AlfredHealth

Annual Report 2017–18

theAlfred
Caulfield HOSPITAL
Sandringham HOSPITAL
MSHC MELBOURNE SEXUAL HEALTH CENTRE

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 2017 to 30 June 2018. We value transparency and accountability and aim to have 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 online at: **alfredhealth.org.au**

Contents

About Alfred Health

Alfred Health is one of Australia's leading healthcare services. We have a dual role: caring for more than 700,000 locals who live in inner-southern Melbourne and providing health services for Victorians experiencing the most acute and complex conditions through our 14 statewide services.

Our three hospital campuses – The Alfred, Caulfield Hospital and Sandringham Hospital – as well as numerous community-based clinics provide lifesaving treatments, specialist and rehabilitation services through to accessible local healthcare. We care for a wide range of people, from children to the elderly.

Highlights

110,188	emergency presentations (Alfred and Sandringham)
115,759	episodes of inpatient care
11,238	elective surgeries performed from waiting list
108	lung transplants
25	heart transplants
1,527	major trauma patients
98%	of elective surgery patients treated within clinically recommended times
383	clinical trials open as at 30 June 2018
159,678	specialist outpatient appointments
9,283	employees
542	volunteers

Our hospitals

theAlfred

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

Caulfield HOSPITAL

Caulfield Hospital specialises in community services, rehabilitation, geriatric medicine 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 and local community healthcare providers.

Community services and clinics

MSHC MELBOURNE SEXUAL HEALTH CENTRE

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 continue to develop new services to meet changing community needs, such as HOPE (a psychiatric program aiming to reduce suicide rates).

Our catchments

Alfred Health's catchment reflects our role in providing 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 is over 700,000) is predicted to grow by another 30 per cent over the next 15 years.

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

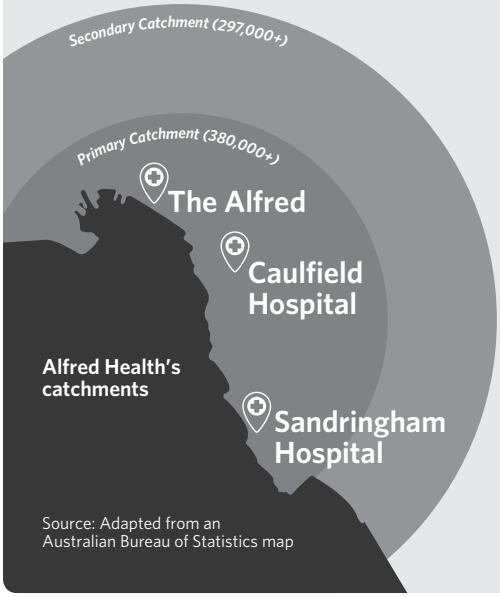
Clinical services

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, stroke services)
- **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, burns)
- **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**

14 statewide services



Alfred Health national service

Paediatric Lung Transplant Service

14 Alfred Health statewide services

Bariatric Service
Clinical Haematology and Haemophilia Services
Cystic Fibrosis Service
Heart and Lung Transplant Service
Hyperbaric Medicine Service
Major Trauma Service
Malignant Haematology and Stem Cell Transplantation Services
Psychiatric Intensive Care Service
Sexual Health Service
Specialist Rehabilitation Service
Victorian Adult Burns Service
Victorian HIV/AIDS Service
Victorian Melanoma Service
Victorian Neuropathology Laboratory Service

Chair And Chief Executive's Year In Review

Chair Michael Gorton and Chief Executive Prof Andrew Way

We are delighted to present this report, representing a year of intense activity focused on providing the best care for our patients and a safe and productive work environment for staff. Demand for our services continues to grow, especially due to last year's severe flu season.

Our trauma and critical care services continue to deal with more of Victoria's most injured patients. Our hard working staff across Alfred Health maintain a focus on delivering great care and it is appreciated by our patients.

We are grateful to all who have contributed to another year of achievement, in so many ways.

Delivering safe, effective timely care for Victorians

Ensuring consistently high quality, effective and timely care, while balancing high demand, was a significant challenge this year, and one we met, while consistently meeting access targets.

As a leading health service for Victorians, we again saw an increase in patient admissions across our services with:

- around 115,000 episodes of inpatient care: a 3.4 per cent increase
- 10 transfers per day (an 18 per cent increase) of acutely unwell patients from other hospitals
- more than 110,000 people presenting to our two Emergency Departments, a three per cent increase on last year.

Improving care , safety and quality

Fundamental to best care is listening to patients and learning what is important to them.

Results through our Patient Experience Survey have been consistently high. This year 95.8 per cent of Alfred Health patients rated their overall care as 'very good' or 'good'. And importantly, 89 per cent felt they were treated with respect and dignity 'always' and 8 per cent 'almost always'.

While these results are pleasing, we know we can improve. Better listening to family feedback has been a key learning from an incident in Caulfield Hospital's ABI Unit, where there were serious concerns about the treatment of a patient by a nurse. The incident was shocking to us all and taken extremely seriously. The nurse subsequently left the health service after an internal investigation and we welcomed the involvement of Safer Care Victoria in reviewing the unit. We have accepted all the review's recommendations and are building on staff commitment to improve patient and staff safety.

Clinical trials and research are also pivotal in discovering the healthcare for the future. We are a centre of excellence for clinical research and this year our researchers improved clinical practice worldwide with two ground-breaking studies that solved aged old debates about levels of IV fluids in surgery and the continued use of asprin prior to surgery. We also physically expanded our neurosciences unit, which now includes a clinical trials area dedicated to finding innovative new treatments and first-in-human trials.

Patients at the forefront

Even with growing presentations and major construction works within our Emergency and Trauma Centre this year, The Alfred remained the number one major Australian hospital for timely treatment of emergency patients. The Alfred achieved an average National Emergency Access Target (NEAT) of 81 per cent and Sandringham Hospital performed extremely well with 88 per cent.

The same is true for elective surgery with 98 per cent of all our patients treated within clinically recommended times.

Challenges for the year were not only the community's need for care, but the high acuity of patients who required complex treatment.

As a tertiary and quaternary health service, Alfred Health cares for our growing local community while playing a leadership role in Victoria's health system. This is most evident when our community needs us the most, such as during the Flinders St/ Bourke St incident where many pedestrians were seriously injured.

On any given night, more than half of our inpatients come from around the state, due to our role running 14 statewide services and many specialist clinics. Patients are referred to us from other health services, particularly for trauma, neurology, cardiac and infectious diseases.

Along with growth in Victoria's population, demand continued for statewide services with 1,520 major trauma presentations and growth in organ transplantation. Our expert clinicians gave many people a second chance of life through the generosity of organ donors. Tranplants were up 11 per cent for lungs, 25 per cent up for hearts and 28 per cent up for kidneys.

Winter demand pressure

Winter 2017 saw one of the most severe influenza seasons on record and at Alfred Health there was a 70 per cent increase in diagnosed cases from 2016. We responded to the high acuity of patients, thanks to a detailed winter operational plan.

Most of the state's critically ill influenza patients were cared for at The Alfred (25 per cent of ICU beds were occupied by influenza patients and heart-lung bypass grew by 17 per cent over winter).

Our expertise in lifesaving techniques like ECMO (extracorporeal membrane oxygenation), which provides heart lung bypass, highlighted the great need for our Intensive Care Unit, Victoria's largest, which cares for the most acutely ill patients in the country. ECMO cases increased by 31 per cent this year as we retrieved acutely unwell patients throughout Victoria as well as Queensland and Tasmania.

Staff wellbeing

Healthcare is increasingly a challenging work environment.

We have taken steps to improve our physical environment, making it more secure for patients and staff. The new assessment room and low stimulation wing in the redeveloped Emergency and Trauma Centre is helping patients exhibiting distress and aggression.

Changes to receptions at the entrances to The Alfred and Alfred Psychiatry are contributing to safer staff and patient environments, with better control of people moving in and out of the hospital.

Also, a new approach to responding to the deterioration of mental health patients sooner is proving highly effective in reducing incidents, as is training for frontline staff to de-escalate difficult situations.

Through our People Matter Survey, we know our staff have a high level of engagement and belief in our work and a strong attachment to the organisation. While employees report very positive results for equal opportunity, human rights and empowerment, we know that workplace stress continues to be a factor, so we will be doing more to address that.

Caring for our community

This year we were the first Victorian health service to raise concerns about vulnerability of the LGBTIQ community during the marriage equality ballot, encouraging patients who felt vulnerable to seek assistance. As our statewide services provide substantial support to this community, we hosted a forum in June where health professionals and community shared ideas about inclusive, supportive care for the LGBTI community.

Also, our reconciliation journey continued through our Reconciliation Action Plan, which was launched in August 2017 with staff, local elders and representatives of the Boon Wurrung people. This work focuses on building a greater understanding zand respect for Aboriginal culture and ensuring our health services are accessible to all.

We're also responding to our many patients whose preference is to be treated at home, where possible. This includes our GEM at Home model, an expanded telehealth service and plans for a rehabilitation at home model.

Addressing future community needs

Due to a high level of support from our community, we were able to extend the Les and Eva Erdi Emergency & Trauma Centre at The Alfred, which was opened by Premier Daniel Andrews and Minister for Health Jill Hennessy. It is the result of the largest donation received in our history.

Our new Day Procedure Centre at Sandringham, opened in early August 2018, was also possible due to strong community support. This points to the deep appreciation our community has for the care we provide and we thank them for their commitment.

This year we turned our focus to planning for the future to ensure the next generations of Victorians can continue to receive high level care.

In our Strategic Plan, we made a commitment to redevelop The Alfred as one of our key flagship projects. With a growing population, ongoing increases in patient care across all services and limited clinical space, we have created a vision for state-of-the-art critical care facilities to meet the needs of Victoria in the future. Importantly, this includes a new vision for mental healthcare facilities. We are working closely with the Department of Health and Human Services on this project.

We're also addressing pressing needs by progressing urgent infrastructure maintenance works in The Alfred's Main Ward Block. In May, the Victorian Government announced $69.5 million to support these works, which are currently being planned.

Appreciation

Thanks are due to the Board and Executive team for their ongoing dedication this year. We acknowledge the new Board members this year (including the Chair). The Board and Executive have been challenged by the issues facing the organisation and to tackle those, while delivering safe, timely care and services. But we've worked hard as a team to achieve this.

This gratitude extends to all our committed, hardworking staff, our generous volunteers and our donors, who make such a difference to the care we provide. Finally, thanks must go to our community, both locally and throughout Victoria, who support their healthcare service and inspire us to continually improve our care to meet their needs.

Michael Gorton

Chair
Alfred Health

28 August 2018

Prof Andrew Way

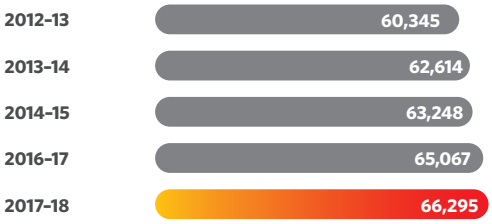
Chief Executive
Alfred Health

28 August 2018

Key indicators 2017–18

Emergency Department presentations (The Alfred)

Almost 10 per cent over four years and up 2 per cent this year.



Emergency Department presentations (Sandringham including Sandringham Ambulatory Care Centre)

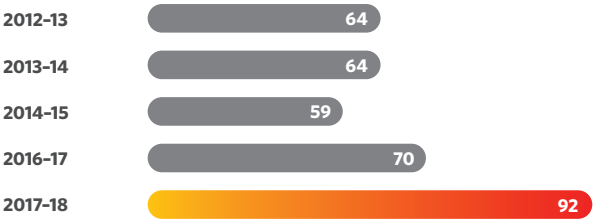
Up 5.5 per cent on last year and 26 per cent over four years.

Emergency Operating Room procedures (Alfred Health)

Up 27 per cent over four years.

Increase in ECMO patients

Patients undergoing ECMO in The Alfred's ICU increased by 31 per cent on last year.



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

Over 97 per cent for last three years and up to 98.4 per cent this year.

Acute/Geriatric Evaluation and Management (GEM) Aged Care bed days (Caulfield Hospital)

Geriatric care continues to remain high. Bed days up 16 per cent over four years.

Our patients

This year we reached out to our community, patients and their families more than ever before and incorporated their lived experiences into service planning and delivery.

By working closely with our consumers, we are gaining a better understanding of what it means to live with disability, chronic disease and mental health issues. We're also looking at alternative ways to providing care, other than traditional inpatient treatment.

Vulnerable patient initiative

Development continued on our initiative to support vulnerable patients. To date, we have:

- established a steering committee and held three workshops with community partners to set future directions
- developed a 'vulnerability risk screen' of four questions to support clinical decision making in practice. These will be trialled as part of the electronic record following electronic Timely Quality Care (eTQC) implementation
- developed training and awareness materials for staff
- explored research partnerships to increase knowledge about patient vulnerability, which may inform future health service planning and delivery
- enhanced identification of patients' disability-related needs within eTQC and explored workforce capability to support people with disabilities while using our services.

Work also continued on projects to support other specific vulnerable populations, including those who are culturally and linguistically diverse, LGBTIQ and Aboriginal and Torres Strait Islander peoples.

Vulnerability risk screening questions

1 Do you live alone?

2 Do you care for someone else?

3 Who supports you?

4 What worries you about leaving hospital?

Family violence

The Family Violence project's whole-of-hospital response includes training and support of staff, updating guidelines and enhancing referral pathways for patients in need. The project expanded in 2017–18 to focus training in The Alfred and Sandringham Hospital emergency departments (EDs) and Alfred Psychiatry. We are also engaging with LGBTIQ communities to ensure our approaches to family violence are inclusive.

In planning for our electronic medical record rollout, we have developed tools to respond and enhance safety for survivors, including a Family Violence Interdisciplinary Care Plan and a patient alert for extreme clinical risk of family violence.

Key achievements this year include:

- training over 400 frontline staff, which has given them the ability to recognise clinical risk indicators for family violence, understand risk factors and know how to respond sensitively and safely
- establishing comprehensive pathways for staff to support patients experiencing family violence
- continued consultation with family violence survivor advocates.

Who are our patients?

Patients reflect our dual role, which is caring for our local catchment and taking a leadership role for the state.

Our primary catchment is growing, with an expected annual growth of 1.7 per cent.

While our patients come from across Victoria for many specialised services, our primary catchment makes up 48 per cent of patient activity.

Transfers from other hospitals grew by 18 per cent

2016–17 2,910

2017–18 3,432

Cultural diversity

Our patients are diverse, from 212 different countries, speaking 117 different languages, including AUSLAN. Of our patients born outside of Australia, 65.5 per cent were born in non-English speaking countries. Our patients' main religious group is Christian (24.8 per cent), followed by Judaism, Islam, Buddhism and Hinduism.

The languages most commonly spoken by our patients are:

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

With such a diverse patient community, our interpreter service is invaluable. We had:

- **21,466** total occasions of service, which was made up of:
  - **17,915** face-to-face occasions
  - **3,439** phone occasions
  - **112** video interpreting.

Diversity and inclusion

We undertook a number of initiatives to strengthen inclusion, including:

- launching bilingual volunteer badges in 18 languages, so patients and visitors know which volunteers speak their language. The Alfred and Caulfield Hospital have 130 volunteers speaking 43 different languages. These volunteers provide support to CALD patients and families who often have difficulty navigating our hospitals. There are plans to roll out this initiative to interested staff
- an Alfred Health Pride Network was established to support our LGBTIQ employees and provide an opportunity for people passionate about equality to come together and improve the experience of our LGBTIQ employees, patients, carers and visitors
- an LGBTIQ-inclusive practice health sector forum in June, held to identify priorities for enhancing LGBTIQ-inclusive practice and patient experience in hospitals and health services
- creation of a staff video celebrating the ways our staff are unique. We know that having a diverse workforce helps us care for a diverse patient group.

Our volunteers with the new biligual badges

Patients Come First

The Patients Come First Strategy 2016–20 is our roadmap to supporting the best possible patient experience. In the second year of this strategy, we focused on access, communication, comfort and environment.

Access: As well as improved signage and concierge service to help people find their way, we developed a navigation app – PowerNav – in partnership with Power Health Solutions. The app guides patients through the hospital to their intended destination and has a 'meet me here' function that patients can send to their family and friends. Planned enhancements include multilingual app support.

Communication: With the help of consumers, we continued communicating in an engaging way, across different channels, such as a patient-focused website, online resource library and welcome guides. New this year:

- the rollout of public digital screens at all three hospitals, providing important health and event information
- an expanded bedside TV channel for inpatients, which is also now available on the website, as advised by the Patient Information Working Group.

Comfort and environment: Creating a comfortable place for patients to recover is integral in ensuring they will leave the hospital with a positive outlook. Our patients say that our ageing infrastructure in some facilities continues to impact their experience. Improvement initiatives included consumer participation in cleaning walk-arounds, infrared auditing in high-risk areas and specialised review in operating suites and wards 3West and 6West. Our large capital works program is also improving areas.

A working group, started in April 2018, reviews patient experience data on cleanliness and develops actions to address problem areas. Our revised patient experience survey has provided more meaningful data on the environment, including whether infrastructure and untidiness contribute to perceptions of cleanliness. We are trialling several initiatives, including visible cleaning rosters for public toilets.

Patient feedback

We regularly collect and measure our patients' views about their experiences.

Victorian Healthcare Experience Survey (VHES)

The VHES collects data from a range of healthcare users of Victorian public health services. The survey is conducted on behalf of DHHS by Ipsos, an independent contractor.

Adult patients were surveyed from July 2017 to March 2018 about overall care at Alfred Health:

- 91 per cent of inpatients rated it 'very good' or 'good'
- 93 per cent of Emergency patients rated it 'very good' or 'good'.

Adult specialist clinics

Of those who attended a specialist clinic:

- 96 per cent rated the care received as 'very good' or 'good', 4 per cent above the state average
- 85 per cent were provided with a contact if they were worried about their condition or treatment after they left the clinic, 5 per cent above the state average.

Community health

At Caulfield Hospital's Caulfield Community Health Service:

- 100 per cent of patients rated the care received as 'very good' or 'good', 4 per cent above the state average
- 87.5 per cent never had to repeat information that should have been recorded, well above the statewide average of 66 per cent
- 92.1 per cent felt the time spent waiting was about right, above the state average of 76.8 per cent
- 97.7 per cent felt that health workers were always compassionate, compared to the statewide average of 85.9 per cent.

Social worker Ellen Ford and lawyer Katie Murphy help patient Rajini Nigli with a superannuation claim.

HeLP reaches 1,000

HeLP – Health Legal Partnership – a patient legal clinic run in partnership with Maurice Blackburn Lawyers, Justice Connect and the Michael Kirby Centre helped its 1,000th patient this year. HeLP provides free legal advice and referrals for those with health-related legal problems like end-of-life planning, housing and property, criminal charges, family law, family violence and immigration problems. A team of five lawyers attend The Alfred twice weekly. Cases have included:

Family law: An ICU patient, in a critical condition, was involved in a custody dispute with an ex-partner in relation to their two young children. While an inpatient, the ex-partner would not allow the children to visit and made arrangements to move with the children overseas. HeLP arranged for family lawyers who obtained Family Court orders to prevent the move and allow for clear visitation and custody arrangements into the future. The children were able to see their parent in hospital.

Criminal law: A serious family violence incident saw a patient brought to the hospital under police custody. The patient's partner was also brought to the hospital in a critical condition. HeLP arranged for a criminal lawyer to attend the hospital on the same day to provide immediate advice to the patient prior to police charges being laid.

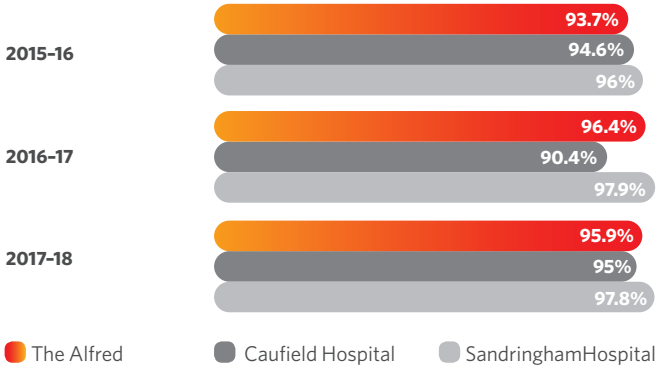
Health insurance: A young international student was admitted following a brain injury. The patient's compulsory private health insurance paid for acute care at The Alfred, but refused a claim for rehabilitation, meaning the patient could not be transferred to Caulfield Hospital. HeLP linked the patient's family with the health insurance ombudsman, which led to the insurer reversing its decision and providing funding for rehabilitation.

Our patients (cont'd)

Patient Experience Survey

Our Patient Experience Survey (PES) captures patient feedback across the health service. Feedback is collected by trained consumers who have a lived experience of Alfred Health. We surveyed 2,147 patients from July 2017 to June 2018 and found:

- **95.8 per cent** of Alfred Health patients rated their overall care as 'very good' or 'good'. By hospital campus results were:
  - **95.9 per cent** for The Alfred
  - **95 per cent** for Caulfield Hospital
  - **97.8 per cent** for Sandringham Hospital.



Results from July 2017 to 30 April 2018 revealed:

- 95 per cent said there was 'always' or 'almost always' someone on staff to talk to about worries and fears
- 89 per cent felt they were treated with respect and dignity 'always' and 8 per cent 'almost always'

Our survey questions changed in May 2018 to reflect the Patients Come First strategy. A separate survey for outpatient and ambulatory services was developed for the first time, giving those services valuable experience data.

We will be focusing on 'comfort and environment', which received a rating of 55 per cent, reflecting our hospital's old infrastructure.

Compliments and complaints

We welcome feedback from our patients and in 2017–18, we:

- received 1,630 complaints, which is similar to last year. This equates to 3.7 complaints for 1,000 bed days (not including Alfred Psychiatry), compared to 3.5 last year
- received 1,224 compliments, an increase of 88 compliments from last year.

Improving patient experiences

Expansion of telehealth

We continue to look for ways to improve access to our expert care across the state and nationally. Telehealth – where our clinicians consult with patients through video – has been introduced as an option in our specialist and statewide clinics, enhancing our capacity to deliver specialist care. The program was expanded in 2018. Key benefits for patients include increased access to services, decreased travel time and less cost.

Over 12 months we:

- held 564 telehealth appointments across 19 clinical areas
- were most active in clinic consultations for cystic fibrosis, inflammatory bowel disease, neurology and the infectious diseases regional service to Mildura
- involved rural and regional GPs in some consultations, which allowed for additional support and improved coordination of ongoing local care.

We also held telehealth sessions for rural and regional hospitals, including 40 video meetings on our antimicrobial stewardship program.

Waiting is waste

Reducing unnecessary waiting for patients was the aim of a new initiative this year. After broad consultation with various staff groups, we implemented several strategies to ensure a patient's care was progressed in a timely way. This included:

- introducing a new electronic medical unit referral system to streamline referrals for consultations provided by specialist medical teams
- improvements in the discharge processes for patients, including the adoption of an 'estimated date of discharge', enhanced patient information and improved collaboration between the team and patient to ensure a smooth discharge
- identification of factors that delay surgical start times and new strategies to streamline the process.

Environmental reorientation

A new trial, using a standardised reorientation program in acute care, reduced post-traumatic amnesia experienced by adults with traumatic brain injury, who typically are disoriented to their location, time and the identity of others.

Forty participants took part in the trial, with those in the reorientation program having the advantage of several environmental cues including a clock and signage. The reorientation was successful, with these patients experiencing amnesia for nine days, down from an average 13 days.

The reorientation program has now been rolled out across Alfred Health's neuro-trauma and Acquired Brain Injury Rehabilitation Services. The RACV Sir Edmund Herring Scholarship Program provided the funding for this work.

Phasing out tattoos

The Alfred introduced radiation without skin mark tattoos for patients with breast cancer, becoming one of only a handful of centres worldwide to do so. Instead, we are using surface-guided technology to find the correct alignment. The tattoo marks were permanent reminders of a patient's cancer experience and can be difficult to cover up, especially for breast cancer patients, who felt most impacted by the four or five tattoos traditionally used. The Alfred, and our satellite centre in Traralgon, have been setting up breast cancer patients without any skin markings and without any negative impact on the accuracy of the treatment.

National Disability Insurance Scheme

In response to the nationwide rollout of the National Disability Insurance Scheme (NDIS), we have developed an NDIS transition strategy. This has involved staff education and training to understand the scheme, its interface with health and how Alfred Health can support the community to understand and access the scheme if eligible. We are also registered NDIS service providers in some of our well-established services, including prosthetics, community Acquired Brain Injury Service and the Occupational Therapy Driving Service.

Carer involvement and recognition

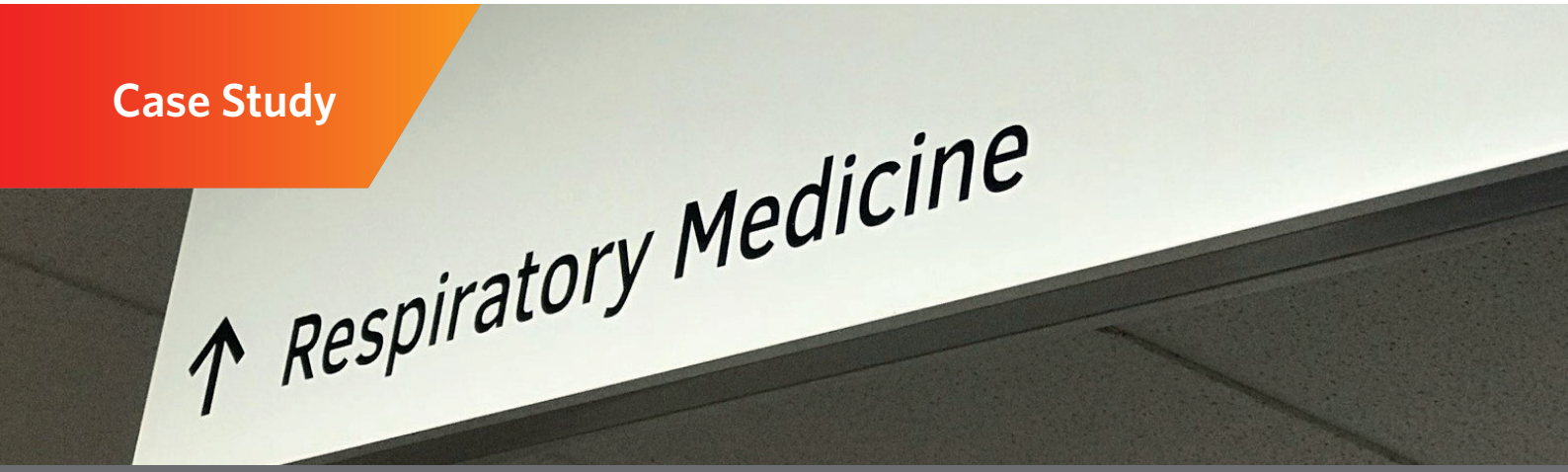
A new guideline was developed in response to Carers Recognition Act, advancing our commitment to patients and their carers. It helps staff recognise the role of unpaid carers (friends or family members) in the patient's care plan. Staff will now routinely ask: "Is there a carer?" during admission and carers will be more involved in patient care progression.

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.

