melbourne VIC 3004

Telephone: (03) 9076 2000
Facsimile: (03) 9076 2222

Caulfield Hospital

260 Kooyong Road, Caulfield VIC 3162

Telephone: (03) 9076 6000
Facsimile: (03) 9076 6434

Sandringham Hospital

193 Bluff Road, Sandringham VIC 3191

Telephone: (03) 9076 1000
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Melbourne Sexual Health Centre

580 Swanston Street, Carlton VIC 3053

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