Guardianship in hospitals pilot

A collaborative pilot between Alfred Health, Eastern Health, Monash Health and the Office of Public Advocate decreased waiting time for a guardian allocation from 46.5 to 23.4 days in its first year. This initiative reduces the time hospital patients with a cognitive impairment, who are unable to make important lifestyle and personal decisions, spend waiting to be allocated a guardian advocate. A dedicated hospital guardian team was created within the Office of the Public Advocate, funded by the health services. This pilot project, which has been funded for a second year, benefits vulnerable patients and improves access to healthcare and guardianship.

Case Study



Working in partnership

Plans to relocate our Respiratory Medicine outpatient clinics from Level 5 to Level 2 at The Alfred involved more than architects, builders and staff. Patients who rely on our respiratory services were at the centre of the planning process. There were two reasons for the relocation: the need for a new ward on Level 5 to treat trauma inpatients and the opportunity to improve facilities for respiratory care.

Through a patient reference group established for the project, patients with cystic fibrosis, lung transplants and other respiratory conditions provided detailed feedback on the draft designs of the new clinical areas as well as the model of care. The Cystic Fibrosis Advisory Group also provided suggestions and oversight.

Patient priorities were waiting areas, timely care, comfort and accessibility, infection prevention and patient flow through clinic appointments. Design of the new clinics, which are due to open by early 2019, has factored in these priorities along with greater capacity to treat a growing number of patients. There will be six isolation clinic rooms for the most vulnerable patients and multiple waiting areas for our patients.

Case Study

Patient escalation of care

The Let Me Know Program, which was implemented in 2014, encourages patients and their families to raise concerns directly with nurses and doctors if they are worried that something is ''not quite right'' with their loved one. 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.

32 calls
2015–16

65 calls
2016–17

45 calls
2017–18

Case 1: A relative of a severely autistic patient rang Let Me Know concerned that care of their relative was potentially not being prioritised, due to the patient's communication problems. The Let Me Know responder (an ICU liaison nurse) followed up with the ward's nurse manager, who was unaware of the family's concerns. Ongoing meetings were organised, with medical and nursing staff and all the family were involved in ongoing care, including the discharge plan.

Case 2: Patient rang unhappy with his pain relief. His neurologist had suggested pain control medication be increased; however, no order was written, despite follow-up by nursing staff. The Let Me Know responder reviewed the patient and escalated the situation to the nurse manager, who organised for the consultant to document the order. Pain control infusion was then increased, easing discomfort.

Aboriginal health

Reconciliation Action Plan launch

We launched our Reconciliation Action Plan (RAP) in August 2017. The RAP aligns with the Alfred Health 2016–20 Strategic Plan. The RAP acknowledges our need to embark on an educational journey towards greater understanding and acknowledgement of past truths about our shared history, respect for Aboriginal culture and knowing our local community.

The RAP focuses on building relationships, supporting staff with education and cultural awareness training, employment and education planning.

To make our health service more inclusive and welcoming for Indigenous Australians, we:

- employed a part-time access and support position at Carer Services to work with vulnerable Indigenous Australians with dementia and their carers
- reviewed our involvement in the Improving Cultural Responsiveness of Victorian Hospitals Project, which aims to improve cultural responsiveness and cultural safety. We received positive feedback on our high level of commitment, the role of the Aboriginal Hospital Liaison Officers (AHLOs) and our increased efforts in community engagement
- will continue to be represented at the Korin Korin Balit-Djak 2017–27 strategic planning forums
- established an Aboriginal Health Advisory Working Group, which will oversee systems, processes and initiatives to build strong relationships and enhance respect by ensuring we celebrate key Indigenous events each year, improve cultural competency through promotion and training, oversee the employment strategy to increase Indigenous Australian participation in the Alfred Health Workforce Strategy and ensure we meet minimum requirements of the National Safety and Quality Healthcare Service Standards (NSQHS Edition 2) for Indigenous Australians.

Access Health outreach

A health 'walk around' in St Kilda, in partnership with Access Health, is a new initiative. This outreach aims to work with local Indigenous Australians who don't engage with mainstream health services, such as the homeless or transient. The walk provides immediate non-acute medical attention, such as flu shots and dressings and our AHLO provides cultural support and a link to tertiary health services if required.

Local community support

The AHLOs extended their roles to provide hands-on support to local Elders. This includes providing local transport, support with discharge resources and ensuring that Elders are supplied with food basics upon discharge. Feedback from Elders has been very positive.

Patient car parking

Car parking at our hospital sites is limited, causing difficulties for our patients and visitors. We are looking at various ways to resolve this.

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:

alfredhealth.org.au/alfred-parking

alfredhealth.org.au/caulfield-parking

alfredhealth.org.au/sandringham-parking

We're seeking greater understanding and respect for Aboriginal culture.

Our employees

Feedback from our staff this year is that, while challenging, Alfred Health is a great place to work. We're focusing on staff wellbeing, caring with compassion and further developing skills to ensure patient care is exemplary.

Respect project

One of our Strategic Plan's key flagship projects is the Respect and Quality Improvement Project. This work centres on how we do things, to build a work environment that is respectful, innovative and fosters staff wellbeing. The project includes:

- implementation of Schwartz Rounds
- collaborative efforts to review and respond to complaints
- ongoing and expanded delivery of our AWARE training program
- promotion of our Treat mindfulness app

We also delivered programs to strengthen our ability to have important conversations, including talking about performance.

At the local level, programs are setting goals as part of their Quality and Business Improvement Plans to bolster staff safety, support and health and to build a culture of shared expectations and mutual accountability.

Innovation grants

Our annual innovation grants encourage staff to find new, clever ways to improve care or solve challenges across the organisation. We received 70 applications this year and there were three recipients:

1. **Smart and Safe Alarms (ICU)** – a safety system will be developed where multiple simultaneous alarms trigger a single urgent response. The aim is to reduce alarm fatigue, raise alarm responsiveness and improve patient safety.
2. **Right Nurse, Right Patient, Every Time (Nursing)** – this project automatically allocates nurses, considering the patients they have cared for previously and incorporates patient and nursing requirements and preferences.
3. **The Amazing and Awesome Project:** Learning from Excellence (Centre for Health Innovation) – this project uses a web-enabled reporting form so frontline workers can show their appreciation for the work of their colleagues and help our organisation learn from excellence in the workplace. The online form is now active in ICU and a rollout across the organisation is planned for late 2018.

Staff training

Family violence – increasing skills and awareness

This year we trained Alfred Emergency Department (ED) staff to identify patients who might be at risk of family violence and to sensitively enquire about it, where safe to do so. We trained nearly 70 per cent of frontline ED staff to support patients at risk, by providing access to social work or an external service. We also commenced training Alfred psychiatry staff.

Supporting staff at home

Recognising that family violence affects people across all socioeconomic groups, we supported staff by:

- emphasising self-care through frontline training sessions
- collaborating with Human Resources (HR) and OHS to develop staff family violence responses, with HR presenting on family violence at staff forums
- providing access to family violence leave for all staff.

Nursing and Allied Health education

We established an inter-professional model of education and education strategy, ensuring teams that work together now learn together. This is supported by the first Director of Education of Allied Health and Nursing Education, appointed in June 2017.

Achievements of our new educational approach include:

- piloting a clinical supervision course, which resulted in immediate improvements in participant perceptions of confidence and reflective practice
- being requested by DHHS to mentor rural health services in the Registered Undergraduate Student of Nursing (RUSON) project, first piloted here in 2017.

In partnership with 11 universities across Melbourne, we supported:

- more than 1,600 undergraduate clinical placements and
- over 150 postgraduate students.

Nurses extending practice

Nurses are expanding beyond their traditional roles, with extra training and credentialing. Extra training in the last year has seen nurse-led analgesia and nurse-led FibroScans.

Our nurse practitioner (advanced practice nurse) program continues to grow and has expanded to include urology. Nurse practitioners are registered nurses who have studied further to acquire expert knowledge, complex decision-making skills and clinical competences so they can practice beyond traditional nursing roles. Extended practice can include prescribing medications, ordering diagnostic investigations and direct referral to other healthcare professionals. We now have 21 endorsed nurse practitioners working throughout Alfred Health and six trainees, which includes the new areas of HIV, ophthalmology, haematology (bone marrow transplant and general) and mental health/addiction in the community.

A new project – nurse-initiated pathology orders in the ED with a blood protocol initiating nurse role was approved for implementation and a central venous access device advanced scope of practice nursing role has been introduced in intensive care.

Medical education

We employ more than 600 junior doctors at various stages of postgraduate training and foster a strong culture of education, professional development, mentoring and support.

We are accredited by the Postgraduate Medical Council of Victoria (PMCV) for training doctors in their first and second postgraduate years and are accredited to provide specialist training in over 35 fellowship training programs. Our success rate for trainees entering and completing specialist training is high:

- 87 per cent passed the Royal Australasian College of Physicians (RACP) basic physician exam for 2017
- an Alfred Health candidate was awarded the medal for best overall score
- 180 senior staff were involved in exam preparation teaching and/or delivering college requirements.

Pharmacy intern training program

In 2018, we introduced an Intern Foundation Program for interns to train side-by-side with some of Australia's most advanced clinical pharmacists. Also, we have:

- introduced the Society of Hospital Pharmacists of Australia's accredited residency program – a supported two-year program designed for motivated pharmacists in their foundation years
- started planning a clinical pharmacy fellowship (or advanced residency program) in a specific clinical specialty over two years.

Highlights

9,283 employees as at 30 June

625 length of service awards

eLearning module – end-of-life care

In March 2018, we launched a new eLearning program called The Good Life – A Conversation Worth Having. This program complemented the current end-of-life communication workshop delivered to our junior doctors, but targeted a larger medical audience. Its aim is to help staff have conversations with patients and families around end-of-life care and to support the new legislation.

The program has been well received by junior medical staff, with interest from nursing and allied health staff in accessing something similar.

The course evaluation found:

- 74 per cent of staff believed it has improved their understanding of how their choice of words and body language might influence patient choices when discussing treatment options
- 75 per cent of staff believe that the knowledge, skills and information will help them with confidence in discussing treatment options with patients and their relatives.

Staff engagement

People Matter Survey

The 2018 People Matter Survey, which canvasses the views and experiences of staff, was completed in late May 2018 by 46 per cent of the workforce, a significant increase (up 13 per cent) in participation, compared to 2017.

Positives reported:

- greater employee engagement (74 per cent) and job satisfaction (76 per cent)
- greater satisfaction in the way change is implemented, managed, communicated and supported across the organisation
- very positive results for equal opportunity employment, human rights, reward and empowerment and psychological health
- 84 per cent were more likely to recommend Alfred Health to a friend or relative as a place to be treated, above health industry averages of 76 per cent
- a strong pride and attachment to the organisation, work to a high standard, provide great service and value human rights.

Areas of improvement included:

- workplace stress continues to be a factor, with 25 per cent reporting high stress, compared to 20 per cent in 2017
- 4 per cent indicated they were experiencing bullying in the workplace (same result as 2017), with a further 11 per cent saying that this had occurred in the previous 12 months but was not occurring anymore. This matches the health industry average
- staff want more formal feedback on their performance.

Case Study

The new Schwartz rounds are attracting staff from all areas and encouraging compassion.

Working with compassion

We introduced Schwartz Rounds in early 2018 – this is a forum where clinical and non-clinical staff come together regularly to discuss the emotional and social aspects of working in healthcare. This initiative was developed to address how experiences with patients and their families shape staff's emotional responses, impact their wellbeing and influence the care they provide.

The rounds offer staff a regular time during their fast-paced work to share experiences, thoughts and feelings on topics drawn from actual cases. The focus is on telling the caregivers' stories and experiences, rather than problem solving.

Compelling subjects such as *The Patient I Will Never Forget* and *How to Maintain Empathy* for the Challenging Patient attracted hundreds of staff. Over 90 per cent of participants believed the forums offered new insights and a fresh approach to discussing difficult subjects. Staff feedback included:

"For the first time, I feel that I have had permission to publicly address and process the emotional responses to the difficult situations we face in a work forum. It allows us to move from a 'get on with it approach' and gives a voice to personal impacts of delivering care."

"Great initiative to improve focus on compassion – which can filter to positive changes on how we support each other and patients/family in our local work areas."

Health and wellbeing

We continue to support staff health and wellbeing, which contributes to a higher quality of healthcare.

Working in the demanding, sometimes intense, area of healthcare results in staff experiencing workplace stress. This year, one-quarter of our staff reported high stress, which compares to 23 per cent experienced in similar health services. The main cause was the nature or demands of the work people perform and time pressures.

Recognising that workplace stress often impacts people's personal lives, we hold regular debriefing sessions in our high-intensity areas like ICU and ED and are looking at holding similar debriefings at Caulfield Hospital.

Employee Assistance Program (EAP)

EAP services, provided by Benestar (formerly known as Davidson Trahaire Corpsych) were taken up by 2.8 per cent of staff this year, marginally above health industry average usage of 2.6 per cent.

There was a significant increase in the number of onsite Trauma Assist counselling and debriefing sessions held with staff, at manager request, to cover traumatic patient and staff events.

Over two-thirds of EAP access is for personal reasons, mainly stress, anxiety and marital discord. The main work-related reasons for accessing the service are work trauma, manager issues and dealing with bullying or harassment.

Staff fitness

Our Active Travel Zone (ATZ) at The Alfred has more than 500 members. Many staff look after their health:

- over 50 per cent of ATZ members cycle to work every day
- 370 employees are members of our two hospital gyms
- 44 per cent of employees are meeting recommended national physical activity guidelines for good health.

Healthy choices

In 2018, our hospital cafes again met the Victorian Healthy Choices guidelines, which demonstrates our commitment to supporting staff and visitors to eat healthily.

We renewed contracts with an agreed panel of catering providers, including social enterprises, who ensure catered events have the most nutritious foods possible.

Quitting support

We continue to support our staff to quit smoking, including providing nicotine replacement therapy and best practice support. To date we've supported 83 employees and so far in 2018, more than 50 per cent of staff supported have quit.

We continue to support staff health and wellbeing, which contributes to a higher quality of healthcare.

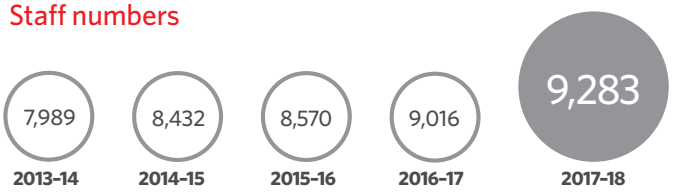
Recruiting and retaining

We welcomed 1,839 new employees.

Headcount

Staff numbers grew by 14 per cent over the last five years, as services have expanded and demand increased.

Staff numbers



				2017
Location	**Casual**	**Full Time**	**Part Time**	**Grand Total**
Alfred	835	2,976	3,198	7,009
Caulfield	203	537	713	1,453
Sandringham	83	160	311	554
Grand total	1,121	3,673	4,222	9,016

				2018
Location	**Casual**	**Full Time**	**Part Time**	**Grand Total**
Alfred	985	2,893	3,376	7,254
Caulfield	213	553	717	1,483
Sandringham	76	141	329	546
Grand total	1,274	3,587	4,422	9,283

Workforce

	Current month FTE		YTD FTE*	
Hospitals labour category	**2017**	**2018**	**2017**	**2018**
Nursing	2,532	2,595	2,371	2,532
Administration/Clerical	989	1,049	977	1,009
Medical Support	557	576	545	558
Hotel and Allied Services	207	208	211	206
Medical Officers	204	218	205	208
Hospital Medical Officers	531	557	537	554
Sessional Clinical	155	163	157	159
Ancillary Staff (Allied Health)	987	978	941	959

*The average FTE is calculated based on the weighted average of employees in each category in the 2017–18 year.

Staff are expected to adhere to the Alfred Health beliefs and the Public Sector Code of Conduct for Victorian Public Sector employees.

All staff are issued with, and expected to adhere to, the Alfred Health Code of Conduct and Compliance, which is consistent with the Charter of Human Rights and Responsibilities and promotes the principles of equal opportunity and fair and reasonable treatment for all.

Occupational health and safety

Keeping our staff safe, healthy and supported at work remains a key organisational commitment. We continued to communicate our zero tolerance for violence towards health workers.

The Occupational Health, Safety and Wellbeing (OHSW) Executive Committee focused on implementing key initiatives from our OHSW Strategy, including:

- implementing an early intervention program to provide staff with timely access to medical treatment and support so they can stay at work
- managing the risks associated with manual handling and occupational aggression and violence
- improving how we monitor and report on our performance
- implementing new OHSW consultative committees, chaired by senior leaders.

We also developed a framework for sustaining safe behaviours at work, with a roadmap for implementing a safety behaviour change program across Alfred Health. The framework is based on staff feedback and a literature review to ensure it meets our needs.

Physical works to improve our environment has included a new Behaviours of Concern area in ED and a psychiatry reception.

Overview of health and safety

Measure	2015–16	2016–17	2017–18	Explanation
Number of hazards reported	– *	1,600	1,380	Approximately 16 per cent reduction in hazards reported and we hope to see a further reduction next year.
Number of lost time standard claims	66	87	56	A 36% reduction in the number of standard WorkCover claims lodged, with manual handling injuries the main reduction, due to a renewed focus in this area.
Average cost per claim (including estimate)	$65,126	$63,112	$56,215	An 11% reduction in the average cost of WorkCover claims, with the most significant in manual handling injuries, due to improved return to work practices and fewer injuries.
Fatality	0	0	0	N/A

** data not collected*

Occupational violence

In healthcare, occupational violence remains an issue. We are introducing measures to make it safer for our staff at work.

Key achievements:

- trained a further 910 frontline staff in de-escalation techniques through our AWARE program, which aims to reduce conflict situations
- established an Occupational Violence Steering Committee, with representation from across Alfred Health and unions
- continued to communicate our zero tolerance for violence towards health workers
- developed a process to support staff who experienced occupational violence, helping them lodge complaints with police and pursue legal options.

Injury from incidents almost halved

Occupational violence statistics *	2016–17	2017–18
WorkCover-accepted claims with an occupational violence cause per 100 FTE	0.218	0.217
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0.02	0.269
Number of occupational violence incidents reported	516	489
Number of occupational violence incidents reported per 100 FTE	8.68	7.91
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	29%	15%

**Definitions are in the glossary on page 129*

In May, ED staff stood together with our friends from Ambulance Victoria - workplace violence is never OK.

It's never okay

We continued supporting and promoting the Victorian Government's It's never OK campaign, which aims to reduce occupational violence and aggression against healthcare workers.

We know that to provide the best patient care, you need to feel safe and secure at work. We have reminded 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 and not part of our jobs.

Manual handling

Reducing manual handling injuries remains a priority, as it is our biggest OHS risk. More staff are injured while undertaking manual handling activities than any other incident. These injuries contribute more than 50 per cent of our annual WorkCover premium. This year, we saw manual handling claims decrease by 46 per cent. Our work in this area included:

- introduction of a new manual handling and SafeMoves policy, which has seen an increase in the completion of SafeMoves training and competency requirements and encourages local ownership
- work plans and key actions through all OHSW committees, focusing on incident and injury prevention, with assessment and review of key high-risk tasks
- purchase of additional manual handling equipment, such as overhead hoists, to reduce risk.

WorkCover claims

Total claims were reduced by 19 per cent compared to 2016–17.

Incident type	2016–17	2017–18
Exposure to noise, chemicals, etc	3	4
Hit or hit by, excluding violence	1	11
Mental stress	2	8
Occupational violence	9	4
Other	2	7
Slips, trips and falls	16	12
Manual handling	58	31
Grand total	**91**	**73**

Recognising excellence

Australia Day honours

Senior neurosurgeon Professor Jeffrey Rosenfeld was awarded the Companion of the Order of Australia (AC) for eminent achievement and merit of the highest degree in service to the country and humanity at large.

Adjunct Professor John Kelly, The Alfred's head of the Victorian Melanoma Service, received the Member of the Order of Australia award for significant service to medicine through the management and treatment of melanoma, and service to education.

Medals of the Order of Australia (OAM) were awarded to:

- **Archivist Peter Frawley** for service to cricket and the community.
- Former Caulfield Hospital employee **Annette Madden** for her contribution to aged care.

Queen's Birthday honours

Professor Kit Fairley, Director of Melbourne Sexual Health Centre, was awarded Officer of the Order of Australia (AO) for his distinguished service to community health, particularly in the area of infectious and sexually transmitted diseases, as a clinician, researcher and administrator, and to medical education.

Professor John Wilson, Head of Cystic Fibrosis Service, was awarded the Member of the Order of Australia (AM) for significant service to medicine and to medical research, in the field of respiratory disease and to professional organisations.

Staff awards

The expertise of our staff was recognised in numerous ways:

- **Professor Wendy Brown**, Chair of the Monash University Department of Surgery at The Alfred, received the Royal Australasian College of Surgeons (RACS) John Mitchell Crouch Fellowship. The first woman awarded this honour, Professor Brown was recognised for her work on the treatment of obesity in the public health system.
- Alfred's **Dr Robbie Gillies** was named Young Victorian of the Year. He co-founded HoMie, a not-for-profit clothing store to provide clothes, training and employment to young people experiencing homelessness. He has also volunteered overseas and in remote Australian communities and founded three other charities.
- ICU's **Dr Paul Nixon and Dr Sacha Richardson**, received the trophy for the fastest extracorporeal membrane oxygenation (ECMO) cannulation in the world at the SMACCannulate conference in Berlin.
- Alfred nurse **Roni Murphy** won HESTA's Outstanding Graduate in its Australian Nursing and Midwifery Awards for developing a record-keeping system that improves the care experience of patients who have difficulty communicating.

Delivering quality care

Key indicators demonstrate the level of care we provide to our community. As well as monitoring performance against benchmarks, we are continually working on ways to improve. For example, a harm minimisation strategy recognises that patients with delirium have an increased risk of having a fall and encouraging good infection prevention strategies with our staff protects our patients.

Working with Safer Care Victoria

In January, serious concerns about the care of a patient at Caulfield Hospital were raised by the patient's family. Alfred Health management took immediate action, which included notifying Victoria Police and the Australian Health Practitioner Regulation Agency (AHPRA) and starting an internal investigation. The staff member involved was stood down and no longer works for Alfred Health.

Also, we welcomed the independent review by Safer Care Victoria which acknowledged many positive examples of care, as well as identifying areas for improvement. We have accepted all the recommendations and are working with local staff to ensure their implementation by December 2018.

"Our doctors, nurses and allied health specialists provide a high-level of specialised care, often in challenging situations," Alfred Health Chief Executive, Professor Andrew Way said.

"It is essential that all our patients feel safe and heard, and we are changing the way our clinical team escalates and acts on family feedback effectively."

Infection prevention

Infection control and prevention measures are adopted across the organisation to minimise the risks of hospital-acquired infection and improve patient safety and care.

SAB rate

Staphylococcus aureus bloodstream (SAB) infections are serious infections with significant associated morbidity and mortality. Our initiatives to reduce these infections have resulted in one SAB infection related to peripheral cannulae since July 2017. The benchmark rate has decreased from 2/10,000 occupied bed days (OBDs) to 1/10,000 OBDs.

CLABSI decline

We continue to see a sustained reduction in central line-associated bloodstream infections (CLABSIs) in our ICU, monitored against the statewide target of zero.

Multiple interventions implemented in the ICU include:

- investment in an infection prevention clinical support nurse
- a dedicated nursing resource to insert central lines
- sustained improvement with hand hygiene compliance and
- compliance assessments for aseptic technique.

Despite an increasingly complex patient group, we have sustained a decreased rate of CLABSIs, with zero infections observed in seven of the previous 10 months, with a consecutive rate of zero from January–June 2018.

Hand hygiene

With a government target set at 80 per cent, we achieved an average of 82.3 per cent compliance across the year, with:

- 81.2 per cent compliance in the first audit period (June–October 2017)
- 82.6 per cent for period two (November 2017–March 2018) and
- 84.2 per cent for period three (April–June 2018).

This year's activities included:

- developing a new hand hygiene campaign, with incentives for staff
- a new non-clinical support worker online education package.

Immunisations:

- **Influenza vaccination:** The 2017 influenza campaign, which ended in August 2017, saw 81 per cent of staff vaccinated, exceeding the DHHS target of 75 per cent. As of 30 June, and part way through the 2018 campaign, 85 per cent of staff had been vaccinated. The target vaccination rate was raised to 80 per cent. We have exceeded this new target since 2013. Due to a vaccine shortage in late May, we restricted supplies of the vaccine to staff working in high-risk areas from that date.
- **Surgical site infection:** We monitor infections related to key surgeries, as per requirements. In 2017–18 surveillance was undertaken on orthopaedic surgery, hip and knee replacements and colorectal surgery. Both areas fell below benchmark rates of infection.

  We also monitor infections in cardiothoracic surgery. Traditionally, The Alfred has performed well in coronary artery bypass graft surgery, especially considering the complexity of the cases treated here. However, following an increased rate of surgical site infections after coronary artery bypass graft surgery this year, we:

  - reviewed hand hygiene and antimicrobial prophylaxis
  - undertook additional auditing to examine the theatre environment, cleaning, and operating room processes and practices
  - commissioned an external review
  - implemented additional education and a program of patient decolonisation.

Infection rates have declined to baseline levels and efforts to reduce this further are continuing.

Antimicrobial stewardship (AMS)

Sepsis has been the focus of this program for the last 18 months, with the aim of optimising antimicrobial prescribing to ensure patients 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. A collaborative campaign was initiated by the AMS team, with stakeholders including intensive care, emergency, general medicine and nursing. This has resulted in a sustained improvement in the timeliness of antibiotics and reduction in ICU admission and mortality from sepsis.

Carbapenemase-producing Enterobacteriaceae (CPE)

Like many other Australian hospitals, our health service has been challenged by cases of multi-resistant bacteria, including CPE. Following several cases, we initiated a program of active screening for high-risk patients for CPE colonisation, and have completed tracing, counselling and screening for potential contacts.

Mycobacterium chimaera

Cases of infection with this unusual organism have been reported worldwide following cardiac surgery, including one patient at Alfred Health. We believe this infection relates to contamination of a key piece of medical equipment. We have worked closely with the Therapeutic Goods Administration (TGA) and public health authorities to screen and contact patients who underwent cardiac surgery. We replaced the equipment involved and maintain enhanced testing and cleaning practices.

Blood management

We used over 25,500 fresh blood products in 2017–18, with wastage rates remaining below target.

To address any wastage we:

- provide wards of high wastage with monthly reports for investigation and follow-up
- continue to educate staff about the need to return blood products within 30 minutes if it is not going to be used and to have patients ready for blood transfusions as soon as the blood arrives on the ward
- have added time stamps to units dispensed to ICU through the chute system
- are participating in a prospective audit involving the Blood Service and Ambulance Victoria regarding wastage of units that occur due to patient transfer from other hospital sites.

Focus on transfusion

Patient blood management strategies are in place for all patients who require transfusion. We continue to monitor transfusion rates in orthopaedics and since involvement in a national collaborative, transfusion rates in pre-operative patients decreased significantly, with an increase in single unit transfusions, where appropriate. The use of tranexamic acid to decrease the risk of bleeding for this group of patients has increased. The plan is to roll this out to all surgical groups where there is a high likelihood of blood loss and need for transfusion.

Medication safety

Analgesic stewardship

Our Analgesic Stewardship Committee has led efforts to reduce the use of opiate analgesia by engaging with health professionals and patients. Our experts appeared at the Law Reform, Road and Community Safety Committee's public hearing in June 2017, as part of its inquiry into drug law reform. The committee's pharmacist was invited to present on our stewardship model, which works to reduce inappropriate prescription and misuse.

The Victorian Government is now developing a sector-wide stewardship trial program for the medical profession (hospitals, specialist services and GPs) based on Alfred Health's model. It will promote best practice in the prescribing and use of medications with potential for misuse (such as analgesics and benzodiazepines).

Improving labelling

Since 2014, our Pharmacy has applied alerts in-house to every neuromuscular blocking agent (NMBA) ampoule and pack, as current labelling does not differentiate these from other medications. NMBAs are high-risk medications administered in critical care settings.

In November 2017, our senior pharmacy and anaesthetics staff were invited to the TGA roundtable to discuss improving the safety of NMBAs in Australia with healthcare agencies and manufacturers. This led to the TGA issuing a mandatory requirement for manufacturers to have colour-coded warning labels on NMBAs by 2020.

Improving medication safety at discharge

Our research in reducing medication errors in hospital discharge summaries won a national prize for excellence award from the *Medical Journal of Australia*. It found that when pharmacists and junior doctors work collaboratively in completing the medication management plan in the discharge summary, the number of medication errors is reduced significantly. This is made possible by having clinical pharmacists as part of the team in all medical units.

Harm minimisation

Our harm minimisation committee oversees the risk management of falls, delirium, malnutrition and pressure injury prevention. This integrated approach allows us to better understand patient risks. This year we have focused on:

- team-based risk rounds that involve patients and their families/carers to ensure a thorough and comprehensive risk management plan for patients
- exploring our patients' understanding of their risks. We are conducting a Patient Safety Consumer Focus Group to understand how best to deliver key safety messages to patients to further minimise risk.

Falls and delirium

This year, while the total number of falls increased by 7 per cent, falls with serious injury decreased by 34 per cent.

Other initiatives included:

- a data review by Caulfield Hospital, after a strong performance in reducing inpatient falls that resulted in serious injury in both rehabilitation and GEM (Geriatric Evaluation and Management) patients. We plan to investigate opportunities for acute hospital benchmarking in the coming year
- development of a safer footwear patient education package to highlight the importance of patient safety when walking.

Pressure injury prevention

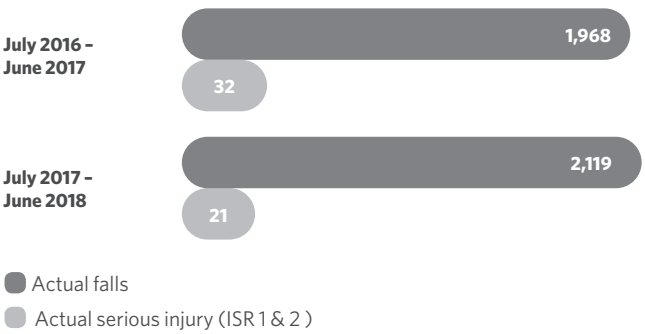
The number of serious full thickness pressure injuries that were acquired or worsened in care was 23 per cent less this year.

Our work in areas at high risk of pressure injuries is based around education, skin assessment, equipment, consumer education and risk assessments.

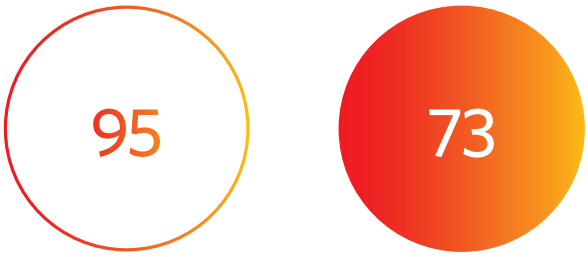
Other initiatives include:

- a Wound Matters flyer to improve staff education on pressure injury prevention and wound management
- review of the indications for use of pressure relieving mattresses for the high-risk patient population
- review of the literature, education and audit process of incontinence-associated dermatitis (IAD), which can be linked to pressure injury risk.

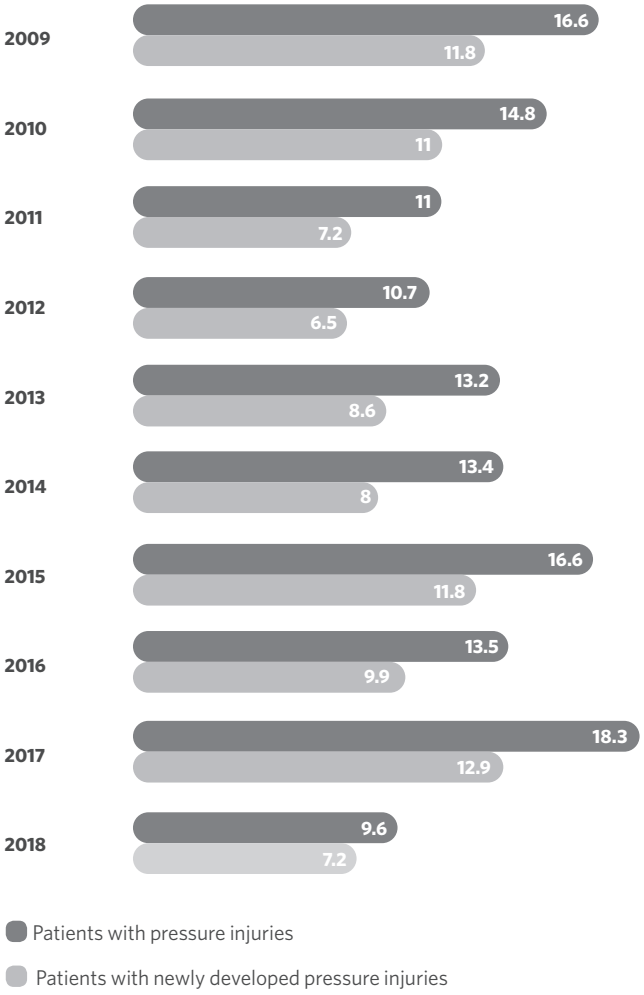
Falls and delirium



Full thickness pressure injuries



Pressure Ulcer Point Prevalence Survey (PUPPs) results



Advance care planning

The new Medical Treatment Planning and Decisions Act, implemented in March this year, has required significant work to train staff and to update documentation, policies and guidelines. We also introduced new documentation incorporating 'Goals of Care', which specifically asks patients about advance care plans. A new system has been created in the Electronic Medical Record to alert staff when a patient has an advance care directive, a medical treatment decision maker or a Refusal of Treatment Certificate.

The number of referrals to our advance care service is similar to the previous year; however, only 6 per cent of patients over the age of 75 have an advance care directive in place. Our approach is two-fold: raising awareness in patients and families and educating staff about asking patients about what is important to them.

Successful psychiatry initiatives

A marked increase in patient aggression in 2016 saw our Psychiatric Behaviour of Concern (Psy-BOC) call introduced in February 2017. It continues to be effective in reducing aggression and seclusion* rates. Psy-BOC is the equivalent of a MET (Medical Emergency Team) call for physical health deterioration and is aimed at preventing behavioural health deterioration and improving responses to individual need.

The initiative has seen clinicians responding to patient deterioration sooner. Our evaluation shows:

- 92 Psy-BOC calls made within first six months, mostly for aggression, early warning signs or non-adherence to treatment
- most common interventions to distract and comfort were pharmacological and verbal de-escalation, with sensory-based interventions used in 40 per cent of cases
- a significant reduction across the four measured behaviours of concern
- post-intervention, seclusion episodes reduced by 65 per cent, seclusion hours by 72 per cent and security standby episodes reduced by 20 per cent.

Significant refurbishment work is underway in both inpatient units, with planned development for a sensory room to offer soothing and quiet spaces, with specialist resources for patients to access.

Group programs informed by patient choice and feedback through 'Coffee on the Couch' sessions have led to expansion of music and art therapy groups over the weekend and a nurse-led Sunday breakfast club.

* definition in glossary

Mental health scoreboard

Our proactive approach in calming patients early, rather than waiting for an incident to escalate has resulted in improved rates of restraint and seclusion, which are only used as a final measure.

Adult inpatients

	Target	2017–18 actuals
Seclusions	Less than 15	5.8
Physical restraints	No set target	2
Mechanical restraint	No set target	0.4

Aged psychiatry inpatients

	Target	2017–18 actuals
Seclusions	Less than 15	0.2
Physical restraints	No set target	7.7
Mechanical restraint	No set target	0

· Data is calculated on the average monthly rate per 1,000 bed days

Performance highlights

Timely care was a big achievement in a busy year, along with initiatives to improve patient care and partnerships that furthered care of our community.

Alfred Health highlights

Top timely performance

Our National Emergency Access Target (NEAT) performance has consistently exceeded government targets in treating emergency patients in a timely way, while ED presentations increased another 3.3 per cent to 110,188.

With more than 3,000 presentations through our Emergency Departments over the 2017–18 Christmas/New Year period, our performance showed 86 per cent of patients at The Alfred and 88 per cent at Sandringham Hospital had a length of stay less than four hours. This is well above the statewide target of 81 per cent.

For the year, our NEAT performance was:

- 83 per cent for Alfred Health
- 81 per cent for The Alfred
- 88 per cent for Sandringham Hospital.

The National Elective Surgery Target (NEST) is to admit 100 per cent of Category 1 patients within 30 days – a target that was reached. The target to admit 94 per cent Category 1, 2 and 3 elective surgery patients within clinically recommended times was surpassed, with 98 per cent admitted on time.

81%

National Emergency Access Target (NEAT) Target

83%

Alfred Health

81%

The Alfred

88%

Sandringham Hospital

Partnerships

New partnership targets injury burden

Advancing the prevention and management of injury and acute trauma is the focus of a new partnership between Alfred Health and Monash University.

Each year, approximately 973 million people worldwide sustain injuries that require healthcare intervention.

The Monash Alfred Injury Network (MAIN) launched in December to bring together some of the brightest minds in medicine, and medical research. This network of 21 groups – which includes representation from anaesthesia, trauma, rehabilitation and other Alfred Health units – will work together to reinforce Australia's expertise in injury research, education, training, and clinical services by making our expertise visible and accessible in our region and beyond.

Guiding trauma systems internationally

We are working with numerous countries to improve their trauma systems, including:

- Saudi Arabia, following a service collaboration agreement signed in 2016 with King Saud Medical City (KSMC) Riyadh and Alfred Health. KSMC is collaborating with us with the aim of establishing a Level 1 Trauma Centre. We are ensuring that the project components around trauma reception and resuscitation, trauma services development, advanced trauma training and trauma registry are delivered.
- Developing China's Huizhou First Hospital into a Level 1 Trauma Centre in Guangdong. This has been complemented by the establishment of a trauma critical care program at nearby LongGang District Peoples Hospital.
- An ongoing collaboration with the Tamil Nadu Health Ministry in India, which has seen significant reductions in road deaths (over 600 in the first four months of 2018).
- A visit by our Director of Trauma Services to the Mater Hospital in Dublin, Ireland in April to advise on the establishment of their trauma system. If Ireland implements similar reforms that took place in Victoria 20 years ago, they would see significant improvements in patient outcomes.

Cardiac pathway – Latrobe region

As part of our commitment to ensuring patients receive treatment close to where they live, we have entered into a Clinical Collaborative Partnership with Latrobe Regional Hospital to help care for patients with heart disease. This partnership has resulted in Gippsland having its first cardiac catheterisation laboratory and in the co-appointment of two cardiologists.

The cath lab began activity in December 2017, has already performed more than 50 diagnostic procedures and will provide coronary interventions in 2019.

Cardiovascular disease rates in Gippsland are high compared with the rest of the state.

Our partnership with Latrobe includes:

- expedited referrals for early assessment and treatment of complex conditions
- rapid transfer of patients requiring urgent cardiac management
- a shared management model with regional specialists to allow the patient to be treated closer to home.

Plans for further expansion of the collaborative service include the provision of telehealth services.

Virtual intensivist project

In 2017, a new partnership with Mildura Base Hospital (MBH) delivered Victoria's first virtual intensivist. The telehealth service provided 24-hour access, clinical consultations and education to MBH clinical staff operating a five-bed ICU. At least 16 ICU patients avoided ambulance transfers to Melbourne and the care experience for patients and families improved, especially for the local Indigenous Australian community. Funded by Better Care Victoria, the telehealth service demonstrated how technology can help solve the skills shortage in rural health settings. Bairnsdale Regional Health Service is interested in replicating the model.

100 per cent of Category 1 elective surgery patients were admitted within 30 days

Case Study

Long-term patient Sarah Hawthorn returned to The Alfred in April, with baby Axel, to thank the many staff who cared for her.

Flu response

Sarah Hawthorn was critically ill when she was airlifted to The Alfred in September 2017. She had contracted the flu late in pregnancy and had delivered a baby boy four weeks early while unconscious. Complications of pneumonia and other serious conditions saw Sarah go into respiratory failure. Our ICU team worked around the clock to keep Sarah alive. She was put on ECMO – a life support machine that functions for the heart and lungs, oxygenating blood and removing carbon dioxide. After three months in a coma, she woke up and spent time on our respiratory ward before being transferred to Caulfield Hospital for rehabilitation.

Sarah is just one of the patients we treated during the influenza season of 2017. More people were admitted to our ICU with pneumonia or sepsis during the flu peak in September than previously on record. Emergency Departments at The Alfred and Sandringham Hospital saw a huge jump in presentations.

- The Alfred received 526 patients with influenza, a 68 per cent increase from 2016
- Sandringham Hospital received 151 flu patients, a 125 per cent increase on the previous year
- 25 per cent of The Alfred's ICU beds were occupied by influenza patients and heart–lung bypass grew by 17 per cent during this period.

Our work around managing winter demand helped us treat this large influx of very sick patients, while maintaining timely care.

Significant operational activities

The Alfred

The Alfred is a leader in healthcare, home to many statewide services and provides care for the most complex patients. We're also building the next generation of healthcare through translational research and education. Demand for acute care continues to rise, with continued increases in ED presentations and major trauma each year. We run Australia's most acute Intensive Care Unit (ICU), the largest in Victoria, with 80 per cent of ICU hours for statewide services.

Achievements and initiatives in 2017–18

Record number of lung transplants

More than 100 people received new lungs at The Alfred, a milestone for the transplant program.

Our medical teams performed a record 108 lung transplantations, including five paediatric lung transplants. This is 11 per cent more than last year and double the number of lung transplants we did in 2009.

Around 96 per cent of people on the waiting list are receiving new lungs, compared with 70 per cent a decade ago.

The Alfred is outperforming the United States, United Kingdom, France and Belgium with the number of lung transplants performed and Alfred transplant patients are living longer on average compared to the rest of the world.

Transplants we performed to save lives in 2017–18:

Lung – 108

Heart – 25

Kidney – 36
(including five transplants from live donors)

Stem cell transplants for cancer patients
29 allogeneic (donated cells)
56 autologous (own cells).

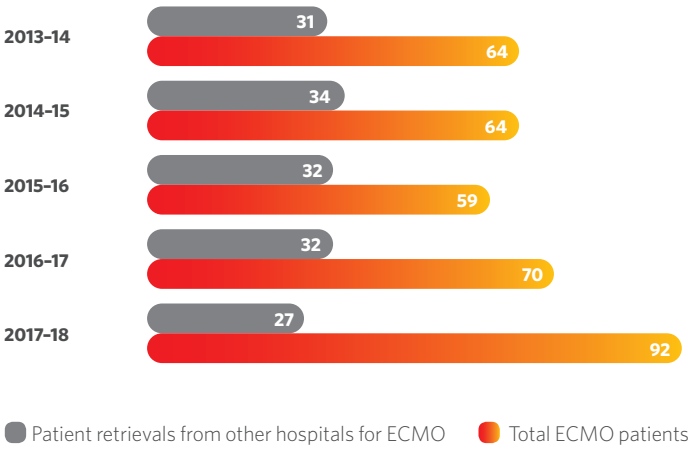
Demand for expert care

We saw a record year for ECMO (extracorporeal membrane oxygenation), with a 31 per cent increase.

ECMO (extracorporeal membrane oxygenation) is used in intensive care to provide both cardiac and respiratory support to patients whose heart and lungs are unable to work effectively on their own. The Alfred has become an expert in this technique, transferring patients in from hospitals around the country, including Queensland, Tasmania and Victoria.

Not only did many more patients need this lifesaving treatment in 2017–18, but the days these patients were on ECMO increased by 19.5 per cent, indicating the high acuity or complexity of these very sick patients.

ECMO (extracorporeal membrane oxygenation)



Expanded Emergency and Trauma Centre

We increased our capacity to care for the state's sickest and most severely injured patients thanks to a multi-million-dollar upgrade of the Eva and Les Erdi Emergency and Trauma Centre (E&TC).

The Alfred now manages risk by seeing and assessing everyone soon after arrival. We have adopted a 'streaming' system, where patients are streamed through to definitive care, which is provided by a team of doctors, nurses and Allied Health staff. This year, the centre saw more than 66,200 patients come through Alfred E&TC. That includes more than 9,000 trauma admissions. This year, we saw 1,527 major trauma cases, a 2 per cent increase on the previous year.

Prior to Christmas, our trauma expertise was required when a car collided with pedestrians at Flinders Street. Of the 19 people injured, The Alfred received 10 of them, some of whom were in a critical condition. One man died from his injuries several days later.

Neurosciences: service expansion

We created an expanded service for neurology patients on Ward 7 West. In June 2018, we opened an expanded Video EEG service, with four new beds for those with epilepsy, increasing the service to six beds. This dedicated facility, run by a multidisciplinary team, will provide advanced treatments for those with uncontrolled epilepsy in a purpose-built environment.

Renovations to this ward also resulted in a dedicated neurology trials area, with a focus on early phase clinical trials.

An ageing population and growing commonality of neurological diseases, like Parkinson's disease, stroke, multiple sclerosis, movement disorders and Alzheimer's disease, has seen our referrals increase 30–40 per cent each year.

More regional cancer care

We launched our advanced seed brachytherapy program at Latrobe Regional Hospital (LRH) in February. The treatment involves radioactive 'seeds', smaller than a grain of rice, being placed inside the patient near the tumour. Over time, the radiation damages the cancer cells so they are unable to grow or divide. Seed brachytherapy is a proven treatment for prostate cancer, with a lower risk of side effects than other treatment options.

Previously, it had been necessary to travel to a metropolitan area to access these treatments.

New innovation – bionic eye

Alfred neurosurgeons have received ethics approval to start human trials with the 'bionic eye', which is designed to restore some vision in people who are completely blind. The bionic vision system will be surgically implanted in the brain through a wireless antenna worn on the back of the head, making it suitable for those with glaucoma or those who have lost their eyes through trauma.

The device has been in development for several years. Patient recruitment will begin later in 2018.

Australian-first in treating breast cancer

In an Australian-first, Deep Inspiration Breath Hold – supported by 3D surface imaging – is being used by our radiation oncology experts at The Alfred and through our satellite site at Latrobe Regional Hospital. The breathing technique reduces radiation to the heart, lessening the risk of heart damage for women being treated for left-sided breast cancer.

The surface-guided radiation therapy technology accurately detects if the patient moves during treatment and enables treating staff to make adjustments to compensate for the movement so that radiation is administered exactly where it needs to go.

Rare surgery

The Alfred, the only hospital in Australia to perform pulmonary thromboendarterectomy (PTE) surgery performed 49 of these procedures this year. The operation removes clotted blood from pulmonary arteries. As experts in this area and with good outcomes, the New Zealand Ministry of Health contacted our surgeon to take on this lifesaving surgery for people in New Zealand, in addition to providing this national service for Australians.

Paul Butterworth, seated, was the first man from Gippsland region to receive seed brachytherapy at LRH.

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 (ABI) Rehabilitation Centre and Transitional Living Service which works to further independence before discharge. Work was continued in caring for people in their homes, which remains a patient preference.

New ways of caring for the elderly

A new program this year saw our geriatricians travel into the community to provide care, so those with mobility issues or dementia did not have to attend hospital outpatient appointments.

Our geriatricians are working together with Mobile Assessment and Treatment Service, which treats acutely unwell people in the community and has a daily presence in the orthopaedic and emergency units at The Alfred to help in the management of older people.

The new program also aims to increase the number of people receiving advance care planning to ensure family and healthcare teams know how the patient prefers to be treated when unwell or at end of life. Patients include those who have recently been discharged from our hospitals and new patients referred by a GP.

A DHHS grant has also been received to provide geriatrician services via telehealth to older people in the Wonthaggi area, in partnership with Bass Coast Health.

Behaviour management planning

Behaviours of concern, which are common in healthcare, increase the likelihood of harm to patients and staff and typically lead to an increase in a patient's length of stay in hospital.

Funded by a DHHS Advanced Practitioner Grant, we implemented a psychology-led interdisciplinary approach to behaviour management. The aim was to increase planning for behaviours of concern and improve patient outcomes. We saw an 815 per cent increase in referrals to psychology for behaviour management, of which 82 per cent resulted in a documented Behaviour Plan, a 19-fold increase.

The initiative led to:

- a statistically significant reduction in the frequency and severity of challenging behaviour
- credentialing of all psychology staff in behaviour management
- a psychology assessment occurred on the same day as the referral in 77 per cent of cases.

Patients prefer to be treated at home and we're exploring more ways to accommodate this.

Dr Margot Lodge travels to residential facilities to treat elderly patients.

Case Study

Our GEM at Home program is proving successful, with staff treating patients in the relaxed environment of their own homes.

Personalised home-based care

In 2015, we had a constantly increasing demand for beds, an ageing local population and heightened expectations of care which could no longer be managed by simply improving efficiency. Something had to change.

We needed new, more efficient choices for our patients. And so began GEM at Home, a personalised home-based model of 'inpatient' care for older patients, designed to avoid or shorten the need for hospital admission and lower the odds of developing delirium.

The program operates as a 'virtual ward' within Caulfield Hospital's Aged Care Service. It increases choice and access to care for older Victorians and provides therapy and care in the patient's own home environment, tailored to individual needs. All disciplines provide home-based services, geriatrician and pharmacist included. Patients receive eight clinical visits each week.

The initiative has been successful, with 650 admissions over two years. The length of stay has reduced by 24 per cent and clinical incidents are almost 80 per cent lower than in GEM hospital wards. Patient comments included:

"The care I received helped me recover in the comfort of my home, surrounded by my family."

Activity room for dementia

We created a large, fit-for-purpose activities room for patients with moderate delirium and dementia in one of our aged care wards. The area allows patients to comfortably participate in therapy activities, provides a quiet area outside of the noisy ward environment and is a space family and visitors can use.

New community diabetes service

We launched a new program in Caulfield Community Health Service to help adults with type 2 diabetes self-manage their condition. The service offers access to a diabetes nurse educator, dietitian and exercise physiologist who work with clients to help them achieve their goals and support them develop healthier lifestyles. In its first year, the program received more than 220 referrals, with up to 90 per cent reporting they had not previously accessed these community-based services. Participants also reported greater confidence managing their diabetes and ability to exercise, as well as knowing when to seek help from their doctor.

Preventing hospital admissions

The development of HealthLinks (an alternative funding model for those with complex medical issues at risk of hospital admission) has seen a growth in the Hospital Admission Risk Program (HARP). The new model sees a more integrated and coordinated approach to care, with clients linked with the services they need.

Patients specifically targeted are those with chronic and complex conditions, such as chronic obstructive pulmonary disease and heart failure.

This year, we saw 2,037 HealthLinks clients, representing 3,657 hospital presentations. HealthLinks clients presented to hospital on average 1.7 times from program enrolment and had at least three avoidable presentations in the previous six months. Of these patients, 534 were cared for in the HARP program. Following HARP intervention, an average of 86 per cent of HARP clients did not come back to hospital within 90 days of discharge.

Community services come together

This year our community and pulmonary rehabilitation services were all co-located on the Caulfield site, moving from the City of Port Phillip. This has enhanced service delivery and created a designated space for many Alfred Health community-based services. New models of care have been developed, increasing our ability to provide outreach services and therapy in our clients' homes. New partnerships with community gyms and volunteer transport have ensured individual client needs continue to be met in the local community.

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, taking a partnership approach in providing maternal and gynaecological services.

Emergency admissions at Sandringham Hospital reached record levels this year, with more than 43,800 people presenting and continued high ambulance arrivals to the community hospital.

Day procedure activity

The need to provide day procedures in the Sandringham area is high. In the last five years, same-day cases, which includes the use of theatres for gynaecological cases for Womens@Sandringham, have stayed consistently high, with more than 2,000 annual cases over the last four years.

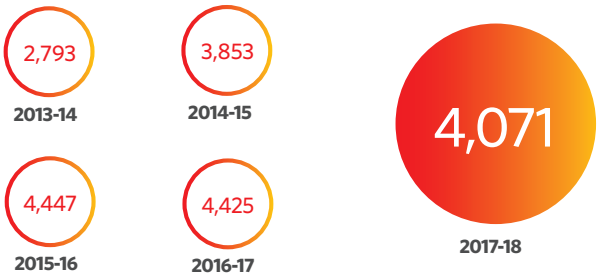
Same-day surgical cases

Increased ED activity

We have seen another significant increase in the number of presentations to Sandringham Hospital's ED, both in total numbers and ambulance presentations. Most EDs see a 2–3 per cent annual increase in presentations. We are exceeding this average growth rate, doubling the average rate, with a 5.4 per cent increase in the last year, rising from 41,628 presentations last year to 43,893 this year.

Patients arriving by ambulance are typically more acute than those who make their own way into the ED. Last year, we again saw more than 4,000 patients arrive by ambulance.

ED activity



Paediatric presentations

We continue to see a rise in the number of children presenting at Sandringham Hospital, mostly for sporting injuries.

Children treated

**In 2017, there was a change in the classification of 'paediatric', which now also includes those aged 16 and 17 years.*

Ambulatory care

The Sandringham Ambulatory Care Centre (SACC – previously called the Urgent Care Centre) began running under new providers in October 2017. This service, next to the ED, treats streamed non-urgent patients, allowing our ED staff to care for higher-acuity patients. On average, 21 per cent of patients are being streamed into the SACC daily.

Partnership with The Women's Hospital

Our partnership with The Women's Hospital continues, with The Womens@Sandringham providing maternity and gynaecological services to the local and surrounding community. In July, Minister for Health Jill Hennessy, joined by The Women's and Alfred Health staff, opened the redeveloped Special Care Nursery, which has increased from six to eight cots.

New staffing structures

During the year, we introduced a new senior staffing system at night – a senior ED registrar now fulfils the role of the clinical lead for the hospital overnight. This ensures patient safety and continuity of care plus support for the junior medical staff onsite overnight.

We have also:

- appointed a clinical lead for paediatrics
- introduced extra security, with two security officers patrolling the site during the day and helping visitors with parking and finding their way around the hospital.

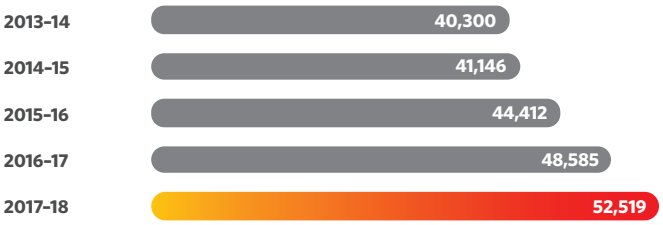
Melbourne Sexual Health Centre

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. Extensive research is also done here, with the aim of finding better treatments and improving patient care.

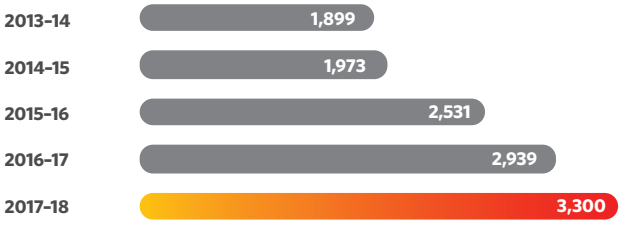
Record demand

In July, MSHC celebrated 25 years at the 580 Swanston Street, Melbourne site and again had a record year in consultations. This year, 52,519 consultations were provided, an 8 per cent increase on last year. We diagnosed a record 3,300 cases of chlamydia (a 12 per cent increase) and 2,190 cases of gonorrhoea (an 11 per cent increase).

Patient presentations



Chlamydia infections



Express testing

We have introduced an express HIV and STI testing service, called Test-and-Go, for asymptomatic men who have sex with men. Our evaluation revealed this service required less waiting and consultation time and therefore additional clinic capacity to see clients who are at higher risk.

Research to fight resistance

Our research on *Mycoplasma genitalium (MG)*, a sexually transmitted infection, continued this year, following earlier work that showed in 85 per cent of cases, men who have sex with men are resistant to antibiotic treatment, highlighting the need for new treatment. We completed two large studies – one of 1,000 asymptomatic men who have sex with men found MG present in 11 per cent.

The second study, the first of its type internationally to use resistance-guided therapy for MG, found the use of high-dose antibiotics resulted in more than 92 per cent cured, compared to recommended regimens internationally where half of cases fail first-line therapy.

Male partner treatment trial

With NHMRC funding, we conducted a multi-site male partner treatment trial for bacterial vaginosis (BV). This follows international recognition of our work in describing the epidemiological characteristics of BV and showing that it has similar features to an STI. Our trial uses a combined topical and oral antimicrobial therapy in males to examine the impact on BV recurrence in treated women.

New awareness website

In March, we launched a new website – What's Going on Down There? **(wgodt.com.au)** – to provide credible, trustworthy information on vaginal health. A previous study revealed women often have little awareness of BV and commonly mistake symptoms for thrush. Women recently diagnosed with BV or thrush at MSHC helped inform the website's design and content, ensuring it was simple and included symptoms, risk factors, treatment, other women's experiences and current research.

Increase in published research

MSHC staff have been heavily involved in research this year, with a significant increase in the number of peer-reviewed journal research published, rising from 30 in 2013 to 120 in 2017. Our research covers a number of important areas in sexually transmissible infections, including the difference screening makes in reducing infections.

Case Study

Daniel Rylatt, Team Leader HOPE and Madeleine Sullivan, HOPE psych-social support worker let a patient know about supports available.

Making a difference

Alarming numbers of people present to The Alfred's ED after a suicide attempt. In 2015, this number reached 40 patients each month. Within 12 months, 38 per cent of these returned to hospital, having attempted suicide or self-harm again.

There was a need for more support in the community, a need to strengthen pathways from hospital to community care to lessen risk of recurrent suicide attempts. The Victorian Government provided funding over four years, as part of its Suicide Prevention Framework.

In June 2017, The Alfred's Hospital Outreach Post-suicidal Engagement (HOPE) team was established to care for these very vulnerable patients. HOPE, made up of psychiatry, clinical psychology, family therapy and psycho-social workers, saw 94 people in the first 10 months of operation. They provided clinical review, treatment (1–3 sessions) and psychosocial support for up to three months to help with stress self-management and to establish engagement with health, social and addiction services

Early results show participants experienced improvements in hope and coping confidence and less distress. We believe the program is filling a very real gap in care and strengthening our community ties.

"People don't realise how important it is to have someone come and visit, to spend time with you."
— former consumer

MSHC awards

Research Fellow Dr Eric Chow was awarded:

- the Monash University Central Clinical School – 2017 Dean's Award Excellence in Research (Early Career). His research focuses on a wide range of aspects of gonorrhoea and the human papillomavirus
- the 2017 Victorian Young Tall Poppy Scientist of the Year, an award created in 1998 by the Australian Institute of Policy and Science (AIPS) to recognise and celebrate Australian intellectual and scientific excellence and to encourage younger Australians to follow in the footsteps of our outstanding achievers.

MSHC Director, Professor Kit Fairley was awarded:

- the Eric Susman Prize by The Royal Australasian College of Physicians, which is awarded annually to a Fellow of the College for the best contribution to knowledge of any branch of internal medicine
- the Australasian Sexual Health Alliance (ASHA) Distinguished Services to Sexual Health Award at the Sexual Health Conference in Canberra. This award acknowledged Professor Fairley as a distinguished and visionary leader who has made an outstanding contribution to the field of sexual health, both nationally and internationally.

Community clinics and programs

We provide a range of programs in the community, many of them designed to keep people well and out of hospital.

The prevalence of mental health conditions, as well as drug and alcohol addiction in our catchment is increasing, with a recent research study showing that one in four people with mental health conditions who present at The Alfred ED are homeless. The Southcity Clinic Addiction Medicine Service recently became part of Alfred Health and assists clients with complex addictions, bridging the gap between drug addiction and our mental health services.

Community rehabilitation success

Rehabilitation for clients of Alma Road Community Care (ARCC) – which provides care for those recovering from mental health issues– has vastly improved since rehabilitation scales were introduced. Almost 20 per cent more patients are being discharged to community care after much shorter stays.

The rehabilitation scales consist of 12 assessment areas, including personal care, cleaning, cooking, productivity, transportation, finances, routine, social, mental health, physical health, medication and substances. They are completed during an initial six-week assessment, at 91-day review and at discharge. At each 91-day review, the client identifies three priority goals they would like to focus on, with an action plan developed, which helps inform discharge conversations.

In 2013–15 (pre-scales):

- 46 discharges – 66 per cent to the community, 25 per cent to inpatient services, and 8.5 per cent to Secure Extended Care Units. Average length of stay was 393 days

In 2017:

- 18 discharges – 83 per cent to the community and 17 per cent to inpatient services, with an average length of stay of 292 days.

Building experts in own care

Discovery College Australia, part of headspace, is offering a recovery-focused service, which complements traditional mental healthcare and empowers individuals and families to become experts in their own care, developing skills and chasing goals.

As of June 2018, Discovery College had:

- run 42 separate courses across four campuses in six locations
- 259 students (including mums, dads, young people, mental health professionals and community members) attending Discovery College courses
- 57 recovery educators (made up of 28 experts by profession and 23 experts by experience)
- undertaken two research projects and have two articles under review for potential publication in the *Journal of Mental Health and Social Inclusion.*

New courses are being developed on an ongoing basis. In 2018, new courses included:

- Breaking the taboo: Giving a voice to the topic of suicide
- In your write mind: Exploring creativity writing and recovery
- Mind and Body: Nutrition.

Keeping siblings together

Siblings needing out-of-home care now have a greater chance of remaining together, thanks to a new program supported by Alfred Health's Child and Youth Mental Health Service (CYMHS).

As part of the Keeping Connected Program, more emergency carers are available to take in siblings and CYMHS will receive funding to increase the number of mobile mental health specialists dedicated to supporting these children.

Our specialists will continue to work alongside Uniting Victoria staff, who are delivering the program, to assess and provide mental healthcare.

Significant operational activities (cont'd)

Alfred Health activity

Admitted patients	Acute	Subacute	Mental health	Other	Total
Separations					
Same day	67,663	9	9	0	67,681
Multi-day	42,985	3,662	1,433	0	48,080
Total separations	**110,648**	**3,671**	**1,442**	**0**	**115,761**
Emergency	50,066	23	1,036	0	51,125
Elective	60,580	3,648	406	0	64,634
Total separations	**110,646**	**3,671**	**1,442**	**0**	**115,759**
Other					
Total bed days	**292,165**	**85,526**	**24,376**	**0**	**402,067**
Total WIES	**111,902**	**0**	**0**	**0**	**111,902**

Non-admitted patients	Alfred	Caulfield	Sandringham	Other	Total
Emergency Department presentations	66,295	0	36,723*	0	103,018
Specialist outpatient appointments	143,433	4,650	11,595	0	159,678
Allied Health outpatient appointments	36,279	0	1,640	0	37,919
Diagnostic outpatient events	146,475	3,457	30,108	0	180,040
Radiotherapy occasions of service	24,721	0	0	23,063	47,784
Other services – occasions of service	132,945	238,309	0	52,519	423,773
Total occasions of service	**550,148**	**246,416**	**80,066**	**75,582**	**952,212**

* excludes Sandringham Ambulatory Care Centre

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 2018.

Michael Gorton
Chair, Alfred Health Board
21 August 2018

Strategic performance

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

DHHS strategies	Alfred Health deliverables	Progress as at 30 June 2018	Status
Better health			
Reduce statewide risks	Support implementation of the Victorian HIV Strategy to improve prevention, testing and treatment of HIV, including leading the expansion of the PrEPX study across the state, with a target of recruiting 3800 people to the study by April 2018 and support the transition to a public access model if Pharmaceutical Benefits Scheme (PBS) funding approved.	PrEPX study continued to expand across the state with over 4,000 Victorians receiving PrEPX treatment. Pharmaceutical Benefits Scheme (PBS) funding was approved and Alfred Health has continued to support the transition to a public access model through collaboration and training with GPs across the state. Alfred Health will continue to work with DHHS to further support the integration of PREP and PrEPX in 2018–19.	Completed
Build healthy neighbourhoods	Expand and implement alternative models of care in community and home settings including HealthLink, GEM at Home and Health Care Homes.	Alfred Health's HealthLink Program, aimed to improve coordinated care provided to patients with chronic and complex conditions, has actively recruited 583 clients to the program. Better at Home business case was approved by Alfred Health Executive and Board and detailed a service model designed to enable more patients to access their subacute care at home. A pilot is to be implemented, as part of a winter demand strategy, with full implementation of the expansion planned for Q3 2019. The Victorian Integrated Care Model Project has been established and current state mapping is underway, with an overarching aim to establish systems to support the integration of the Health Care Homes.	Completed
Help people to stay healthy	Implement transition plan for NDIS rollout to ensure seamless patient pathway between healthcare and disability services promoting patient choice. Determine viability of service provision and implementation of agreed outcomes.	AH is now a registered NDIS provider across a range of services, including prosthetics, community ABI and OT driving services. Patients have commenced accessing these services. Education program for clinicians navigating NDIS have occurred across all sites. Carer services have implemented a model of care change to respond to NDIS rollout and reduction in funding.	Completed
Target health gaps	Aligned to the Strengthening Hospital Responses to Family Violence initiative (SHRFV), continue the implementation across Alfred Health that includes: capacity building across the organisation in the awareness of family violence, responding to the needs of vulnerable populations, sensitive enquiry and connecting with family violence support services.	The SHRFV initiative aims to embed a 'whole of hospital' model for identifying and responding to family violence internally, and to implement a Family Violence Workplace Support Program (part of the SHRFV model) to support staff experiencing family violence. Over 500 staff have been trained, with an initial focus on Emergency and Trauma Centre staff. Awareness campaign (16 days) was completed in November 2017. Family violence screening has been integrated into eTQC process Tier 1 alerts and Interdisciplinary Plan of Care (IPOC) due for implementation in October 2018.	Good Progress

table continued overleaf

Performance (cont'd)

Strategic performance (cont'd)

DHHS strategies	Alfred Health deliverables	Progress as at 30 June 2018	Status
Better access			
Plan and invest	Progress planning for the St Kilda Wing, to ensure Alfred Health can continue to provide state-of-the-art specialist and critical care services to Victoria.	AH Service Plan 2017 was completed and endorsed Dec 2017. Revised forecast demand prompted the development of The Alfred Masterplan 2017 and subsequently, Feasibility Studies Phase 1 (completed in June 2018), Phase 2 (commenced July 2018). DHHS has commissioned The Alfred Redevelopment Business Case which is currently underway, due for completion August 2018.	Good Progress
Plan and invest unlock innovation	Address failing infrastructure through upgrades to sewerage and stormwater systems at The Alfred.	Detailed planning completed with contractors appointed and works commenced, due for completion June 2019.	Good Progress
	Expand clinical capacity to deliver target activity through capital works at The Alfred and Sandringham Hospital, increasing multi-day and short-stay beds at The Alfred Centre and improving day procedure access and flow at Sandringham Hospital.	Alfred Centre Medical Day Unit/Short Stay Unit (MDU/SSU) expansion works completed and operationalised in April 2018. Sandringham Day Procedure Unit completed in July 2018. The Ward 5 West redevelopment and associated relocation works are progressing, with podiatry and East Block, Level 2 occupants relocated to commence development of Respiratory Outpatient Clinics; new Ward 5 West will be completed in 2019.	Good Progress
Provide easier access	Improve access to and the patient experience of specialist clinics, including innovative models of care, streamlined referral processes and alternative access pathways.	Telehealth initiatives continue to expand, providing approximately 100 telehealth contacts per month, with 40 consultation rooms telehealth-enabled. Telehealth survey has provided positive feedback from patients and staff. The e-referral program has been established for over 20 GPs and will continue to expand in 2018–19. There has been a significant reduction in rework with all e-referrals received having 100% compliance to the referral criteria. Currently over 27 units are participating, with intended expansion to all units to be completed by June 2019.	Good Progress
Provide easier access	Improve timely, quality emergency care through the E&TC redevelopment and implementation of model of care to meet emergency access targets.	Eva and Les Erdi Emergency and Trauma Centre has been fully commissioned, providing much needed additional capacity within the ED to meet the growing demands of the service.	Completed
Better care			
Target zero avoidable harm – in partnership with consumers, identify three priority improvement areas using Victorian Healthcare Experience Survey data and establish an improvement plan for each. These should be reviewed every six months to reflect new areas for improvement inpatient experience (mandatory).	Partnering with patients, we will respond to Victorian Healthcare Experience Survey (VHES) findings to: • improve patient experience of food services, though a targeted Food is Therapy campaign including initiatives to expand menu options, enhanced presentation of meals and improve customer service	Food is Therapy Action Plan developed. Local improvement driver diagram established with change ideas implemented. Key initiatives included: an animated script for Food is Therapy and collaboration with consumers to improve experience with food, new crockery, new menus and testing of thermal trolleys. Improved VHES results recorded for The Alfred, above target.	Good Progress
	• increase compassionate and respectful care. This will include: education to support individualised compassionate care, communication and diversity; the pilot of Schwartz Rounds and staff recognition programs such as the Little Things Matter campaign	Two Schwartz Rounds have taken place at The Alfred on 14 March with 150+ attendees, and at Caulfield Hospital on 30 May with 200+ attendees. Participants included senior and junior staff from a range of disciplines and from clinical and business support service areas. Participants provided overwhelmingly positive feedback for each round.	Good Progress
	• improve patient experience for patients attending specialist consulting clinics though the delivery of streamlined and more timely communication to GPs and initiatives to promote a positive experience at the clinics.	VHES survey conducted for adult specialist clinics for the first time, with Alfred Health recording 96% positive experience overall, 5% greater than the state average. Feedback data analysed and aligns to current initiatives aimed at improving timely access to outpatient clinics, improved communication and improved waiting areas. Consumer feedback incorporated into design process for capital works, particularly for waiting areas and reception. Information Development Division to progress with changes required to improve communication, pending implementation of eTQC.	Good Progress

DHHS strategies	Alfred Health deliverables	Progress as at 30 June 2018	Status
Better care			
Put quality first Join up care Partner with patients Strengthen the workforce Embed evidence Ensure equal care	Improve prevention and management of patients with multi-resistant organisms.	Implemented a range of strategies including regular screening of all ICU patients, regular disinfection trial in ICU sinks and ongoing control measures in accordance with Victorian guidelines. Appropriate prescribing is reported to be higher than the national average according to the National Antimicrobial Prevalence Survey (NAPS).	Good Progress
	Develop a strategy based on social inclusion and diversity, to embed consistent approaches and build capacity across the health service in addressing the health needs of communities and consumers at risk of poor access to healthcare, e.g. Aboriginal and Torres Strait Islander people; lesbian, gay, bisexual, transgender, intersex and questioning (LGTBIQ), people with disabilities, linguistically diverse (CALD); homeless people.	A Reconciliation Action Plan was developed and launched in August 2017. A smoking ceremony and presentation from an Indigenous Australian Elder occurred during Reconciliation Week. This will be included in a video as an ongoing resource for cultural awareness training. Vulnerable Persons Working Group has been established and will continue to develop the Vulnerable Persons Guideline and capability framework. A vulnerability screening risk assessment tool will to be implemented as part of Phase 2 of eTQC. An inclusive statement has been added to our *Welcome Guide* and bedside TVs informing patients of their rights and encouraging them to speak up if they feel they are being treated unfairly or feel unsafe	Good Progress
	Ensure staff feel safe and are skilled through the implementation of the Occupational Violence and Aggression Policy Plan including: increased access to duress alarms, consistent and clear process for management and escalation of behaviours of concern, capital works to promote a safe environment and eLearning package to support the AWARE training program.	2500 staff have completed AWARE training. eLearning module has been finalised and online. Community duress alarms are in place. Caulfield Hospital has received funding to rollout duress alarms across all inpatient wards (planning underway). OVA Steering Committee in place and monitoring progress against the OVA Action Plan.	Completed
	Develop and validate 30 patient pathways (both in referral to Alfred Health and throughout the patient journey), design of clinical workflows and completion of design of inpatient electronic documentation in preparation for the transition from paper-based methods to an Electronic Medical Record (EMR).	Clinical pathways (called PowerPlan) have been defined and designed. New clinical documentation design and clinical decision support has been completed and built ready for implementation as Phase 1 eTQC in October 2018.	Completed
Target zero avoidable harm – develop and implement a plan to educate staff about obligations to report patient safety concerns (mandatory).	Implement an agreed and consistent quality improvement process across Alfred Health and develop and implement a plan to educate staff about obligations to report patient safety concerns as measured through staff surveys.	Building Quality Improvement Capability (BQIC) Steering Group has been established. A baseline assessment of organisational capability has been undertaken using the Improvement Capability Quotient Tool and has informed the Quality Improvement Strategy. This will include the quality and safety education that supports improvement inpatient safety culture through the organisation. Orientation and induction process includes staff obligations for reporting.	Good Progress

Part B: Performance priorities

Quality and safety	Target	2017–18 actuals
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Full compliance	Achieved
Infection prevention and control		
Compliance with the Hand Hygiene Australia program	80%	82.3%
Percentage of healthcare workers immunised for influenza (2017)	75%	81%
Patient experience		
Victorian Healthcare Experience Survey – data submission		Achieved
Victorian Healthcare Experience Survey – positive patient experience – Quarter 1	95%	88%
Victorian Healthcare Experience Survey – positive patient experience – Quarter 2	95%	91%
Victorian Healthcare Experience Survey – positive patient experience – Quarter 3	95%	94%
Victorian Healthcare Experience Survey – discharge care – Quarter 1	75%	72%
Victorian Healthcare Experience Survey – discharge care – Quarter 2	75%	75%
Victorian Healthcare Experience Survey – discharge care – Quarter 3	75%	79%
Victorian Healthcare Experience Survey – patients' perceptions of cleanliness – Quarter 1	70%	64%
Victorian Healthcare Experience Survey – patients' perceptions of cleanliness – Quarter 2	70%	54%
Victorian Healthcare Experience Survey – patients' perceptions of cleanliness – Quarter 3	70%	61%
Healthcare-associated infections		
Number of patients with surgical site infection	No outliers	No outliers
Number of patients with ICU central-line-associated bloodstream infection (CLABSI)	Nil	Nil
Rate of patients with SAB1 per occupied bed day	≤ 1/10,000	≤ 1.06/10,000
Adverse events		
Number of sentinel events	Nil	2
Mortality – number of deaths in low mortality DRGs2	N/A	N/A

* This indicator was withdrawn during 2017-18 and is currently under review by the Victorian Agency for Health Information

Mental health	Target	2017–18 actuals
Percentage of adult acute mental health inpatients who are readmitted within 28 days of discharge (Alfred only)	14%	11%
Rate of seclusion events relating to a mental health acute admission – all age groups	≤ 15/1,000	4.7
Rate of seclusion events relating to a child and adolescent acute mental health admission	≤ 15/1,000	N/A
Rate of seclusion events relating to an adult acute mental health admission	≤ 15/1,000	5.8
Rate of seclusion events relating to an aged acute mental health admission	≤ 15/1,000	0.2

Key performance indicators		
Percentage of child and adolescent acute mental health inpatients who have a post-discharge follow-up within seven days	75%	N/A
Percentage of adult acute mental health inpatients who have a post-discharge follow-up within seven days	75%	82%
Percentage of aged acute mental health inpatients who have a post-discharge follow-up within seven days	75%	93%

Continuing care		
Functional independence gains from an episode of GEM3 admission to discharge relative to length of stay	≤ 0.39	0.71
Functional independence gains from an episode of rehabilitation admission to discharge relative to length of stay	≤ 0.645	0.765

Governance, leadership and culture	Target	Actuals
People Matter Survey – percentage of staff with an overall positive response to safety and culture questions	80%	75%
People Matter Survey – percentage of staff with a positive response to the statement: "I am encouraged by my colleagues to report any patient safety concerns I may have"	80%	81%
People Matter Survey – percentage of staff with a positive response to the statement: "Patient care errors are handled appropriately in my work area"	80%	77%
People Matter Survey – percentage of staff with a positive response to the statement: "My suggestions about patient safety would be acted upon if I expressed them to my manager"	80%	75%
People Matter Survey – percentage of staff with a positive response to the statement: "The culture in my work area makes it easy to learn from the errors of others"	80%	70%
People Matter Survey – percentage of staff with a positive response to the statement: "Management is driving us to be a safety-centred organisation"	80%	76%
People Matter Survey – percentage of staff with a positive response to the statement: "This health service does a good job of training new and existing staff"	80%	67%
People Matter Survey – percentage of staff with a positive response to the statement: "Trainees in my discipline are adequately supervised"	80%	69%
People Matter Survey – percentage of staff with a positive response to the statement: "I would recommend a friend or relative to be treated as a patient here"	80%	85%

table continued overleaf

Part B: Performance priorities (cont'd)

Timely access to care	Target	2017–18 actuals Alfred	Sandringham
Emergency care			
Percentage of patients transferred from ambulance to emergency department within 40 minutes	90%	84%	94%
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 time	80%	79%	86%
Percentage of emergency patients with a length of stay in the emergency department of less than four hours	81%	81%	88%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	0	0
Elective surgery			
Percentage of urgency Category 1 elective surgery patients admitted within 30 days	100%		100%
Percentage of urgency Category 1, 2 and 3 elective surgery patients admitted within clinically recommended time	94%		98%
Percentage of patients on the waiting list who have waited longer than clinically recommended time for their respective triage category	5% or 15% Proportional improvement from prior year		0
Number of patients on the elective surgery waiting list (as of 30 June 2018)	2,000		1,945
Number of hospital-initiated postponements per 100 scheduled elective surgery admissions	≤ 8 /100		3
Number of patients admitted from the elective surgery waiting list	11,500		11,257
Specialist clinics			
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%		N/A**
Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%		N/A**
Effective financial management			
Finance			
Operating result ($million)	0.00		0.24
Average number of days to paying trade creditors	60 days		50
Average number of days to receiving patient fee debtors	60 days		64
Public and private WIES activity performance to target*	100%		96.2%
Adjusted current asset ratio	0.64		0.62
Number of days of available cash	14 days		7.2

*The changes arising in the WIES funding model following the introduction of AR-DRG version 8 in 2016–17 have impacted Alfred Health's ability to recognise WIES activity in 2017–18. DHHS has acknowledged these issues at a system level and provided assurances around minimum funding levels throughout 2017–18.

**Alfred Health expects to report this data for 2018–19

Part C: Activity and funding

	2017–18 activity achievement
Acute admitted	
WIES DVA	877
WIES private	16,569
WIES public	84,058
WIES TAC	6,456
Acute non-admitted	
Emergency services	103,018
Home enteral nutrition	81
Home renal dialysis	113
Radiotherapy WAUs public	74,976
Radiotherapy WAUs DVA	1,505
Specialist clinics – public	181,782
Subacute and non-acute admitted	
Subacute WIES – rehabilitation public	1,282
Subacute WIES – rehabilitation private	373
Subacute WIES – rehabilitation DVA	15
Subacute WIES – GEM Public	1,816
Subacute WIES – GEM Private	614
Subacute WIES – DVA	15
Transition care – bed days	24,964
Transition care – home day	5,318
Subacute non-admitted	
Health Independence Program – public	94,711
Victorian Artificial Limb Program	2,583
Aged care	
HACC	20,992
Mental health and drug services	
Mental health ambulatory	75,763
Mental health inpatient – available bed days	23,653
Mental health subacute	2,755
Primary health	
Community health/primary care programs	19,669
Other	
NFC – paediatric lung transplantation	5
Health workforce	218

Financial summary 2017–18

The operating result for 2017–18 was a $0.24 million surplus. The result is in line with the operating result target in the Statement of Priorities.

Revenue increased by $52.1 million, largely due to government grants from activity growth throughout the health service.

The comprehensive result was a surplus of $31.1 million, compared to a deficit of $(0.3) million in the previous year. This was largely due to an asset revaluation of $62.1 million in 2017–18 compared to a $26.4 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 health service continuing its commitment to achieving savings targets through efficiency programs and close monitoring of the costs of growing activity.

	2017–18 $m	2016–17 $m	2015–16 $m	2014–15 $m	2013–14 $m
Total Revenue	1,197.6	1,145.5	1,062.3	975.3	915.7
Total Expenses	1,197.4	1,145.3	1,058.0	975.4	915.4
Operating Result*	**0.24**	**0.2**	**4.3**	**(0.1)**	**0.3**
Capital and Specific Items	(36.5)	(24.6)	(24.1)	(30.8)	(25.1)
Other Economic Flows	2.6	(4.1)	(4.5)	0.3	(0.1)
Net Result for the Year	**(33.7)**	**(28.5)**	**(24.3)**	**(30.6)**	**(24.9)**
Other**	64.8	28.2	37.8	2.3	286.7
Comprehensive Result	**31.1**	**(0.3)**	**13.5**	**(28.3)**	**261.8**
Retained Surplus/Deficit	(290.0)	(250.5)	(228.1)	(186.5)	(159.4)
Total Assets	1,160.1	1,096.9	1,085.1	1,056.8	1,086.2
Total Liabilities	338.3	306.2	294.1	279.4	265.1
Net Assets	821.8	790.7	791.0	777.4	821.8

*The Operating result is the result for which the health service is monitored in its Statement of Priorities also referred to as 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.

Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2017–18 is $34.9 million (excluding GST) with the details shown below:

($million)

Business as usual (BAU) ICT expenditure	Non-business as usual (non-BAU) ICT expenditure	Operational expenditure	Capital expenditure	Year
28.6	6.3	5.6	0.7	30-Jun-18

Research through partnership

Alfred Health is one of the most research-intense health services in Australia. All of our research is translational – meaning the patient receives the direct benefit of clinicians' and scientists' work. As of 30 June 2018, we had 383 open clinical trials, with 55 per cent of those commercially sponsored.

Major research highlights

Trial solves age-old debate

A global study led by The Alfred has found giving patients more IV fluids during surgery can reduce the risk of kidney damage and wound infection post-surgery.

Anaesthetists have fiercely debated whether to give patients more or less IV fluids during and in the days following surgery. While small studies had previously indicated that limiting intravenous (IV) fluids was beneficial for patients undergoing abdominal surgery, the RELIEF trial (or Restrictive versus Liberal Fluid therapy in major abdominal surgery trial) proved otherwise.

Professor Paul Myles, lead researcher and Director of Anaesthesia and Perioperative Medicine at The Alfred and Monash University, says this study will change anaesthetic procedure across the world.

The study, which was conducted across 47 hospitals in seven countries, was funded by the National Health and Medical Research Council (NHMRC) and the Australia and New Zealand College of Anaesthetists.

High-tech glasses a future vision

High-tech glasses for trauma doctors have the potential to change emergency resuscitation at The Alfred.

The National Trauma Research Institute (NTRI) at The Alfred has partnered with Dialog Information Technology to develop voice-activated, heads-up display glasses that combine the Trauma Reception and Resuscitation System (TR&R) with Google Glass for Enterprise.

Project lead at NTRI and Director of Trauma Services at The Alfred, Professor Mark Fitzgerald said the glasses have the potential to save thousands of lives across the globe.

The idea is to use The Alfred's TR&R system, which gives hospital trauma teams computerised decision support for the first 60 minutes of trauma patient resuscitation. Combining TR&R with Google Glass will mean doctors have vital patient information – including heart rate, oxygen saturation, blood pressure and more – right in front of their eyes, without having to leave or look away from the patient.

The glasses also have a camera and 4G+ connectivity, which will enable trauma teams to connect with medical specialists offsite.

Major funding boost to investigate rare diseases

Medical researchers from The Alfred and Monash University were awarded more than $5.5 million in funding to tackle rare cancers and diseases.

The four major research projects were among 19 Australia-wide to receive federal government backing under the Medical Research Future Fund's Rare Cancers, Rare Diseases and Unmet Needs Clinical Trials Program.

The funded projects are:

- an integrated national clinical trial program aimed at improving outcomes for patients with acute myeloid leukaemia (AML) by introducing precision-based diagnosis, treatment and monitoring within the Australasian Leukaemia and Lymphoma Group. Adjunct Associate Professor Andrew Wei – $1,507,785
- bone marrow transplant research – study to compare two strategies to prevent graft versus host disease (GVHD) – the standard drugs used for almost 30 years against a new treatment. Associate Professor David Curtis – $1,570,198
- the DIAAMOND study: diagnosis of aplastic anaemia (a bone marrow disorder), management, and outcomes utilising a national dataset. Associate Professor Erica Wood – $1,750,726
- the BLENDER trial – Blend to Limit Oxygen in ECMO: A randomised controlled registry trial investigating a more conservative oxygen level for very sick patients on extracorporeal membrane oxygenation (ECMO), as high oxygen levels may be harmful. Professor David Pilcher, Deputy Director ICU – $753,355.

Research through partnership (cont'd)

Increased organ donation possibilities

A team of researchers – led by The Alfred's Dr Sandeep Rakhra and Professor David Pilcher – has found potential to increase organ donation after investigating the overall capacity for Donation after Circulatory Death (DCD) across 75 Australian hospitals.

The study, published in the Medical Journal of Australia, analysed DonateLife data and found of the 8,780 patient deaths analysed between June 2012 and December 2014, 506 met specific organ donor suitability criteria, but hadn't been discussed with the family. Potentially, another 416 kidneys, 117 lungs, 41 livers and 7 hearts may have been available for transplant.

Australia has large untapped pool of potential deceased organ donors. Most deceased organ donors come from brain-dead patients, but the number of donations after circulatory death (DCD) has been growing, making up one-quarter of all deceased organ donors in 2016.

Researchers recommended assessing all end-of-life patients in intensive care units for organ donation.

Coffee not causing heart problems

Patients being treated for heart rhythm disorders are commonly advised to avoid caffeine; however, a new study suggests coffee and tea may be tolerated – and could even help manage an irregular heart rate.

Study lead, Professor Peter Kistler, the director of electrophysiology at The Alfred and the Baker Heart and Diabetes Institute said that the widely held belief that moderate intake can exacerbate arrhythmias is not supported by the medical literature.

Large-scale studies have suggested coffee and tea are safe, and some caffeinated beverages may even have long-term anti-arrhythmic properties – suppressing abnormal rhythms of the heart.

Professor Kistler's study, 'Caffeine and Arrhythmias: Time to grind the data' was published in the *Journal of the American College of Cardiology.*

PrEPX Tasmania

Alfred Health's highly successful PrEPX study for those at risk of HIV infection, which was been running in Victoria and South Australia, was expanded into Tasmania this year, thanks to funding from the Tasmanian Government. The study continued to expand in Victoria to meet the increasing demand for PrEP (pre-exposure prophylaxis) and opened new sites in metropolitan Melbourne and rural and regional Victoria. Over 5,000 participants were enrolled in the study across the three states.

PrEP became available on PBS in April and the study team began work educating GPs about PrEP and transitioning all those enrolled in the study onto PBS access with GPs.

The study aims to reduce new HIV infections.

Research awards

American excellence award

Professor Paul Myles, The Alfred's Director Anaesthesia and Perioperative Medicine, was the first Australian to be awarded the Excellence in Research award from the American Society of Anesthesiologists.

Finalist – Trial of the Year Award

The Alfred's Intensive Care specialist Professor Jamie Cooper and the TRANSFUSE trial team were named Finalists for the ACTA Trial of the Year Award. The international study demonstrated that red-cell transfusions in critically ill patients using blood that's been stored for a longer (standard-issue) time is just as beneficial as using fresher blood.

Prestigious prize for excellence

Chief Pharmacy Information Officer Erica Tong received the National Prize for Excellence from the *Medical Journal of Australia* for her research on reducing medication errors in hospital discharge summaries. The research has resulted in increased collaboration between pharmacists and junior doctors, improving medication safety for patients leaving hospital.

Recognition for tackling dementia

Associate Professor Kate Hoy, from the Monash Alfred Psychiatry Research Centre, won the 2017 Telstra Victorian Public Sector and Academia Award for exploring effective treatments for dementia. She was also recognised for her mentoring work, helping female scientists break into senior positions.

Surgery and patient outcomes – excellence award

Dr Trisha Peel, from our Infectious Diseases Unit, was awarded an NHMRC Research Excellence Award for her work on optimising patient outcomes following surgery. Dr Peel's work centres on better understanding the role the skin's bacteria plays in infection development, determining the best preventative options, examining the efficacy of current prevention treatments and determining how to most effectively implement evidenced-based measures nationwide.

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 across the precinct, including external research funding secured, research publications, and masters and doctoral degree completions.

In 2017, AMREP researchers:

- secured more than $107 million in external research funding
- published a total of 2,393 publications, including journal articles, reviews, book chapters and books.

Also, 211 students completed their masters and doctoral degrees.

Academic Health Science Centre

The Monash Partners Academic Health Science Centre, of which Alfred Health is a lead partner, completed its strategic plan and refined its purpose to connect researchers, health professionals and the community to innovate for better health. The Federal Government committed a further $6 million ($8.25 million to date) for Monash Partners to support high-impact research projects that deliver direct health benefit. Monash Partners continues to play a leading role in the development of a national strategy in data-driven healthcare improvement through the Australian Health Research Alliance across all NHMRC accredited centres. During the year, Monash Partners:

- progressed 12 rapid applied translational research projects
- led engagement with government to secure additional Medical Research Future Funding of $6.1 million for 2019–21 projects delivered through capacity-building fellowships and high-impact innovation projects
- progressed consumer and community involvement in research
- reached over 1,000 staff through our workforce capacity-building program
- streamlined ethics and governance processes and progressed a statewide system and alignment with other AHRTCs nationally
- launched a new website **(monashpartners.org.au)**
- strengthened national collaboration through the national alliance.

NHMRC funding

Alfred Health researchers were lead investigators of several new NHMRC grants commencing in 2018:

Project grants

- **Associate Professor Catriona Bradshaw:** Antibiotic treatment of male partners to reduce recurrence of bacterial vaginosis in women: a randomised double-blind controlled trial. 2018-20: $636,673
- **Professor Anne Holland:** Ambulatory oxygen for interstitial lung disease. 2018-22: $1,503,718
- **Professor David Kaye:** Novel therapy for heart failure with preserved ejection fraction. 2018-21: $1,054,225
- **Associate Professor Natasha Lannin:** Effectiveness of occupational therapy home visits to improve participation after stroke. 2018-21: $1,774,083
- **Professor Harshal Nandurkar:** Targeted delivery of CD39 to ischaemic brain improves outcomes in stroke. 2018-21: $895,780
- **Professor Anton Peleg:** Antibiotic resistance and host immune evasion in *Staphylococcus aureus.* 2018-20: $644,428
- **Professor Anton Peleg:** Bacterial and host drivers of fulminant community-acquired *Acinetobacter baumannii* infection. 2018–20: $729,315
- **Professor Andrew Spencer:** Analysis of circulating tumour DNA for mutational characterisation and tracking disease progression in multiple myeloma. 2018–21: $908,676
- **Associate Professor Glen Westall:** Extending life after lung transplantation – defining the structural and immunological drivers of chronic lung allograft dysfunction. 2018–20: $739,189

Partnership projects

Associate Professor Carol Hodgson: The EXCEL Project: A collaborative approach to improve outcomes of Australian patients with acute heart failure and cardiac arrest requiring extracorporeal life support. 2018-21: $692,656

Practitioner fellowships

- Professor Jamie Cooper (2018–22)
- Professor Paul Myles (2018–22)

Research fellowships

- Associate Professor David Curtis (2018–22)
- Professor David Kaye (2018–22)

Career development fellowships

- Dr Trisha Peel (2018–21)

Translating research into practice fellowship

- Dr Trisha Peel (2018–19)
- Associate Professor Anita Wluka (2018–19)

Research Poster Display and Research Day

Research was once again highlighted during Alfred Health Week in October, with 168 research posters from across AMREP showcased.

The Hon. John Brumby AO presented a keynote address on Research Day, reflecting on Australia's and Victoria's strengths and weaknesses in medical innovation and considering how to position our thinking to address key issues while capitalising on opportunities.

Mr Brumby also presented the 2017 AMREP Research Prizes for the highest-impact original clinical and basic research articles published by AMREP researchers in the previous year.

Associate Professor Christoph Hagemeyer, Australian Centre for Blood Diseases, was awarded the Basic Research Prize for "Polymer Capsules for Plaque-Targeted In Vivo Delivery" published in the *Advanced Materials Journa*l. Professor Paul Myles, Director of Anaesthesia and Perioperative Medicine at The Alfred, received the prize for Clinical Research for "Stopping vs. Continuing Aspirin before Coronary Artery Surgery", published in the *New England Journal of Medicine.*

Projects and infrastructure

With growing demand for our services continuing, much of our capital project work this year centred around creating further clinical capacity. Major projects included an expanded Emergency and Trauma Centre, a new day surgery centre and a new clinical trials area.

Emergency and Trauma Centre redevelopment

Redevelopment of The Alfred's Eva and Les Erdi Emergency and Trauma Centre was completed in April 2018. The redesigned centre was officially opened by the Premier Hon. Daniel Andrews and Victorian Minister for Health, The Hon. Jill Hennessy, MP in June. The expanded unit has:

- an additional 19 clinical cubicles
- a new Rapid Intervention Treatment Zone
- new imaging equipment including a second MRI, a second CT and new ultrasound equipment
- expanded clinical space for short-stay patients
- three new staff base areas
- a Behaviours of Concern wing.

Completed over 10 stages since December 2016, and while the department maintained full care of patients, the project was completed on budget. Work also included a major upgrade of the Emergency Department Information System (EDIS).

New day procedure centre

Sandringham's new Community Bank Day Procedure Centre will be used to perform a range of procedures, including orthopaedic, general, ophthalmology and gynaecology surgery, when it opens in August 2018. The new $2.5 million centre is located next to the existing operating theatre building and features six Stage 3 recovery bays, interview rooms and reception. Works have included alterations to staff areas within the existing theatre and recovery areas.

The new centre will ensure same-day surgical patients recover in a dedicated centre, rather than use the hospital's inpatient beds.

New equipment to be installed in the new centre includes recovery recliners, patient monitors, patient and visitor furniture.

Expanded neurology care

This year, we redeveloped part of Ward 7 West to accommodate the expansion of the neurology service, to include:

- six video EEG monitoring inpatient beds at the west end of the ward, with two beds for epilepsy monitoring of emergency-admitted patients and management of acutely uncontrolled seizures, and four beds for elective patients admitted for diagnostic evaluation
- four short-stay inpatient and same-day observation beds for patients undergoing clinical trials
- two additional multi-day beds.

It has been one of our busiest years for building works, with much maintenance and upgrading required.

Medical equipment funding

In February, the Hon. Daniel Andrews, Premier, visited to announce more than $60 million in funding for Victorian hospitals – including $2.8 million for The Alfred. This funding is for three heart–lung bypass units, a cardiac ultrasound, a digital mammography unit, a neurosurgical operating room table and other specialist pathology equipment used for patient analysis, diagnosis and treatment.

Cardiac ultrasound machines are essential – we perform almost 8,000 cardiac ultrasounds on patients with complex heart conditions each year.

Respiratory Medicine expansion and relocation

Relocation of the existing respiratory administration and clinics from Main Ward Block Level 5 to East and Philip Blocks, Level 2 will result in:

- 14 new clinic spaces for respiratory medicine, including six dedicated isolation rooms and a dedicated spirometry room
- modern administration spaces and
- a new reception/waiting area.

Works are scheduled to be completed by the end of 2018.

The relocation of Respiratory Medicine enables the vacated space on Level 5 to be converted into a 40-bed trauma ward. Detailed design for the new ward will commence in July 2018, with an expected completion date of mid-2019.

Redeveloped units: The Alfred Centre

Some administrative functions within The Alfred Centre were converted into clinical areas this year. The first project saw the Medical Day Unit (MDU) moved to the Ground Floor, taking the area previously used by elective bookings/referral staff. The area was repurposed into an 18-bed unit, providing two additional points of care.

The move of the MDU to the Ground Floor allowed for the vacated area to be redeveloped into a Short Stay Unit on Level 1. The new unit has 14 short-stay surgical beds.

The works, which were completed in April, resulted in an overall increase in bed capacity of 16 beds.

New receptions

We built two new receptions this year to better handle the increase in visitors and address OHS issues experienced by staff:

- Main reception, The Alfred: After a review, a new reception design was developed which focuses on safety and functionality. The new front reception includes a circular reception desk, giving a greater viewpoint for reception staff and a centralised point of contact for visitors.
- Adult inpatient psychiatry reception, The Alfred: Following a review of safety and difficulties controlling the flow of illicit substances and contraband into the building, we designed a secure concierge reception. A curved counter, manned by security staff, was built, along with a controllable glass entrance door. Lockers were installed for visitors to safely leave their belongings outside the ward.

Director, Emergency and Trauma Associate Professor de Villiers Smit shows Minister for Health Jill Hennessy and Premier Daniel Andrews around the expanded Centre.

Sandringham Hospital's capital works

To improve care, we:

- designed a new area for Pathology Services, which will relocate to the main hospital (from the Outpatients Building) to improve turnaround time for blood test results. Currently, blood tests from within the main hospital have to be walked over, usually on an hourly schedule or via the porters. This new site will include a blood chute from ED to pathology to expedite important diagnostic test results. Building works are due to start later in 2018
- established a new Education Centre in the Outpatients Building for staff training and education, Length of Service and Recognition Awards, executive roadshows and Schwartz Rounds
- planned a New Emergency Department Behaviours of Concern clinical area, which will improve safety for staff caring for patients with challenging behaviours.

Works will start later this year to:

- construct purpose-built accommodation for overnight medical staff within the hospital
- install a replacement ramp leading to outpatients to improve safety
- remove all portable buildings.

Redeveloping The Alfred

Working with DHHS, we continued to progress the proposal to redevelop The Alfred. This proposal, which is a flagship project in Alfred Health's Strategy Plan 2016-20, will help meet the growing healthcare needs of the local community as well as the people of Victoria. It proposes two new state-of-the art facilities:

1. new trauma, transplant and critical care facility and 100-bed mental health unit
2. new 800-bed inpatient tower overlooking Fawkner Park with contemporary facilities.

The Alfred is in a growing local catchment and the demand for statewide services is also increasing: almost 60 per cent of inpatients come from outside The Alfred's local area. The need for safe, therapeutic and expanded mental health care at The Alfred is urgent and growing.

eTQC: Connecting care

Our five-year eTQC (electronic Timely Quality Care) program (2016–21) which transitions our current mix of electronic and paper-based clinical information system to an integrated electronic medical information system has been a major focus this year. The eTQC program is our largest-ever investment in clinical information systems and will deliver better outcomes for our staff and patients. eTQC will change the way we work when the new Cerner electronic medical record (EMR) functionality goes live later this year. This will create a comprehensive clinical system across our health service. It will connect our existing Cerner modules and create a consistent way of working across Alfred Health.

eTQC will introduce:

- inpatient clinical documentation
- electronic medication prescribing and administration
- electronic pathology ordering and specimen collection
- ereferrals for internal services
- interdisciplinary plans of care
- care pathways (known as powerplans).

The eTQC program is supported by a significant investment in hardware, including 425 bedside mobile workstations, 250 bedside vital sign monitors, upgraded ECG carts and 500 new tablet computers, increasing clinician access to technology across all campuses.

The first phase of eTQC will go live in October 2018.

Infrastructure and maintenance works

Ongoing maintenance and upgrade to core building infrastructure continues to be a major focus across all sites, reflecting the impact of ageing infrastructure.

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

Maintenance works this year included:

- upgrades to air conditioning and heating systems, with replacement of chillers and upgrades to steam infrastructure
- further works to our fire safety systems and installation of enhanced security and access control systems
- upgrades to our energy management systems to enhance reliability and improve operational efficiencies, and
- ongoing works to improve amenities, including new reception areas, wayfinding system, bathrooms, flooring and patient treatment areas.

Maintenance costs

	2014	2015	2016	2017	2018
Description	$'000	$'000	$'000	$'000	$'000
Plant and non-medical equipment	1,832	1,598	2,018	1,771	959
Buildings	2,320	3,475	4,368	6,593	7,496
Grand total	4,152	5,073	6,386	8,364	8,455

In May 2018, The Victorian Government announced $69.5 million to support urgent works to upgrade fire safety compliance in The Alfred's Main Ward Block. Planning for these works has begun.

Funding of $9.5 million was provided to repair the ageing and inadequate Main Ward Block roof and sewer systems at The Alfred.

High-value equipment and infrastructure funding

In 2017–18, Alfred Health was allocated $5.65 million in funding from DHHS's High Value Statewide Replacement and Violence Prevention Funds.

The funded projects were:

Medical equipment — $'000

- Heart–lung bypass machines (3) — **$1,110**
- Neurosurgical operating table — **$300**
- Digital mammography scanner — **$350**
- Flow cytometry analyser — **$300**
- Tandem mass spectrometer — **$450**
- Echocardiography system — **$300**

Infrastructure works

- ICU chiller — **$300**
- Nurse call system — **$790**
- Domestic water and fire system separation — **$800**

Violence prevention

- Inpatient staff duress system (Caulfield) — **$150**
- Main Entry/Reception — **$207**
- Ward access control — **$250**
- Behaviour Assessment Facility (Sandringham) — **$175**

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

- Alfred Centre – Medical Day Unit
- Alfred Centre – Short Stay Unit
- Emergency Department redevelopment
- Interim fire upgrade works to the Main Ward Block
- Helipad upgrade works
- Infectious Diseases Clinic refurbishment
- Pathology Laboratory upgrade

Caulfield Hospital

- ACG Day activity room

Sandringham Hospital

- Special Care Nursery

Projects with building permits under construction

The Alfred

- Sewer and roofing upgrade works
- Neurology development
- Respiratory Medicine clinics
- Fire ring main upgrade
- Administrative offices 'The Stables'

Sandringham

- Day Procedure Unit

Compliant 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

We provide more than 115,000 episodes of inpatient care annually, with many of our patients suffering one or more preventable chronic diseases. We have more than 9,000 employees and volunteers, 56 per cent of whom report that they don't eat the daily recommended serves of vegetables. Our aim is to keep our community healthy, well and out of hospital.

Right Word. Right Time

Partnering with DHHS, we developed a communication campaign challenging health professionals to recognise the importance of preventive health. *A Right Word. Right Time* video, and supporting microsite, showed a series of life decisions and the impact they have on someone's health. The campaign, launched by the Victorian Minister for Health, reached more than 15,000 people in the first six months.

Healthy eating

To encourage healthy eating, and limit preventable conditions like obesity and type II diabetes, we expanded our point-of-sale system of green, amber and red labels on food at all our onsite cafes, reaching 1.5 million customers annually. This program has been shared with 33 sites around Australia for implementation.

Our work in creating healthy food environments was recognised as winner of the Supporting Healthy Populations category in the 2017 Victorian Public Healthcare Awards.

Our other health interventions included:

- a loyalty card for the salad bar in our main café, which increased 'green' salad purchases by 34 per cent, with 9,500 fewer unhealthy lunches sold each year
- removing fried food from display, resulting in a 38 per cent reduction in fried food sales.

Obesity intervention trial

In partnership with Monash University, we trialled a brief intervention model in upper gastrointestinal surgery, colorectal surgery, breast and endocrine surgery, cardiothoracic surgery, general cardiology, heart failure and endocrinology units. This randomised controlled trial involved 173 patients and sought to test the feasibility and acceptability of medical practitioners having conversations with their patients about their weight.

Preliminary data showed:

- 71 per cent find conversations with medical staff about their weight helpful
- 80 per cent think it is appropriate
- 61 per cent were encouraged to lose weight after their hospital visit.

Of our medical staff:

- 92 per cent agreed that managing a patient's weight is a relevant part of caring for their patients
- only 12 per cent routinely have these discussions
- 45 per cent found discussing weight and obesity uncomfortable.

The study's findings will be used to help patients manage their weight, particularly to prevent further weight gain that may worsen their health outcomes and to help staff manage conversations about obesity.

New melanoma detection

In partnership with a Cancer Council working group, our Victorian Melanoma Service experts recommended new melanoma detection guidelines that could enable more early diagnoses.

Lead author of a study published in the *Medical Journal of Australia,* Dr Victoria Mar from The Alfred's Victorian Melanoma Service, said current guidelines help health practitioners identify melanomas using the ABCD method – asymmetry, border irregularity, colour variegation and diameter. However, some melanomas were difficult to identify using this method and adding EFG – elevated, firm and growing – could help health practitioners diagnose more melanomas in time for more effective treatment.

Melanoma remains the most common cancer in Australians aged 15–39. The working group included specialists from the Victorian Melanoma Service at The Alfred, Monash University Department of Public Health and Preventive Medicine, Peter MacCallum Cancer Centre, the Melanoma Institute Australia and the University of Sydney.

Concierge service: Psychiatry

A new reception opened in The Alfred Psychiatry Inpatient Unit in May, along with a concierge service. The service, run by Security staff, provides a check-in and concierge service to those visiting the unit. The primary role is to welcome and direct visitors to the unit and provide a safety check-in, to prevent unsafe items coming into the ward, such as illicit drugs, weapons and alcohol. While it's too early to evaluate the impacts of the new reception, staff and visitors have reported the changes are welcome and enhance safety for all.

ANZAC event marks 100 years

This year's ANZAC event at Caulfield marked 100 years since the hospital first opened its doors to treat soldiers returning from the First World War.

Senior neurosurgeon Professor Jeffrey Rosenfeld AC, OBE (pictured above) delivered the commemorative address, which also included an exhibition focusing on the hospital's beginnings. The exhibition used materials compiled for Glen Eira Council's *Wounded Soldier* exhibition from 2016 plus memorabilia and artefacts from our archives.

The exhibit highlighted the hospital's important research, which improved treatment and rehabilitation of its patients, as evidenced by its progress of artificial limbs and the introduction of masseurs and physiotherapy by 1918.

Consumer engagement

Our volunteers

Our volunteers have been praised for making a difference this year – from a family grateful to a volunteer who gave their husband/father a hand and foot massage the day before he died, to a volunteer who helped a toddler get through the pain of a broken arm by distracting and comforting him.

We have:

- 542 volunteers across our organisation
  - 265 at The Alfred
  - 147 at Caulfield Hospital
  - 130 at Sandringham Hospital.

Plus we had more than 250 people registering their interest to volunteer this year.

Our volunteers work in a variety of positions, including patient support, administration, support services (such as driving a patient home or showing them around the hospital) as well as running kiosks and compiling feedback.

Highlights included:

- being shortlisted for the 2018 Minister for Health Volunteer Award for helping develop and test PowerNav – our app to help people find their way around The Alfred. Our Sandringham Hospital Emergency Department Patient/Family Support Volunteer Team members attended and were also acknowledged at the 2017 awards
- a pamper day for volunteers to celebrate National Volunteer Week
- recognition of two Sandringham volunteers – Lorraine Plecher and Joan McLean – for both giving over 30 years of volunteer service.

New initiatives

New initiatives introduced:

- a hairdresser volunteered to give inpatients haircuts and styling
- a new social activity in the rehabilitation units at Caulfield Hospital, involving one-on-one and group activities with patients. The activities are aimed at reducing social isolation for patients and providing an avenue for cognitive stimulation
- volunteers began working in our Day Procedure Ward at Sandringham Hospital. Once the new Day Procedure Unit is completed, volunteers will play a key role in assisting patients.

Consumer advisers

A group of diverse consumers are members of our Consumer Advisor Register. The register has continued to grow, with:

- 80 consumer advisors
- 32 consumers on various staff committees.

Some ways consumers have contributed:

- taste-testing new menus
- being on the interview panel of graduate nurse positions
- providing input on new clinical spaces.

We have seen more requests for consumer representation on organisational committees, working groups and quality improvement projects. All national standard committees have consumers as members, or will shortly. Consumer advisors have become members of Board committees, including our Board Quality Committee.

There has also been an increase in requests to assist areas with the facilitation of focus groups, made up of patients who use the service. Areas using the lived patient experience to improve service delivery, include the:

- Respiratory Clinic
- Functional Gut Clinic
- Multiple Sclerosis Clinic
- the Diabetes Pilot Project at Caulfield Community Health Service.

Gifts and donations

The Alfred Foundation

The Alfred Foundation raised more than $13 million for The Alfred in 2017–18, with strong and ongoing support from the community. Trusts, foundations, estates, individuals, corporate partners, and other local and national organisations supported world-leading research and healthcare at the hospital.

Major fundraising activities were focused on assisting the hospital's upgrade to eTQC and continuing to support The Alfred's Trauma Service expansion.

Significant support was received from:

- Eva and Les Erdi Humanitarian Charitable Foundation
- Estate of Belinda Lim
- Estate of Ernest Finlay Burns
- Estate of Rosemary Richards
- Estate of Benjamin Champion
- Merrin Foundation
- Mrs Betty and Mr John Laidlaw AO
- Bulla Dairy Foods
- CB and GE Miller Research Fund
- Estate of John Arnold Hughes
- Estate of Gladys Jean Stott
- The Muriel May and Les Talbot Batten Foundation
- Lungitude Foundation
- AAMI
- Estate of John McCartney Dunlop
- Estate of Peter Krafel
- Estate of Henry Hardcastle Watson
- Fox Family Foundation
- Estate of Gary Kenneth Efron
- Estate of David John Grills
- James and Elsie Borrowman Trust
- Estate of Alice G Newman
- Swiss Concept Australia Pty Ltd
- Dry July Foundation

eTQC

The Foundation's primary fundraising focus for 2017–18 was supporting The Alfred's transition to digital medical records. Our major appeal centred on raising money to fund key equipment compatible with the new system.

Trauma Service expansion

We continued to raise funds to redevelop Level 5 of The Alfred's Main Ward Block into a specialised trauma inpatient ward – the hospital's first, purpose-built facility dedicated to the early recovery of trauma inpatients.

Nursing scholarship

The Foundation held a special lunch to support an innovative new scholarship for Alfred Health nurses. Her Excellency, the Hon. Linda Dessau AC, the Governor of Victoria, was the guest speaker, with broadcaster and journalist Virginia Trioli as the MC.

Community fundraising

The Alfred was named as a beneficiary of Dry July for the fifth year running. Thanks to this event, two new projects were undertaken to improve the experience of our cancer patients: a musical therapy program for palliative care patients and a special sky ceiling in our radiotherapy room.

Father's Day Appeal

Our annual Father's Day Appeal focuses on men's health. Supported by presenting partner Bulla Dairy, the appeal raised funds for The Alfred's Trauma Service expansion.

As part of the campaign, long-time supporter Radio 3AW broadcast live from The Alfred over the Father's Day weekend and featured some of the hospital's leading clinicians and inspiring patients.

The annual *Healthy Men* publication shared health tips for everyday dads by looking at the health risks of some common male occupations. The publication was distributed extensively throughout Victoria.

Life Support Committee

This dedicated committee, which raises funds to support trauma care at The Alfred, hosted a number of successful events in 2017–18, including a jazz event and a marquee at the Portsea Polo.

In 2017–18, The Alfred Foundation Board comprised:

Sir Rod Eddington AO (Chair)

Mr Ian Cootes AM (Deputy Chair)

Mr Peter Barnett (retired 2017)

Mr Ravi Bhatia

Mr Anthony Charles

Mr Didier Elzinga

Mr Peter Fox AM (retired 2017)

Mr Michael Kiely

Mr Eddie McGuire AM

Mrs Judy Reeves (Acting Director, The Alfred Foundation)

Mr Chris Nolan (Father's Day Committee Chair)

Mr Nicholas O'Donohue (Life Support Committee Chair)

Mr Tony Phillips

Mr George Richards

Mr Rob Sayer

Mr Paul Sheahan AM

Mrs Carolyn Stubbs OAM (Women@TheAlfred Chair)

Professor Andrew Way (Chief Executive, Alfred Health)

Mr Alan Williams

Sir Donald Trescowthick AC KBE (Patron)

Caulfield Hospital Fundraising

Pin and Win

Alfred Health was the official charity partner for the Melbourne Racing Club's (MRC) 2017 Pin and Win promotion. The popular pins were sold by volunteers throughout the Caulfield Cup Carnival and other MRC racing events. The promotion was also supported by local businesses. All proceeds go towards the Hydrotherapy Centre upgrade.

Auxiliary support

The onsite Helmsmen Auxiliary Kiosk, formed 39 years ago, donated over $48,000 this year. The donation was used to purchase equipment for the Aged Care and Rehabilitation wards and included an ECG machine, ward observation equipment and modern lifting equipment.

Significant support was received from:

- Helmsmen Kiosk Auxiliary
- Mr Edward 'Eddie' Hughes
- Mrs Gweneth Cooper
- Estate of William Galloway Trust
- Estate of Jennifer Taplin
- Estate of Henry Herbert Yoffa

Sandringham Hospital Fundraising

Capital appeal

Many local organisations and residents have supported the appeal to raise funds to build the much-needed same-day surgical procedure centre. This includes a significant contribution by the Sandringham Community Bank, after which the Day Procedure Centre will be named. With the $2.5 million target reached, construction commenced in December.

Community support

Sandringham Hospital received generous support from individuals, community groups, businesses and trusts and foundations. Major fundraising events held in support of the hospital included the PRG 24-hour Charity Bike Ride, the Black Rock Sports Auxiliary Annual Charity Golf Day at Royal Melbourne Golf Club, the Oaks Day lunch at Royal Brighton Yacht Club, the SUP Vic Mad Paddle and *Lunch by the Bay* fundraising luncheon.

Community support resulted in:

- a Bayside City Council Australia Day Award for Community Event of the Year for the PRG 24-hour Charity Bike Ride
- a new weekly therapy dog program, with the support of the Rotary Club of Bentleigh Moorabbin Central
- local children participating in a familiarisation tour of the radiology department, as part of the Sandringham Community Bank Kinder Radiology program
- Sandringham Hospital being named the official charity of the Bayside Christmas Carols.

This support enabled the purchase of a range of medical equipment including an omni tract, tourniquet and diathermy generator for theatres, an overhead heater/infant warmer, neopuff and ophthalmoscope/otoscope sets for the ED, along with patient recliners, over-bed tables and vital signs monitors for the Sandringham Community Bank Day Procedure Centre.

Significant support was received from:

- Sandringham Community Bank Branch of Bendigo Bank
- All Souls Opportunity Shop
- Bayside Companion Dog Training School
- Black Rock Sports Auxiliary
- Collier Charitable Fund
- Dr Howard Farrow Sandringham Hospital GP 1965–95
- Isobel Hill Brown Charitable Trust
- Ethel Herman Charitable Trust
- F and M Hofmann

Community support (continued)

- In memory of Gladys Muriel Marriott and Alfred Marriott
- Lions Club of Beaumaris
- Lions Club of Sandringham and the Australian Lions Foundation
- PRG 24-hour Charity Bike Ride
- Royal Brighton Yacht Club
- Sandringham Hospital Kiosk volunteers
- The Alfred and Jean Dickson Foundation
- The Estate of the Late GWA Griffiths
- The Copley Family
- The SUP Vic Mad Paddle

Environmental sustainability

Environmental performance reporting

The environmental data management system (EDMS) collates environmental performance data and generates reports on our:

- greenhouse gas (GHG) emissions related to energy consumption
- energy consumption (electricity, gas, cogeneration steam and LPG)
- water consumption
- waste generation and disposal.

EDMS data collection and reporting will extend to paper consumption and GHG emissions from transport use in the near future.

Due to changes in the EDMS structure and calculation methodology, figures related to carbon emissions in previous years have changed. Estimated data has been used to calculate carbon emissions for this financial year. A full environmental report will be published on our website when full 2017–18 data is available.

Greenhouse gas emissions

Our total greenhouse gas emissions have trended down slightly over the past five years. Direct and indirect emissions for 2017–18 were 50,240 tonnes CO^2-e, down more than 2 per cent on last year.

Water consumption

Our organisation has seen water consumption fluctuate over the last five years. In 2017–18 water consumption returned to levels seen in 2015–16, after a significant reduction in usage during 2016–17.

Environmental sustainability highlights

Our new Environmental Sustainability Committee developed and launched our inaugural Environmental Sustainability Strategy (2017–21), which replaced the Environmental Management Plan 2015–17. The strategy aims to engage, educate and empower staff to create an environmentally sustainable workplace across eight sustainability themes, from energy and water efficiency, to waste management and green procurement.

Waste education

We secured funding to conduct waste audits across all three hospitals, as part of the DHHS Waste Education in Healthcare Project. This project will initially focus on identifying common items in our general waste that can be recycled. A standardised waste audit scope has been developed for the audits, which will be conducted in 2018–19.

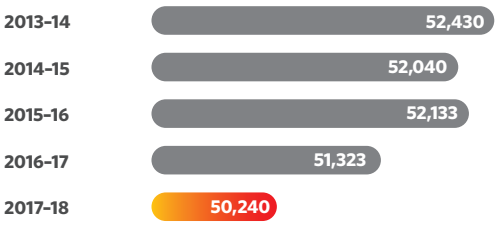
Pan flusher replacement program

A program to replace bed pan flushers across The Alfred's Main Ward Block has helped reduce energy and water consumption associated with cleaning bed pans. The existing pan flushers were in operation for over 40 years and more than 10 of these were replaced with newer efficient units this year. On completion of this project, we will be able to decommission the energy-intensive steam infrastructure currently used in the existing pan flushers.

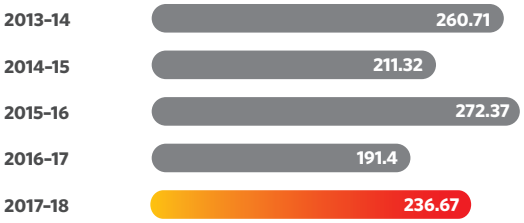
Specialised recycling streams

We continue to operate successful recycling programs targeting waste items, such as sterilisation wrap, batteries and medical PVC. This recycling helps reduce our waste to landfill and the recovered product is reprocessed into useful items such as park benches and children's play equipment. Our operating suites at The Alfred and Sandringham Hospital have recently established aluminium recycling programs to divert aluminium packaging used in theatre from landfill.

CO^2-e (tonnes)



Water (ML)



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.

During 2017–18 the Board was assisted by two Advisory Committee members. These individuals provided their expertise and advice to the committees in their deliberations. Mr Desmond Pearson was appointed in September 2017 to assist the Audit Committee. Dr Cathy Balding was appointed in January 2018 to assist the Quality Committee.

Objectives, functions, power and duties

The core 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) ('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.
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.

Board of Directors as at 30 June 2018

Mr Michael Gorton AM

BCom. LLB

Chair of the Board

Chair: Remuneration Committee
Member: Finance, Audit and Quality committees

Mr Gorton is a senior partner at Russell Kennedy Lawyers and has more than 25 years of experience advising the health and medical sector.

He has assisted boards of health organisations to understand their legal obligations for effective governance structures, governance policies and implementing risk management strategies.

Mr Gorton was a Board member of Melbourne Health and was appointed Chair of Alfred Health in July 2017.

He is a Board member of Australasian College for Emergency Medicine, Ambulance Victoria and is the Chair of the Australian Health Practitioner Regulation Agency (AHPRA). He is a former Chair of the Victorian Equal Opportunity and Human Rights Commission.

Mr Julian Gardner

AM BA LLB FIPAA

Deputy Chair of the Board

Member: Quality and People and Culture committees

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 the Chair of the Implementation Taskforce 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: People and Culture 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, the Law Institute of Victoria's (LIV) Family Courts Practice Committee as well as the LIV's Children and Youth Issues Committee.

Dr Benjamin Goodfellow

FRANZCP MBBS MPM CAPC

Chair: Primary Care and Population Health Advisory Committee
Member: Community Advisory 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 various public health roles, he is the consultant for the infant psychiatry program and paediatric consultation-liaison service at Geelong University Hospital and a standing member of the High-risk Infant Panel at DHHS–Child Protection. Dr Goodfellow has a background in public policy with a focus on ethics, mental health and philosophy within the health system at large.

He is a senior lecturer at Deakin University, former editor of the Australian Infant Mental Health Association newsletter and is in formation as an analyst with the Freudian School of Melbourne.

Ms Miriam Suss

OAM BA MSW

Chair: Community Advisory Committee
Member: People and Culture Committee

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. Ms Suss is currently the Deputy Chair of Multicultural Arts Victoria, and Deputy Chair of Language Loop, 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 and 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 served on the boards of a wide range of organisations including Hanover Welfare, and Prahran Mission. She is a currently a Director of Hepatitis Australia, Star Health, is a Victorian Disability Advisory Council member and a Patron of the Epilepsy Foundation.

Dr Victoria Atkinson

MBBS, FRACS, AFRACMA, Masters of Health Management

Chair: Quality Committee
Member: Finance and Remuneration committees

Dr Victoria Atkinson is a cardiac surgeon and the Chief Medical Officer and Group General Manager Clinical Governance at St Vincent's Health Australia.

Building on a strong clinical background, Dr Atkinson works to integrate the clinical, operational and governance aspects of healthcare to enhance patient care. She believes that executive, clinical and Board must come together to achieve patient-focused and harm-free care.

Dr Atkinson is the Deputy Chair of the Board for Better Care Victoria and a member of the Royal Flying Doctor Service Board. She is a graduate of the Australian Institute of Company Directors and holds an EDAC qualification from the Center for Healthcare Design in the United States.

Ms Sally Campbell

BA LLB GAID

Chair: Audit Committee
Member: Primary Care and Population Health Advisory Committee

Ms Campbell is an experienced business leader with extensive executive commercial and public sector experience gained in a commercial and government industries in Australia, New Zealand and the United Kingdom. Ms Campbell's background includes working in law, informatics, technology, telecommunications, manufacturing and services. Her most recent positions have been in the health and research sectors. She has an exemplary track record in designing and delivering major business strategies and systems that drive significant cultural change and continuous improvement. She is skilled at delivering strong operational performance and managing organisational change in large, complex and politically sensitive organisations. Ms Campbell works to ensure all employees, governance leads and stakeholders respect and value the various contributions of the many who intersect with health service delivery.

In 2017, Ms Campbell retired from Melbourne Health (as the Executive Director of Corporate and Information Services) and concluded an executive role managing strategy and planning at Barwon Health at the end of June. Ms Campbell is also a director of Forensicare.

Ms Campbell has degrees in law and arts.

Ms Anne Howells

BCom CA MB (Corporate Governance) GAICD

Chair: Finance Committee
Member: Audit and Remuneration committees

Ms Howells is a chartered accountant who is passionate about excellence in customer service and corporate governance.

She began her career with PwC advising small and medium sized enterprises and later consulted in risk management, compliance and corporate governance. She was appointed Assistant Company Secretary, Governance and Compliance by Telstra in 2005 and subsequently held a number of senior quality and complaints management roles as part of Telstra's journey to improve customer service.

Ms Howells is the General Manager of a nursing agency, Chair of Family Planning Victoria and the Director of CP Solutions Pty Ltd (a private company providing interim executive support to medium sized businesses experiencing growth or other changes).

Board changes

New appointments included:

- **Ms Anne Howells**, who was appointed to the Board on 19 September 2017
- **Ms Sally Campbell,** who was appointed to the Board on 22 August 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
- reviewing the annual accounts for recommendation to the Board.

Community Advisory Committee

The Community Advisory Committee 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 and Population Health Advisory Committee

The Primary Care and 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
- arrangements are put in place with other relevant agencies and service providers to enable effective and efficient service delivery and continuity of care.

People and Culture Committee

This new committee held its first meeting on 16 February 2017. The People and Culture Committee has been established to assist the Board in ensuring that:

- effective and accountable systems are in place to monitor and improve the OHSW of staff
- any systemic problems identified with the OHSW of staff services are addressed
- 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 2018

Audit Committee

Ms Sally Campbell (Chair)
Ms Kaye McNaught
Ms Anne Howells
Mr Des Pearson

Finance Committee

Ms Anne Howells (Chair)
Mr Michael Gorton
Dr Victoria Atkinson
Ms Melanie Eagle
Professor Andrew Way

Community Advisory Committee

Ms Miriam Suss (Chair)
Mr Kevin Boyce
Ms Kay Currie
Dr Benjamin Goodfellow
Ms Carol Gordon
Mr John Hawker
Mr Chris Karagiannis
Mr Stuart Martin
Ms Estie Teller
Mr Barry Westhorpe
Mr David Mills

Primary Care and Population Health Advisory Committee

Dr Benjamin Goodfellow (Chair)
Ms Sally Campbell
Ms Melanie Eagle
Professor Andrew Way
Associate Professor Peter Hunter
Associate Professor Simon Stafrace

People and Culture Committee

Ms Kaye McNaught (Chair)
Mr Julian Gardner
Ms Miriam Suss

Quality Committee

Dr Victoria Atkinson (Chair)
Mr Julian Gardner
Mr Michael Gorton
Ms Cathy Balding
Dr Carolyn Ward
Ms Kay Currie
Dr Amelia Crabtree
Mr Devereaux De Silva
Ms Eugenija Johnson

Remuneration Committee

Mr Michael Gorton (Chair)
Ms Anne Howells
Dr Victoria Atkinson
Ms Melanie Eagle

Risk management

Alfred Health has an integrated clinical and enterprise risk register which consisted of 33 open risks at 30 June 2018. High and extreme risks 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 and our patients and uses the data to support improvement in safety. The incident reporting system, using the data set of the Victorian Health Incident Management System, is an integral component of our risk management framework. Regular training and information and support is provided for staff on the use of the incident reporting data base throughout the year and all staff are encouraged to report adverse events within a culture of 'no blame'.

The incident data is routinely analysed for trends and reported to the various committees and groups responsible, including to the Executive Committee, the Quality Committee and the Audit Committee. In the event of a serious adverse event, staff undertake formal reviews to identify contributing factors and opportunities for improvement for the systems of care. Grand Rounds, newsletters and clinical alerts are used to provide feedback to staff on the outcomes of reviews and any related system changes for implementation. The Operations Leadership Committee provides oversight of follow-up and completion of the recommended actions and improvements from these formal reviews.

Safe Patient Care Act 2015

In accordance with our obligations under section 40 of the *Safe Patient Care Act 2015* (Vic), we report that Alfred Health was not subject to any adverse findings, injunctions, penalties, or directions.

Senior officers

Chief Executive

Professor Andrew Way

RN BSc (Hons) MBA FAICD

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.

Professor 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.

Professor 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 National Health Service (NHS) in the United Kingdom, latterly as CEO of the Royal Free Hampstead NHS Trust.

Chief Operating Officer (acting)

Ms Simone Alexander

MHAdmin, MClinNurs, BN

Ms Alexander has more than 20 years' experience in the healthcare sector. Acting in the Chief Operating Officer role since December 2017, she is responsible for the management and performance of Alfred Health's clinical operations.

Ms Alexander has spent the last eight years as a Clinical Service Director at Alfred Health, most recently as the Clinical Service Director, Emergency and Acute Medicine. In this role, she provided leadership and operational management of many areas including The Alfred's and Sandringham Hospital's Emergency Departments, ICU, hyperbaric, cardiology, general medicine, neurology, hospital in the home and five inpatient wards. She was responsible for meeting national emergency access targets and service development. Ms Alexander has also taken part in advising on trauma centre development in other countries, including Saudi Arabia. Ms Alexander has masters degrees in health management and clinical nursing.

Executive Director – Medical Services and 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 Council of the Victorian Institute of Forensic Medicine.

Executive Director – Nursing Services and Chief Nursing Officer

Ms Janet Weir-Phyland

RN BScN MBA

Ms Weir-Phyland is responsible for professional leadership to Alfred Health's nursing workforce and operational leadership for Allied Health. She is also responsible for non-clinical Support services, Patient Experience & Community Participation, Environmental Sustainability, Population Health and Carer Services. The position is also accountable for site coordination of Sandringham Hospital and Caulfield Hospital.

Ms Weir-Phyland is an Adjunct Professor at the School of Nursing and Midwifery at Deakin University. She is the chair and executive sponsor for many clinical and quality care initiatives, workforce strategies and has a particular interest in interdisciplinary practice development.

Prior to her appointment, she worked in Canada in several clinical, leadership and management positions in acute, rehabilitation and community care.

Executive Director – Strategy and 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 healthcare 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

Professor Jane is responsible to the Chief Executive for the strategic direction and governance of research at Alfred Health. An experienced haematologist, Professor 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.

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.

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 six 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 and 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.

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.

Ms Larkins has a long history of critical care clinical practice and management roles in health, hospitality management in New South Wales and Queensland, and was the Chief Knowledge and Information Officer/CIO at Barwon Health, prior to appointment to Alfred Health in 2015.

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.

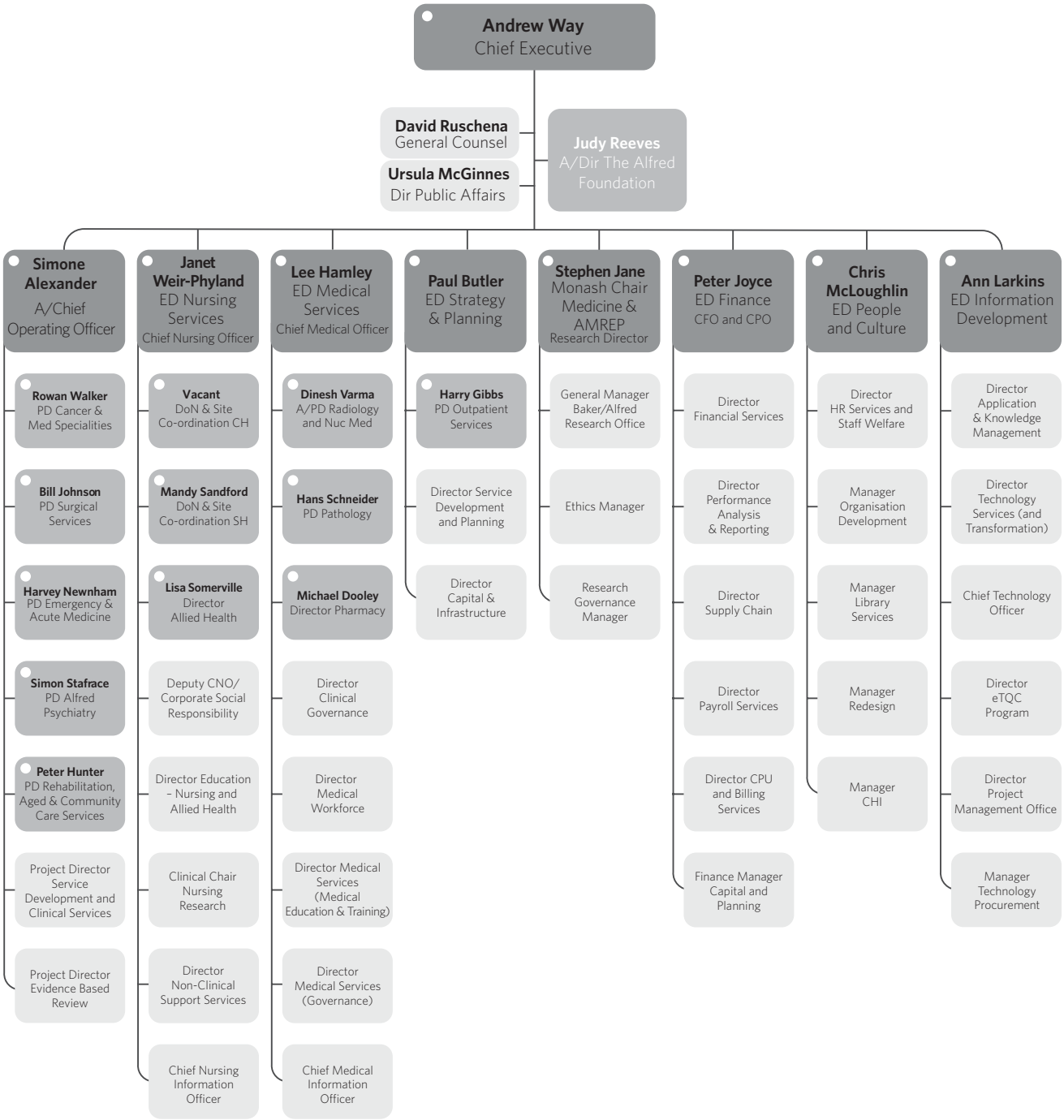
General Counsel

Mr David Ruschena

PhD LLB (Hons)/BSc (Hons)

Mr Ruschena is responsible for providing legal advice across Alfred Health.

Organisational Structure June 2018



Key

ED Executive Director
PD Program Director
Dir Director
DoN Director of Nursing
Mgr Manager
AH Alfred Hospital
CH Caulfield Hospital
SH Sandringham Hospital
● HSEC Member

Legislation changes

Medical Treatment Planning and Decisions Act

The Medical Treatment Planning and Decisions Act commenced operation on 12 March 2018. It significantly changes 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 Refusal of Treatment Certificates that have already been executed will still be legally effective. 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.

Voluntary Assisted Dying Act

The *Voluntary Assisted Dying Act* 2017 creates a process whereby certain patients can request a medically assisted death. It commences operations on 19 June 2019.

Under the legislation, eligible patients must make two formal requests and complete a written statement. Two doctors must sign off on the process, to assess whether the patient meets the eligibility criteria. Patients who lack competence will not be able to utilise the process.

If the patient is able, the patient will self-administer a lethal substance but if they are not, a doctor will be able to assist. Doctors will have the right to refuse to provide information, prescribe or administer an assisted-dying substance.

Alfred Health has commenced the process of developing a response to the legislation.

Paediatric governance

In 2017, we provided almost 26,000 encounters of care for children under the age of 18 across The Alfred, Caulfield and Sandringham hospitals.

We introduced a new governance system for Alfred Health paediatric services, which further engages senior clinicians and Executive and takes account of new legislation. This includes the DHHS Healthcare that Counts Program – a framework for improving care of vulnerable children in Victorian health services.

The Victorian Child Safe Standards were updated in 2018. Complying with the standards is compulsory for all organisations that provide services to children, including public hospitals and health services. The standards aim to promote the safety of children, prevent child abuse, and ensure organisations have effective processes in place to respond to and report allegations of child abuse. The standards are designed to drive cultural change in organisations, so that protecting children from abuse is embedded in the everyday thinking and practice of leaders, staff and volunteers.

The Alfred Health Paediatric Services Steering Committee held its first meeting in August 2017. Significant initiatives included:

- engaging senior clinicians to develop an updated service provision model
- recognising care of children in an adult hospital as a potential risk on the Alfred Health Risk Register
- upgrading the Children@AlfredHealth intranet, with access to statewide resources
- ensuring eTQC preparations include specific paediatric care.

New legislation on Child Information Sharing (2018) will apply to hospitals in 2020.

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

Rights of the public under the Freedom of Information Act are published on our website. A request for documents must be in writing or on an application form, sufficiently clear to enable a thorough search for documents, accompanied by a prescribed application fee, which can be waived for those experiencing financial hardship. Contact details of our FOI officer are on our website alfredhealth.org.au.

This year's requesters:

- two from Members of Parliament
- one from a news publication
- members of the public.

The majority of information requested was released and acceded to in full.

Information about FOI may be obtained from the Office of the Victorian Information Commissioner.

Freedom of information decisions 2017–18

Applications received	2,623
Applications granted (full)	2,293
Applications granted (part)	13
Access denied	10
No documents	21
Other	117
Not finalised	169
Not finalised 2016–17	137
Access granted in full	123
Access granted in part	1
Access denied	1
Other	12

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: 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 **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 fees (excl GST)	Expenditure (excl GST)	Future approved expenditure
APP Property and Infrastructure Specialists	Evaluation - Caulfield ABI Unit	22,595	22,595	0
Dandolo Partners International Pty Ltd	AMREP strategic review	24,813	24,813	0
Lyons Architects	Masterplan and Feasibility Study	607,850	427,590	180,260
Lisa Delaney Consulting	Psychiatry Service Plan development	81,900	81,900	0
Rivor Pty Ltd	HRIS review	44,000	44,000	0
Silver Thomas Hanley	Masterplan refresh	18,500	12,025	6,475
Safenet (Aust) Pty Ltd	Survey of chemical storage	25,180	25,180	0
Safetyworks Group Pty Ltd	Behaviour safety program	14,775	14,775	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.

Attestations

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
21 August 2018

Financial management compliance

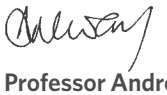
I, Michael Gorton, on behalf of the Responsible Body, certify that Alfred Health has complied with the applicable Standing Directions of the Minister for Finance under the *Financial Management Act 1994* and Instructions.

Michael Gorton
Chair

Melbourne
21 August 2018

Conflict of interest

I, Andrew Way, certify that Alfred Health has put in place appropriate internal controls and processes to ensure that it has complied with the requirements of hospital circular 07/2017 Compliance Reporting in Health Portfolio Entities (revised) and has implemented a 'Conflict of Interest' policy consistent with the minimum accountabilities required by the Victorian Public Sector Commission. Procedures are in place for executive staff to declare any relevant conflicts of interest. Declaration of private interest forms have been completed by members of the Board. All declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive Board meeting.



Professor Andrew Way
Chief Executive

Melbourne
21 August 2018

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
21 August 2018

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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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 2018 and the financial position of Alfred Health and the Consolidated Entity at 30 June 2018.

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 21 August 2018.

Mr Michael Gorton
Board Chairman

Melbourne
21 August 2018

Prof Andrew Way
Accountable Officer

Melbourne
21 August 2018

Mr Peter Joyce
Chief Finance & Accounting Officer

Melbourne
21 August 2018

Established as Bayside Health, the name of the health service was changed to Alfred Health from 10 September 2008, by order of the Governor in Council.

Independent Auditor's Report

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 entities (together the consolidated entity), which comprises the: • consolidated entity and health service balance sheet as at 30 June 2018 • consolidated entity and health service comprehensive operating statement for the year then ended • consolidated entity and health service statement of changes in equity for the year then ended • consolidated entity and health service cash flow statement for the year then ended • notes to the financial statements, including 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 2018 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. I further describe my responsibilities under that Act and those standards 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 Victoria. 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.
Other Information	My opinion on the consolidated financial report does not cover the Other Information and accordingly, I do not express any form of assurance conclusion on the Other Information. However, in connection with my audit of the financial report, my responsibility is to read the Other Information and in doing so, consider whether it is materially inconsistent with the consolidated financial report or the knowledge I obtained during the audit, or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude there is a material misstatement of the Other Information, I am required to report that fact. I have nothing to report in this regard.
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 my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the health service 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 entities 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
22 August 2018

Ron Mak
as delegate for the Auditor-General of Victoria

Comprehensive Operating Statement

for the Financial Year Ended 30 June 2018

	Note	Parent Entity 2018 $'000	Parent Entity 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
Revenue from Operating Activities	2.1	1,193,486	1,141,548	1,193,486	1,141,548
Revenue from Non-Operating Activities	2.1	4,086	3,980	4,943	4,810
Employee Expenses	3.1	(800,601)	(738,403)	(800,601)	(738,403)
Non-Salary Labour Costs	3.1	(12,105)	(16,675)	(12,105)	(16,675)
Supplies and Consumables	3.1	(247,017)	(261,135)	(247,017)	(261,135)
Other Expenses	3.1	(136,538)	(127,990)	(137,395)	(128,819)
Finance Costs	3.3	(1,071)	(1,122)	(1,071)	(1,122)
Net Result Before Capital and Specific Items		**240**	**203**	**240**	**204**
Capital Purpose Income	2.1	30,617	43,569	30,954	44,336
Other Capital Expenses	3.1	(208)	(129)	(307)	(872)
Depreciation and Amortisation	4.4	(66,769)	(67,897)	(66,769)	(67,897)
Interest on Long-Term Borrowings	3.3	(167)	(138)	(167)	(138)
Net Result After Capital and Specific Items		**(36,287)**	**(24,392)**	**(36,049)**	**(24,367)**
Other Economic Flows Included in Net Result					
Net Gain/(Loss) on Non-Financial Assets	4.6	(515)	(1)	(515)	(1)
Net Gain/(Loss) on Financial Instruments		(4,454)	(4,773)	(4,355)	(4,030)
Other Gain/(Loss) from Other Economic Flows	6.1(v)	7,500	-	7,500	-
Revaluation of Long Service Leave		39	649	39	649
Total Other Economic Flows Included in Net Result		**2,570**	**(4,125)**	**2,669**	**(3,382)**
NET RESULT FOR THE YEAR		**(33,717)**	**(28,517)**	**(33,380)**	**(27,749)**
Other Comprehensive Income					
Items that will not be reclassified to Net Result					
Changes in Physical Asset Revaluation Surplus	8.1	62,147	26,423	62,147	26,423
Items that may be reclassified subsequently to Net Result					
Changes to Financial Assets Available-For-Sale Revaluation Surplus	8.1	2,637	1,844	3,054	2,042
Total Other Comprehensive Income		**64,784**	**28,267**	**65,201**	**28,465**
COMPREHENSIVE RESULT FOR THE YEAR		**31,067**	**(250)**	**31,821**	**716**

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

Balance Sheet

as at 30 June 2018

	Note	Parent Entity 2018 $'000	Parent Entity 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
Current Assets					
Cash and Cash Equivalents	6.2	54,825	36,529	54,880	36,767
Receivables	5.1	49,600	51,191	49,755	51,369
Inventories	5.2	10,177	9,495	10,177	9,495
Prepayments and Other Assets	5.4	2,682	2,898	2,682	2,898
Total Current Assets		**117,284**	**100,113**	**117,494**	**100,529**
Non-Current Assets					
Receivables	5.1	16,291	10,242	16,291	10,242
Investments and Other Financial Assets	4.1	46,613	43,788	61,963	58,173
Property, Plant and Equipment	4.3	968,951	930,075	968,951	930,075
Intangible Assets	4.5	10,973	12,686	10,973	12,686
Total Non-Current Assets		**1,042,828**	**996,791**	**1,058,178**	**1,011,176**
TOTAL ASSETS		**1,160,112**	**1,096,904**	**1,175,672**	**1,111,705**
Current Liabilities					
Payables	5.5	83,982	76,680	84,101	76,794
Interest-Bearing Liabilities	6.1	2,597	3,999	2,597	3,999
Provisions	3.4	202,928	174,246	202,928	174,246
Other Current Liabilities	5.3	76	71	76	71
Total Current Liabilities		**289,583**	**254,996**	**289,702**	**255,110**
Non-Current Liabilities					
Interest-Bearing Liabilities	6.1	15,182	20,613	15,182	20,613
Provisions	3.4	33,558	30,573	33,558	30,573
Total Non-Current Liabilities		**48,740**	**51,186**	**48,740**	**51,186**
TOTAL LIABILITIES		**338,323**	**306,182**	**338,442**	**306,296**
NET ASSETS		**821,789**	**790,722**	**837,230**	**805,409**
Equity					
Property, Plant and Equipment Revaluation Surplus	8.1	635,868	573,721	635,868	573,721
Financial Assets Available-For- Sale Revaluation Surplus	8.1	25,382	22,745	26,333	23,279
General Purpose Surplus	8.1	77,741	70,991	77,741	70,991
Restricted Specific Purpose Surplus	8.1	48,636	49,661	62,833	63,521
Contributed Capital	8.1	324,134	324,134	324,134	324,134
Accumulated Deficits	8.1	(289,972)	(250,530)	(289,679)	(250,237)
TOTAL EQUITY		**821,789**	**790,722**	**837,230**	**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 2018

Consolidated	Note	Property, Plant and Equipment Revaluation Surplus $'000	Financial Assets Available-For-Sale Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributed Capital $'000	Accumulated Surpluses/ (Deficits) $'000	Total
Balance at 30 June 2016		**547,298**	**21,237**	**76,057**	**63,793**	**324,134**	**(227,826)**	**804,693**
Net Result for the Year	**8.1c**	-	-	-	-	-	(27,749)	(27,749)
Other Comprehensive Income for the Year	**8.1a**	26,423	2,042	-	-	-	-	28,465
Transfer from Accumulated Surplus	**8.1a,c**	-	-	(5,066)	(272)	-	5,338	-
Balance at 30 June 2017		**573,721**	**23,279**	**70,991**	**63,521**	**324,134**	**(250,237)**	**805,409**
Net Result for the Year	**8.1c**	-	-	-	-	-	(33,380)	(33,380)
Other Comprehensive Income for the Year	**8.1a**	62,147	3,054	-	-	-	-	65,201
Transfer from Accumulated Surplus	**8.1a,c**	-	-	6,750	(688)	-	(6,062)	-
Balance at 30 June 2018		**635,868**	**26,333**	**77,741**	**62,833**	**324,134**	**(289,679)**	**837,230**

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

Statement of Changes in Equity

for the Financial Year Ended 30 June 2018

Parent	Note	Property, Plant and Equipment Revaluation Surplus $'000	Financial Assets Available-For-Sale Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributed Capital $'000	Accumulated Surpluses/ (Deficits) $'000	Total
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**
Net Result for the Year		-	-	-	-	-	(33,717)	(33,717)
Other Comprehensive Income for the Year		62,147	2,637	-	-	-	-	64,784
Transfer from Accumulated Surplus		-	-	6,750	(1,025)	-	(5,725)	-
Balance at 30 June 2018		**635,868**	**25,382**	**77,741**	**48,636**	**324,134**	**(289,972)**	**821,789**

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

Cash Flow Statement

for the Financial Year Ended 30 June 2018

	Note	Parent Entity 2018 $'000	Parent Entity 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
Cash Flows From Operating Activities					
Operating Grants from Government		1,008,776	953,165	1,008,776	953,165
Capital Grants from Government		16,041	31,390	16,041	31,390
Patient and Resident Fees Received		46,787	44,282	46,787	44,282
Private Practice Fees Received		58,698	61,743	58,698	61,743
Donations and Bequests Received		14,505	12,487	14,505	12,487
GST Received from / (paid to) ATO		33,210	33,519	32,553	33,519
Interest Received		1,155	1,059	1,155	1,059
Other Capital Receipts		3,297	4,059	3,297	4,059
Other Receipts		76,455	71,378	76,780	71,655
Total Receipts		**1,258,924**	**1,213,082**	**1,258,592**	**1,213,359**
Employee Expenses Paid		(768,896)	(721,165)	(768,896)	(721,165)
Non-Salary Labour Costs		(12,105)	(16,675)	(12,105)	(16,675)
Payments for Supplies and Consumables		(418,927)	(424,838)	(418,973)	(425,597)
Finance Costs		(1,293)	(1,296)	(1,293)	(1,296)
Total Payments		**(1,201,221)**	**(1,163,974)**	**(1,201,267)**	**(1,164,733)**
NET CASH FLOW FROM OPERATING ACTIVITIES	8.2	**57,703**	**49,108**	**57,325**	**48,626**
Cash Flows From Investing Activities					
Purchase of Non-Financial Assets		(42,302)	(38,934)	(42,302)	(38,934)
Proceeds from Sale of Non-Financial Assets		-	52	-	52
Proceeds from Sale of Investments		2,167	2,072	2,362	2,151
NET (CASH USED) IN INVESTING ACTIVITIES		**(40,135)**	**(36,810)**	**(39,940)**	**(36,731)**
Cash Flows From Financing Activities					
Proceeds from Borrowings		2,000	-	2,000	-
Repayment of Borrowings		(1,277)	(3,777)	(1,277)	(3,777)
NET (CASH USED)/PROVIDED BY FINANCING ACTIVITIES		**723**	**(3,777)**	**723**	**(3,777)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**18,291**	**8,521**	**18,108**	**8,118**
Cash and Cash Equivalents at Beginning of Financial Year		**36,458**	**27,937**	**36,696**	**28,578**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	**54,749**	**36,458**	**54,804**	**36,696**

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

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Basis of Preparation

The financial statements are prepared in accordance with Australian Accounting Standards and relevant FRDs.

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*, contributions by owners (that is contributed capital and its repayment) are treated as equity transactions and, therefore, do not form part of the income and expenses of 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.

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 AAS 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 year ended 30 June 2018. The purpose of the report is to provide users with information about Alfred Health's 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 21 August 2018.

(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.

(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 2018, and the comparative information presented in these financial statements for the year ended 30 June 2017.

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

All amounts shown in the financial statements have been rounded to the nearest thousand dollars, unless otherwise stated. Minor discrepancies in tables between totals and sum of components are due to rounding.

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.

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

Note 1 – Summary of Significant Accounting Policies (cont'd)

Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the Australian Taxation Office (ATO). In this case the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.

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

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

Commitments and contingent assets and liabilities are presented on a gross basis.

(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 2018.
- 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.
- The parent entity is not shown separately in the notes.

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 2018 $'000	Non-Admitted 2018 $'000	EDs 2018 $'000	Mental Health 2018 $'000	Aged Care 2018 $'000	Primary Health 2018 $'000	Other 2018 $'000	Total 2018 $'000
Government Grants	672,207	68,755	29,065	59,626	8,235	11,215	141,949	991,052
Indirect Contributions by Department of Health and Human Services	6,781	-	-	-	-	-	-	6,781
Patient and Resident Fees	40,726	-	-	415	57	456	-	41,654
Commercial Activities	-	-	-	-	-	-	11,835	11,835
Recoupment from Private Practice for use of Hospital Facilities	20,070	-	1,601	109	-	-	38,547	60,327
Other Revenue from Operating Activities	5,754	335	490	12,979	-	3	62,276	81,837
Total Revenue from Operating Activities	**745,538**	**69,090**	**31,156**	**73,129**	**8,292**	**11,674**	**254,607**	**1,193,486**
Interest	-	-	-	-	-	-	4,379	4,379
Other Revenue from Non-Operating Activities	-	-	-	-	-	-	565	565
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**-**	**-**	**4,943**	**4,943**
Government Capital Grants							16,041	16,041
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	14,913	14,913
Total Capital Purpose Income	**-**	**-**	**-**	**-**	**-**	**-**	**30,954**	**30,954**
Total Revenue	**745,538**	**69,090**	**31,156**	**73,129**	**8,292**	**11,674**	**290,504**	**1,229,383**

Note 2.1 – Analysis of Revenue by Source (cont'd)

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 and 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**
Government Grants							31,390	31,390
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	12,946	12,946
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**

Department of Health and Human Services makes certain payments on behalf of Alfred Health.
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 (cont'd)

Revenue Recognition

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 and Human Services

- Insurance is recognised as revenue following advice from the Department of Health and Human Services.
- Long service leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the *Department of Health and Human Services Hospital Circular 04/2017*.

Patient 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. Commercial activity revenue includes car park revenue, ethics review and other external commercial services provided.

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.

Other Income

Other income includes recoveries for salaries and wages and external services provided.

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.

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 costs associated with provision of services are recorded.

Structure

Note 3.1 – Analysis of Expenses by Source

Consolidated	Admitted Patients 2018 $'000	Non-Admitted 2018 $'000	EDs 2018 $'000	Mental Health 2018 $'000	Aged Care 2018 $'000	Primary Health 2018 $'000	Other 2018 $'000	Total 2018 $'000
Employee Expenses	394,965	12,699	55,190	62,113	5,116	3,582	266,936	800,601
Other Operating Expenses								
Non-Salary Labour Costs	7,496	20	280	1,214	29	-	3,066	12,105
Supplies and Consumables	140,881	43,936	3,284	792	2,240	75	55,809	247,017
Domestic Services and Supplies	5,803	85	1,193	263	17	7	25,491	32,859
Other Expenses	22,074	2,252	791	7,295	1,778	20	70,326	104,536
Medical Support Costs	292,279	30,200	31,906	34,267	3,940	1,950	(394,542)	-
Finance Costs (refer Note 3.3)	-	-	-	-	-	-	1,071	1,071
Total Expenditure from Operating Activities	**863,498**	**89,192**	**92,644**	**105,944**	**13,120**	**5,634**	**28,157**	**1,198,189**
Depreciation and Amortisation (refer Note 4.4)	-	-	-	-	-	-	66,769	66,769
Interest on Long-Term Borrowings (refer Note 3.3)	-	-	-	-	-	-	167	167
Other Non-Operating Expenses								
Expenditure for Capital Purposes	-	-	-	-	-	-	307	307
Total Other Expenses	**-**	**-**	**-**	**-**	**-**	**-**	**67,243**	**67,243**
Total Expenses	**863,498**	**89,192**	**92,644**	**105,945**	**13,120**	**5,633**	**95,400**	**1,265,432**

Expenditure has been classified across programs as defined in the Agency Information Management System (AIMS) guidelines.
For clinical support, infrastructure and corporate and diagnostic laboratory and medical services, FTE has been used to allocate expenses across the programs.

Note 3.1 – Analysis of Expenses by Source (cont'd)

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 (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 and Amortisation (refer Note 4.4)	-	-	-	-	-	-	67,897	67,897
Interest on Long-Term Borrowings (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**

Expense Recognition

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

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.
- 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.
- Borrowing costs of qualifying assets – in accordance with the paragraphs of AASB 123 *Borrowing Costs* applicable to not-for-profit public sector entities, 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.

Note 3.1 – Analysis of Expenses by Source (cont'd)

Net Gain/(Loss) on 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 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 4.6 Net gain/(loss) on disposal of non-financial assets.

Revaluations of Financial Instrument at Fair Value

Refer to Note 7.1 Financial instruments.

Other Gains/(Losses) From Other Economic Flows

Other gains/(losses) include:

- 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 certain category groups for reporting purposes for the current and previous financial years. Refer to Note 2.1 Analysis of Revenue by Source for a description of these category groups

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

	Expense		Revenue	
	Consol'd 2018 $'000	**Consol'd 2017 $'000**	**Consol'd 2018 $'000**	**Consol'd 2017 $'000**
Commercial Activities				
Private Practice and Other Patient Activities	3,881	4,255	5,030	6,175
Car Park	3,215	3,150	10,274	9,993
Property Expense/Revenue	117	152	229	212
Other Activities				
Fundraising and Community Support	3,031	2,953	14,667	12,594
Research and Scholarship	27,376	25,563	24,827	24,375
Other	12,480	11,043	18,456	16,455
Total Expenses and Revenue	**50,100**	**47,116**	**73,483**	**69,804**

Note 3.3 – Finance Costs

	Consol'd 2018 $'000	**Consol'd 2017 $'000**
Finance Costs	1,071	1,122
Interest on Long-Term Borrowings (Note 6.1)	167	138
Total Finance Costs	**1,238**	**1,260**

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*.

Note 3.4 – Employee Benefits in the Balance Sheet

	Consol'd 2018 $'000	Consol'd 2017 $'000
Current Provisions		
Employee Benefits		
Accrued Days Off		
- Unconditional and Expected to be Settled within 12 Months (i)	1,908	1,847
Annual Leave		
- Unconditional and Expected to be Settled within 12 Months (i)	56,888	52,276
- Unconditional and Expected to be Settled after 12 Months (ii)	7,279	6,668
Long Service Leave		
- Unconditional and Expected to be Settled within 12 Months (i)	95,759	84,907
	161,834	145,698
Provisions Related to Employee Benefit On-Costs		
- Unconditional and Expected to be Settled within 12 Months (i)	15,925	14,074
- Unconditional and Expected to be Settled after 12 Months (ii)	648	577
	16,573	14,651
Accrued Wages and Salaries	24,521	13,897
Total Current Provisions	**202,928**	**174,246**
Non-Current Provisions		
Employee Benefits (ii)	30,315	27,679
Provisions related to Employee Benefit On-Costs	3,243	2,894
Total Non-Current Provisions	**33,558**	**30,573**
Total Provisions	**236,486**	**204,819**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-Costs		
Unconditional LSL Entitlements	105,858	93,786
Annual Leave Entitlements	70,437	64,522
Accrued Wages and Salaries	24,521	13,897
Accrued Days Off	2,112	2,041
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (ii)	33,558	30,573
Total Employee Benefits and Related On-Costs	**236,486**	**204,819**
(b) Movement in Provisions		
Movement in Long Service Leave:		
Balance at Start of Year	124,359	115,969
Provision Made During the Year	24,270	18,002
Settlement Made During the Year	(9,213)	(9,612)
Balance at End of Year	**139,416**	**124,359**

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

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

Employee Benefit Recognition

Provision is made for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

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 Alfred Health 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 Alfred Health expects to wholly settle within 12 months; or
- present value – if Alfred Health 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; for example, bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flows.

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

Note 3.5 – Superannuation

	Paid Contribution for the Year		Contribution Outstanding at at Year End	
	Consol'd 2018 $'000	Consol'd 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
Defined Benefit Plans (i):				
Health Super	727	784	120	61
Defined Contribution Plans:				
First State	31,481	30,320	2,408	2,459
Vic Super	163	133	15	10
Hesta	21,174	19,675	1,695	1,603
Other	8,031	6,353	2,397	1,995
Total Superannuation	**61,576**	**57,265**	**6,635**	**6,128**

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

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.

Defined Contribution Superannuation Plans

In relation to defined contribution (that is, 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.

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. The Department of Treasury and Finance discloses the State's defined benefits liabilities in its disclosure for administered items.

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

The name and details of the major employee superannuation funds and contributions made by Alfred Health are disclosed above.

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**	**2018** **$'000**	**2017** **$'000**
Managed Investment Schemes	61,963	58,173
Total Non-Current Investments and Other Financial Assets	**61,963**	**58,173**
Represented by:		
Investments Held in Trust	61,963	58,173
Total Investments and Other Financial Assets	**61,963**	**58,173**

Investments Recognition

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
- 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.

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

Alfred Health's controlled entity manage their investments in accordance with their own investment policy as approved by their Board and their investments are consolidated into Alfred Health for reporting purposes as it is the ultimate beneficiary of the Alfred Hospital Whole Time Medical Specialists' Private Practice Trust Fund.

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

Note 4.1 – Investments and Other Financial Assets (cont'd)

Derecognition of Financial Assets

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

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

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

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 Comprehensive Operating Statement, are subject to annual review for impairment.

The impairment 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 2018 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 2018. 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

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 $13.197million and under AASB 3 *Business Combinations*, this amount was recognised in Alfred Health's revenue.

At 30 June 2018, the Trust had net assets of $15.440million (2017: $14.686million) 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 2018 $'000	Consol'd 2017 $'000
Land		
Crown Land at Fair Value	237,347	237,347
Total Land	**237,347**	**237,347**
Buildings		
Buildings Under Construction at Cost	4,644	1,049
Buildings at Fair Value	638,910	740,886
Less Accumulated Depreciation	-	(141,153)
Total Buildings	**643,554**	**600,782**
Leasehold Improvements at Fair Value		
Leasehold Improvements	5,025	4,385
Less Accumulated Amortisation	(1,388)	(1,236)
Total Leasehold Improvements	**3,637**	**3,149**
Plant and Equipment, Furniture and Fittings at Fair Value		
Medical Equipment	161,098	147,025
Less Accumulated Depreciation	(113,413)	(106,227)
Total Medical Equipment	47,685	40,798
Computers and Communication Equipment	53,345	52,351
Less Accumulated Depreciation	(49,841)	(47,597)
Total Computers and Communication Equipment	3,504	4,754
Furniture and Fittings	7,234	7,234
Less Accumulated Depreciation	(6,386)	(6,124)
Total Furniture and Fittings	848	1,110
Other Plant and Equipment	58,544	65,769
Less Accumulated Depreciation	(38,912)	(37,061)
Total Other Equipment	19,632	28,708
Plant and Equipment – Work in Progress	12,744	13,427
Total Plant and Equipment and Furniture and Fittings	**84,413**	**88,797**
Motor Vehicles		
Motor Vehicles at Fair Value	60	60
Less Accumulated Depreciation	(60)	(60)
Total Motor Vehicles	**-**	**-**
Total Property, Plant and Equipment	**968,951**	**930,075**

Note 4.3 – Property, Plant and Equipment (cont'd)

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

Consolidated	Land $'000	Buildings	Leasehold Improve-ments $'000	Medical Equipment $'000	Computers and Communi-cation Equipment $'000	Furniture and Fittings $'000	Other Plant and Equipment $'000	Totals $'000
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)	(131)	(10,085)	(2,022)	(302)	(3,368)	(63,456)
Balance at 1 July 2017	**237,347**	**600,782**	**3,148**	**40,798**	**4,754**	**1,111**	**42,135**	**930,075**
Net additions and transfers between classes		28,164	640	16,392	1,174	-	(6,601)	39,769
Disposals (WDV)	-	-	-	(308)	-	-	(207)	(515)
Revaluation Increments	-	62,147	-	-	-	-	-	62,147
Depreciation (Note 4.4)		(47,539)	(152)	(9,197)	(2,424)	(262)	(2,951)	(62,525)
Balance at 30 June 2018	**237,347**	**643,554**	**3,637**	**47,685**	**3,504**	**848**	**32,376**	**968,951**

Land and buildings carried at valuation

The Valuer-General Victoria undertook to re-value all of Alfred Health's owned land and buildings to determine the fair value. 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 compliance with FRD 103F, in the year ended 30 June 2018, Alfred Health's management conducted an annual assessment of the fair value of land and buildings. To facilitate this, management obtained from the Department of Treasury and Finance the Valuer-General Victoria indices for the financial year ended 30 June 2018.

The latest indices indicated that a managerial revaluation of buildings was required in 2018. The fair value of the buildings had been adjusted by a managerial revaluation in 2018. The indexed value was then compared to individual assets written down book value as at 30 June 2018 to determine the change in their fair values. The Department of Health and Human Services approved a managerial revaluation of the buildings asset class of $62.1million (2017:Nil). The next scheduled full valuation will be conducted in 2019.

There was no material financial impact on the change in fair value of land.

c) Fair Value measurement hierarchy for assets as at 30 June 2018

	Carrying Amount As At 30 June 2018 $'000	Level 1 $'000	Level 2 $'000	Level 3 $'000
Land at Fair Value				
Specialised Land	237,347	-	-	237,347
Total Land at Fair Value	**237,347**	**-**	**-**	**237,347**
Buildings at Fair Value				
Specialised Buildings	643,554	-	-	643,554
Total Buildings at Fair Value	**643,554**	**-**	**-**	**643,554**
Leasehold Improvements at Fair Value				
Leasehold Improvements	3,637	-	-	3,637
Total Leasehold Improvements at Fair Value	**3,637**	**-**	**-**	**3,637**
Plant and Equipment, Furniture and Fittings at Fair Value				
Medical Equipment	47,685	-	-	47,685
Computers and Communication Equipment	3,504	-	-	3,504
Furniture and Fittings	848	-	-	848
Other Plant and Equipment	19,632	-	-	19,632
Plant and Equipment – Work in Progress	12,744	-	-	12,744
Total Plant and Equipment, Furniture and Fittings at Fair Value	**84,413**	**-**	**-**	**84,413**
Total Assets at Fair Value	**968,951**	**-**	**-**	**968,951**

There have been no transfers between levels during the period.

Note 4.3 – Property, Plant and Equipment (cont'd)

c) Fair Value measurement hierarchy for assets as at 30 June 2017 (cont'd)

	Carrying Amount As At 30 June 2017 $'000	Level 1 $'000	Level 2 $'000	Level 3 $'000
Land at Fair Value				
Specialised Land	237,347	-	-	237,347
Total Land at Fair Value	**237,347**	**-**	**-**	**237,347**
Buildings at Fair Value				
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 at Fair Value	**3,149**	**-**	**-**	**3,149**
Plant and Equipment, Furniture and Fittings at Fair Value				
Medical Equipment	40,798	-	-	40,798
Computers and Communication Equipment	4,754	-	-	4,754
Furniture and Fittings	1,110	-	-	1,110
Other Plant and Equipment	28,708	-	-	28,708
Plant and Equipment – Work in Progress	13,427	-	-	13,427
Total Plant and Equipment, Furniture and Fittings at 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.

d) Reconciliation of level 3 fair value

30 June 2018	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment, Furniture and Fittings $'000	Totals $'000
Opening Balance	**237,347**	**600,782**	**3,149**	**88,797**	**930,075**
Additions / (Disposals)	-	28,164	640	10,450	39,254
Depreciation	-	(47,539)	(152)	(14,834)	(62,525)
Subtotal	**237,347**	**581,407**	**3,637**	**84,413**	**906,804**
Items Recognised in Other Comprehensive Income					
Revaluation	-	62,147	-	-	62,147
Subtotal	**-**	**62,147**	**-**	**-**	**62,147**
Closing Balance	**237,347**	**643,554**	**3,637**	**84,413**	**968,951**

30 June 2017	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment, Furniture and Fittings $'000	Totals $'000
Opening Balance	**210,924**	**644,284**	**3,279**	**82,938**	**941,425**
Additions / (Disposals)	-	4,046	-	21,638	25,684
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.

Note 4.3 – Property, Plant and Equipment (cont'd)

e) Fair value determination

Asset class	Examples of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 only)
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	Community service obligations adjustments (ii)
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 no active resale market available	Level 2	Market approach	N/A
	If there is no active resale market available	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life

(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 per cent materiality threshold).

(ii) CSO adjustment of 20% was applied to reduce the market approach value for Alfred Health's specialised land.

AASB 13 *Fair Value Measurement* provides an exemption for not for profit public sector entities from disclosing the sensitivity analysis relating to 'unrealised gains/(losses) on non-financial assets' if the assets are held primarily for their current service potential rather than to generate net cash inflows.

There were no changes in valuation techniques throughout the period to 30 June 2018.

Initial Recognition

Property, plant and equipment

Items of property, plant and equipment are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment loss. Depreciated historical cost is generally a reasonable proxy for fair value because of the short lives of the assets concerned. 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 change are transferred at their carrying amounts.

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.

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 loss.

Subsequent Measurement

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.

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.

The estimates and underlying assumptions are reviewed on an ongoing basis.

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.

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 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.

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.

Note 4.3 – Property, Plant and Equipment (cont'd)

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

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

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

The market approach is also used for specialised land 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 Alfred Health, 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 Alfred Health'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.

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 sets 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 2018.

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

Revaluations of Non-Current Physical Assets

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

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 2018 $'000	Consol'd 2017 $'000
Depreciation		
Buildings	47,539	47,548
Medical Equipment	9,197	10,085
Computers and Communication Equipment	2,424	2,022
Furniture and Fittings	262	303
Other Plant and Equipment	2,951	3,368
Leasehold Improvements	152	130
Total Depreciation	**62,525**	**63,456**
Amortisation		
Computer Software	4,244	4,441
Total Amortisation	**4,244**	**4,441**
Total Depreciation and Amortisation	**66,769**	**67,897**

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 and 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

	2017–18	2016–17
Buildings	25 – 56 years	25 – 56 years
Plant and Equipment	10 – 20 years	10 – 20 years
Medical Equipment	8 – 10 years	8 – 10 years
Computers and Communication Equipment	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

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. Intangible assets with finite lives are amortised over a three to four-year period.

Note 4.5 – Intangible Assets

	Consol'd 2018 $'000	Consol'd 2017 $'000
Computer Software at Cost	33,874	31,160
Less Accumulated Amortisation	(22,901)	(18,474)
Total Intangible Assets	**10,973**	**12,686**

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 2016	**3,912**
Additions	13,215
Amortisation (Note 4.4)	(4,441)
Balance at 1 July 2017	**12,686**
Additions	3,324
Disposals	(793)
Amortisation (Note 4.4)	(4,244)
Balance at 30 June 2018	**10,973**

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 in 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 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

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

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

Note 4.6 – Net Gain/(Loss) on Disposal of Non-Financial Assets

	Consol'd 2018 $'000	Consol'd 2017 $'000
Proceeds from Disposals of Plant and Equipment		
Medical Equipment	-	36
Other Plant and Equipment	-	15
Less: Written Down Value of Non-Current Assets Disposed		
Medical Equipment	(308)	(37)
Other Plant and Equipment	(207)	(15)
Net Gain/(Loss) on Disposal of Non-Financial Assets	**(515)**	**(1)**

Disposal of Non-Financial Assets

Any gain or loss on the disposal of non-financial assets are recognised in the Comprehensive Operating Statement.

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 possible 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 5 – Other Assets and Liabilities

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

Structure

5.1 Receivables

5.2 Inventories

5.3 Other Liabilities

5.4 Prepayments and Other Non-Financial Assets

5.5 Payables

Note 5.1 – Receivables

	Consol'd 2018 $'000	Consol'd 2017 $'000
Current		
Contractual		
Inter-Hospital Debtors	1,834	1,594
Trade Debtors	7,893	4,885
Patient Fees Receivable	19,091	16,473
Accrued Revenue – Other	20,551	19,336
Total	**49,369**	**42,288**
Less Allowance for Doubtful Debts (a)		
Trade Debtors	(215)	(188)
Patient Fees	(3,683)	(3,542)
Total	**(3,898)**	**(3,730)**
Subtotal	**45,471**	**38,558**
Statutory		
GST Receivable	3,099	3,279
Accrued Revenue – Department of Health and Human Services	1,185	9,532
Total Current Receivables	**49,755**	**51,369**
Non-Current		
Statutory		
Long Service Leave – Department of Health and Human Services	16,291	10,242
Total Non-Current Receivables	**16,291**	**10,242**
Total Receivables	**66,046**	**61,611**
(a) Movement in the Allowance for Doubtful Debts		
Balance at beginning of year	(3,730)	(3,713)
Amounts written off/(on) during the year	4,285	4,756
Increase in allowance recognised in net result	(4,453)	(4,773)
Balance at End of Year	**(3,898)**	**(3,730)**

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;
- 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.

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*.

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 2018 $'000	Consol'd 2017 $'000
Pharmaceuticals		
At cost	6,635	6,355
Medical and Surgical Lines		
At cost	1,504	1,368
Radiology Stores		
At cost	424	432
Theatre Stores		
At cost	1,614	1,340
Total Inventories	**10,177**	**9,495**

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

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

Note 5.3 – Other Liabilities

	Consol'd 2018 $'000	Consol'd 2017 $'000
Current		
Patient Monies held in Trust	76	71
Total Other Liabilities	**76**	**71**
Total Monies held in Trust Represented by the following assets:		
Cash Assets (Note 6.2)	76	71

Note 5.4 – Prepayments and Other Non-Financial Assets

	Consol'd 2018 $'000	Consol'd 2017 $'000
Current		
Prepayments	2,682	2,898
Total Prepayments	**2,682**	**2,898**

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 2018 $'000	Consol'd 2017 $'000
Current		
Contractual		
Trade Creditors (i)	27,308	31,506
Accrued Expenses	35,364	30,698
Salary Packaging	4,855	7,168
Superannuation	6,635	6,128
Total Current Payables	**74,162**	**75,500**
Statutory		
Department of Health and Human Services (ii)	9,939	1,294
Total Statutory Payables	9,939	1,294
Total Payables	**84,101**	**76,794**

(i) The average credit period is 50 days (2017: 46 days). No interest is charged on payables.

(ii) Terms and conditions of amounts payable to The Department of Health and Human Services vary according to the particular agreement with the Department.

Payables consist of:

- contractual payables classified as financial instruments and measured at amortised cost. Accounts payable represent liabilities for goods and services provided to Alfred Health prior to the end of the financial year that are unpaid
- statutory payables that 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 5.5 (a) – Maturity Analysis of Financial Liabilities as at 30 June

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 Dates				
	Note	Consol'd Carrying Amount $'000	Consol'd Nominal Amount $'000	Less than 1 Month $'000	1–3 Months $'000	3 Months – 1 Year $'000	1–5 Years $'000	Over 5 Years $'000
2018								
Financial Liabilities								
Payables	**5.5**	74,162	74,162	71,854	1,988	320	-	-
Borrowings	**6.1**	17,779	17,779	-	390	2,207	10,449	4,733
Other Financial Liabilities	**5.3**	76	76	76	-	-	-	-
Total Financial Liabilities		**92,017**	**92,017**	**71,930**	**2,378**	**2,527**	**10,449**	**4,733**
2017								
Financial Liabilities								
Payables	**5.5**	75,500	75,500	72,392	2,539	569	-	-
Borrowings	**6.1**	24,612	24,612	-	366	3,633	13,895	6,718
Other Financial Liabilities	**5.3**	71	71	71	-	-	-	-
Total Financial Liabilities		**100,183**	**100,183**	**72,463**	**2,905**	**4,202**	**13,895**	**6,718**

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

Note 6.1 – Borrowings

	Consol'd 2018 $'000	Consol'd 2017 $'000
Current		
Australian Dollar Borrowings		
- Department of Health and Human Services (v)	1,000	2,500
- Treasury Corporation Victoria Loans (i-iv)	1,597	1,499
Total Current	**2,597**	**3,999**
Non – Current		
Australian Dollar Borrowings		
- Department of Health and Human Services (v)	963	4,796
- Treasury Corporation Victoria Loans (i-iv)	14,219	15,817
Total Non-Current	**15,182**	**20,613**
Total Borrowings	**17,779**	**24,612**

Terms and Conditions of Borrowings

Treasury Corporation Victoria

(i) 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 2018 is $4m.

(ii) Average interest rate applied during 2017/18 was 6.33% (2016/17: 6.33%). Interest rate is fixed for the life of the loans.

(iii) 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 2018 is $11.8m.

(iv) Repayment of these loans has been guaranteed in writing by the Treasurer.

Department of Health and Human Services

(v) In June 2014, the Department of Health and Human Services has provided an interest-free loan to Alfred Health for the amount of $10million. Alfred Health made a repayment of $2.5million in 2017. The remaining loan debt was waived in FY2017–18, therefore no repayments were made to DHHS. The $7.5million debt waiver has been recognised in 'Other economic flows' in the Comprehensive Operating Statement'. The Department of Health and Human Services also provided Alfred Health with an interest free loan of $2m in 2018 to be repaid by 30 June 2020.

(a) Maturity analysis of borrowings – refer to Note 5.5(a) for the ageing analysis of borrowings.

(b) Defaults and breaches – there were no defaults and breaches of any loan during the current and prior year.

Borrowing Recognition

Borrowings

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

Leases

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

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee. All other leases are classified as operating leases, in the manner described in Note 6.3 Commitments for expenditure

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.

Note 6.2 – Cash and Cash Equivalents

	Consol'd 2018 $'000	Consol'd 2017 $'000
Cash on Hand	33	44
Cash at Bank	54,847	36,723
Total Cash and Cash Equivalents	**54,880**	**36,767**
Represented by		
Cash held for:		
Health Service Operations	22,857	2,799
Pre-funded Capital Projects	31,410	31,048
Employee Salary Packaging	537	2,849
Total Cash as per Cash Flow Statement	**54,804**	**36,696**
	76	71
Monies held in Trust on behalf of patients*		
Total	**76**	**71**
Total Cash and Cash Equivalents	**54,880**	**36,767**

Alfred Health has an unused overdraft facility of $1,800,000 (2017: $1,800,000 unused) 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.

Note 6.3 – Commitments for Expenditure

	Consol'd 2018 $'000	Consol'd 2017 $'000
Capital Expenditure Commitments:		
Payable:		
Building Works	5,386	8,661
Plant and Equipment		
- Medical Equipment	5,324	1,981
- Computer Equipment	1,609	804
- Other Equipment	3,224	-
Total Capital Expenditure Commitments	**15,543**	**11,446**
Capital Expenditure Commitments:		
Not later than one year	15,543	11,446
Later than one year but not later than five years	-	-
Total Capital Expenditure Commitments	**15,543**	**11,446**
Other Expenditure Commitments		
Payable:		
Supplies and Consumables		
- Medical	8,521	8,688
- Other	115,189	143,399
Maintenance Contracts		
- Medical	35,326	29,457
- Information Technology	33,774	32,513
Total Other Expenditure Commitments	**192,810**	**214,057**
Other Expenditure Commitments:		
Not later than one year	62,116	63,744
Later than one year but not later than five years	125,343	146,743
Later than 5 years	5,351	3,570
Total Other Expenditure Commitments	**192,810**	**214,057**
Operating Leases Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases		
- Property	15,063	11,132
- Medical Equipment	181	197
- Motor Vehicle	1,493	1,905
Total Operating Leases Commitments	**16,737**	**13,234**
Operating Leases Commitments Payable as Follows:		
Non-Cancellable		
Not later than one year	5,681	5,558
Later than one year but not later than five years	11,031	7,605
Later than five years	25	71
Total Operating Leases Commitments	**16,737**	**13,234**
Total Commitments for Expenditure (inclusive of GST)	**225,090**	**238,737**
Less GST recoverable from the Australian Tax Office	**(20,463)**	**(21,703)**
Total Commitments for Expenditure (exclusive of GST)	**204,627**	**217,034**

All amounts shown in the commitments note are nominal amounts inclusive of GST.
Other supplies and consumables commitments are inclusive of the contract to provide non-clinical support services.

Note 6.3 – Commitments for Expenditure (cont'd)

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.

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.

Note 7 – Risks, Contingencies And Valuation Uncertainties

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

Note 7.1 – Financial Instruments

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

Due to the nature of 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.*

(a) Financial instruments: categorisation

	Note	Contractual Financial Assets– Available-For-Sale 2018 $'000	Contractual Financial Assets – Loans and Receivables 2018 $'000	Contractual Financial Liabilities at Amortised Cost 2018 $'000	Total 2018 $'000
Financial Assets					
Cash and Cash Equivalents	**6.2**	-	54,880	-	54,880
Receivables					
- Trade Debtors	**5.1**	-	7,893	-	7,893
- Other Receivables	**5.1**	-	41,476	-	41,476
Available-for-Sale Financial Assets					
- Managed Investment Schemes	**4.1**	61,963	-	-	61,963
Total Financial Assets (i)		**61,963**	**104,249**	**-**	**166,212**
Financial Liabilities					
Payables	**5.5**	-	-	74,162	74,162
Borrowings	**6.1**	-	-	17,779	17,779
Other Liabilities	**5.3**	-	-	76	76
Total Financial Liabilities (ii)		**-**	**-**	**92,017**	**92,017**

		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	**6.2**	-	36,767	-	36,767
Receivables					
- Trade Debtors	**5.1**	-	4,885	-	4,885
- Other Receivables	**5.1**	-	37,403	-	37,403
Available-for-Sale Financial Assets					
- Managed Investment Schemes	**4.1**	58,173	-	-	58,173
Total Financial Assets (i)		**58,173**	**79,055**	**-**	**137,228**
Financial Liabilities					
Payables	**5.5**	-	-	75,500	75,500
Borrowings	**6.1**	-	-	24,612	24,612
Other Liabilities	**5.3**	-	-	71	71
Total Financial Liabilities (ii)		**-**	**-**	**100,183**	**100,183**

(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 liabilities (i.e. taxes payable).

Note 7.1 – Financial Instruments (cont'd)

(b) Net holding gain/(loss) on financial instruments by category

	Net Holding gain/(loss) 2018 $'000	Net Holding gain/(loss) 2017 $'000
Financial Assets		
Cash and Cash equivalents	4,378	4,286
Available-for-Sale Assets	3,054	2,042
Total Financial Assets	**7,432**	**6,328**
Financial Liabilities		
Borrowings	(1,238)	(1,260)
Total Financial Liabilities	**(1,238)**	**(1,260)**

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.

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.

Categories of financial instruments

Loans and Receivables and Cash

Loans and receivables and cash 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, term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

Available-For-Sale Financial Assets

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, they are measured at fair value with gains and losses arising from changes in fair value, recognised in 'Other economic flows – other comprehensive income' until the investment is disposed. Movements resulting from impairment and foreign currency changes are recognised in the net result as other economic flows. On disposal, the cumulative gain or loss previously recognised in 'Other economic flows – other comprehensive income' is transferred to other economic flows in the net result.

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 comprehensive operating statement.

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.

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 or loss, are subject to annual review for impairment.

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

Note 7.1 – Financial Instruments (continued)

Derecognition of Financial Assets

Refer to Note 4.1 Investments and Other Financial Assets

Derecognition of Financial Liabilities

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

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

Note 7.2 – Contingent Assets and Contingent Liabilities

No contingent assets or liabilities are present for the year ending 30 June 2018. (2017: Nil)

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 8 – Other Disclosures

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

Structure

Note 8.1 – Equity

	Consol'd 2018 $'000	Consol'd 2017 $'000
(a) Surpluses		
(i) Property, Plant and Equipment Revaluation Surplus		
Balance at the Beginning of the Reporting Period	573,721	547,298
Revaluation Increment		
Land	-	26,423
Buildings	62,147	-
Balance at the End of the Reporting Period	**635,868**	**573,721**
Represented by:		
Land	188,083	188,083
Buildings	447,785	385,638
Balance at the End of the Reporting Period	**635,868**	**573,721**
(ii) Financial Assets Available-for-Sale Revaluation Surplus		
Balance at the Beginning of the Reporting Period	23,279	21,237
Valuation gain/(loss) recognised	3,054	2,042
Balance at the End of the Reporting Period	**26,333**	**23,279**
(iii) General Purpose Surplus		
Balance at the Beginning of the Reporting Period	70,991	76,057
Transfers (to)/from Accumulated Deficit	6,750	(5,066)
Balance at the End of the Reporting Period	**77,741**	**70,991**
(iv) Restricted Specific Purpose Surplus		
Balance at the Beginning of the Reporting Period	63,521	63,793
Transfers (to)/from Accumulated Deficit	(688)	(272)
Balance at the End of the Reporting Period	**62,833**	**63,521**
Total Surpluses	**802,775**	**731,512**
(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	(250,237)	(227,826)
Net Result for the Year	(33,380)	(27,749)
Transfers (to)/from General Purpose Surplus	(6,750)	5,066
Transfers (to)/from Restricted Specific Purpose Surplus	688	272
Balance at the End of the Reporting Period	**(289,679)**	**(250,237)**
Total Equity at End of Financial Year	**837,230**	**805,409**

Note 8.1 – Equity (cont'd)

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 (to a value less than cost), that portion of the surplus which relates to that financial asset is recognised in the comprehensive operating statement.

General Purpose Surplus

General purpose surplus represents specific purpose funds over which Alfred Health has management control as well as discretion on the ultimate usage of these funds.

Specific Restricted Purpose Surplus

Specific restricted purpose surplus is 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 2018 $'000	Consol'd 2017 $'000
Net Result for the Year	**(33,380)**	**(27,749)**
Non-Cash Movements:		
Depreciation and Amortisation	66,769	67,897
Provision for Doubtful Debts	168	17
Department of Health and Human Services Loan Discount	167	138
Department of Health and Human Services Loan Forgiveness	(7,500)	-
Non-cash Investment Income	(3,412)	(3,789)
Movements Included in Investing and Financing Activities		
Net Loss from Disposal of Non-Financial Assets	515	1
Movements in Assets and Liabilities		
- Increase /(Decrease) in Employee Benefits	31,667	17,022
- Increase/(Decrease) in Payables	7,307	(1,220)
- Increase/(Decrease) in Other Liabilities	(76)	(76)
- (Increase)/Decrease in Receivables	(4,434)	(3,473)
- Decrease/(Increase) in Prepayments	216	(193)
- (Increase)/Decrease in Inventories	(682)	51
Net Cash Inflows/(Outflows) from Operating Activities	**57,325**	**48,626**

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 2017 to 30 June 2018)

- Mr Michael Gorton
  AM (Chair), BCom, LLB
- Mr Julian Gardner
  BA LLB FIPAA
- Ms Kaye McNaught
  BA (PSYCH, CRIM), LLB (MELB)
- Dr Benjamin Goodfellow
  FRANZCP, MBBS, MPM, CAPC
- Ms Miriam Suss OAM BA MSW
- Ms Melanie Eagle
  BA BSW LLB, GAICD, GradDip (International Development)
- Dr Victoria Atkinson
  MBBS, FRACS, AFRACMA, Masters of Health Management
- Ms Sally Campbell
  LLB/BA (appointed 22 August 2017)
- Ms Anne Howells
  BCom CA MB (Corporate Governance) GAICD (appointed 19 September 2017)

Accountable Officer

- Prof Andrew Way
  (Chief Executive)
  RN BSc (Hons) MBA FAICD

Responsible Persons Remuneration

The number of responsible persons are shown in their relevant income bands:

Income Band	Consolidated	
	2018	2017
$20,000 – $29,999	2	-
$30,000 – $39,999	6	7
$70,000 – $79,999	1	1
$550,000 – $559,999	1	1
Total Number	**10**	**9**
Total Remuneration Received or Due and Receivable by Responsible Persons from the Reporting Entity Amounted to:	**$912,921**	**$892,415**

Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Services' Financial Report as disclosed in Note 8.5 Related parties, and are not included in the above table.

Note 8.4 – Executive Officers' 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.

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. One Executive Officer resigned in the past year. This has had an impact on total remuneration figures due to the inclusion of annual leave and long service leave payments.

Remuneration of Executive Officers (including Key Management Personnel disclosed in Note 8.5)	**2018 $**	**2017 $**
Short-term employee benefits	2,011,307	2,077,747
Post-employment benefits	159,463	174,042
Other long-term benefits	100,550	65,898
Total Remuneration (i) (ii)	**2,271,320**	**2,317,687**
Total Number of Executives	**8**	**9**
Total Annualised Employee Equivalent (AEE) (iii)	**7**	**7**

(i) 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).

(ii) The remuneration of Executive Officers disclosed includes pro-rata remuneration of employees while acting in the executive's roles.

(iii) 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 (KMP) and their close family members
- all cabinet ministers (where applicable) and their close family members
- all hospitals and public sector entities that are controlled and consolidated into the State of Victoria consolidated financial statements.

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of Alfred Health and its controlled entities, directly or indirectly. Key management personnel (KMP) of the hospital include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the hospital.

The Board of Directors and the Executive Directors of Alfred Health are deemed to be KMPs.

Entity	KMPs	Position Title
Alfred Health	Mr Michael Gorton	Board Member
Alfred Health	Mr Julian Gardner	Board Member
Alfred Health	Ms Kaye McNaught	Board Member
Alfred Health	Dr Benjamin Goodfellow	Board Member
Alfred Health	Ms Miriam Suss	Board Member
Alfred Health	Ms Melanie Eagle	Board Member
Alfred Health	Dr Victoria Atkinson	Board Member
Alfred Health	Ms Sally Campbell	Board Member
Alfred Health	Ms Anne Howells	Board Member
Alfred Health	Prof Andrew Way	Chief Executive Officer
Alfred Health	Dr Tim Sinclair	Chief Operating Officer (resigned 8 December 2017)
Alfred Health	Ms Simone Alexander	Acting Chief Operating Officer (appointed 8th December 2017)
Alfred Health	Dr Lee Hamley	Executive Director, Medical Services and Chief Medical Officer
Alfred Health	Ms Janet Weir	Executive Director, Nursing Services and Chief Nursing Officer
Alfred Health	Mr Paul Butler	Executive Director, Strategy and Planning
Alfred Health	Mr Peter Joyce	Executive Director, Finance and Chief Financial Officer
Alfred Health	Ms Christine McLoughlin	Executive Director, People and Culture
Alfred Health	Ms Ann Larkins	Executive Director, Information Development

The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Ministers' remuneration and allowances are set by the *Parliamentary Salaries and Superannuation Act 1968*, and are reported within the Department of Parliamentary Services' Financial Report.

Compensation	2018 $'000	2017 $'000
Short-term employee benefits	2,832	2,881
Post-employment benefits	215	237
Other long-term benefits	137	92
Total	**3,184**	**3,210**

KMPs are also reported in Note 8.3 Responsible persons' disclosures or Note 8.4 Executive officers' disclosures

Significant Transactions with Government-Related Entities

Alfred Health received funding from the Department of Health and Human Services of $888.4 million (2017: $832.9 million).

Alfred Health also provided services to other government-related entities that were not individually significant totaling $12.1 million (2017: $13.9 million), and received services that were not individually significant totaling $9.5 million (2017: $9.5 million).

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

Professional medical indemnity insurance and other insurance products are obtained from a Victorian Public Financial Corporation.

Treasury Risk Management Directions require Alfred Health to hold cash (in excess of working capital) and investments, and source all borrowings from Victorian public financial corporations.

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; for example, 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 the Department of Health and Human Services, all other related party transactions that involved key management personnel and their close family members have been entered into on an arm's length basis. Transactions are disclosed when they are considered material to the users of the financial report in making and evaluating decisions about the allocation of scare resources.

There were no related party transactions with Cabinet Ministers required to be disclosed in 2018 (2017: Nil).

There were no related party transactions required to be disclosed for Alfred Health's Board of Directors and Executive Directors in 2018 (2017: Nil).

Alfred Health's Board member Michael Gorton is also a board member of Ambulance Victoria. The transactions between Alfred Health and Ambulance Victoria forms part of the services to/from government-related entities disclosed in Note 8.5

Note 8.6 – Remuneration of Auditors

	Consol'd 2018 $'000	Consol'd 2017 $'000
Victorian Auditor-General's Office		
Audit of financial statements	247	251
Total Auditor Remuneration	**247**	**251**

Note 8.7 – Australian Accounting Standards Issued That Are Not Yet Effective

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2018 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 2018, 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.

The effective dates noted below are effective dates according to the Australian Accounting Standards. Since Alfred Health is a not-for-profit entity AASB 2016–7 *Amendments to Australian Accounting Standards – Deferral of* AASB 15 for Not-for-Profit Entities is applicable to Alfred Health which defers the effective date on AASB 15 to 1 January 2019. Therefore, these standards will become effective for Alfred Health on 1 July 2019.

Topic	Key requirements	Effective date
AASB 9 *Financial Instruments*	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedge accounting model and a revised impairment loss model to recognise expected impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 January 2018
AASB 2014 1 *Amendments to Australian Accounting Standards [Part E Financial Instruments]*	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018, and to amend reduced disclosure requirements.	1 January 2018
AASB 2014 7 *Amendments to Australian Accounting Standards arising from AASB 9*	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 January 2018
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer. Note that amending standard AASB 2015 8 *Amendments to Australian Accounting Standards – Effective Date of* AASB 15 has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	1 January 2018
AASB 2014 5 *Amendments to Australian Accounting Standards arising from AASB 15*	Amends the measurement of trade receivables and the recognition of dividends as follows: • trade Receivables that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. • dividends are recognised in the profit and loss only when: – the entity's right to receive payment of the dividend is established – it is probable that the economic benefits associated with the dividend will flow to the entity – the amount can be measured reliably.	1 January 2018
AASB 2015-8 *Amendments to Australian Accounting Standards – Effective Date of AASB 15*	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 January 2018
AASB 2016-3 *Amendments to Australian Accounting Standards – Clarifications to AASB 15*	This Standard amends AASB 15 to clarify requirements for identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • a promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation • for items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer • for licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1 January 2018

Topic	Key requirements	Effective date
AASB 2016-7 *Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities*	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1 January 2019
AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit-entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	1 January 2019
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of operating leases (which are currently not recognised) on balance sheet.	1 January 2019
AASB 1058 *Income of Not-for-Profit Entities*	AASB 1058 standard will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 *Contributions.* The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context. AASB 1058 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 objective.	1 January 2019
AASB 1059 *Service Concession Arrangements: Grantor*	This Standard applies to arrangements that involve an operator providing a public service on behalf of a public sector grantor. It involves the use of a service concession asset and where the operator manages at least some of the public service at its own direction. An arrangement within the scope of this standard typically involves an operator constructing the asset used to provide the public service or upgrading the assets and operating and maintaining the assets for a specified period of time. The state has 2 types of PPPs: 1. Social Infrastructure: A PPP that requires the government to make payments to the operator upon commencement of services: • operator finances and constructs • the state pays unitary service payments over the term. 2. Economic Infrastructure: A PPP that is based on user pays model: • operator finances and constructs the infrastructure • state does not pay for the cost of the construction • operator charges asset users and recovers the cost of construction andoperation for the term of the contract.	1 January 2019
AASB 17 *Insurance Contracts*	The new Australian standard eliminates inconsistencies and weaknesses in existing practices by providing a single principle-based framework to account for all types of insurance contracts, including reissuance contract that an insurer holds. It also provides requirements for presentation and disclosure to enhance comparability between entities. This standard does not apply to the not-for-profit public sector entities. The AASB is undertaking further outreach to consider the application of this standard to the not-for-profit public sector.	1 January 2021

Note 8.7 – AASs Issued That Are Not Yet Effective (cont'd)

The following accounting pronouncements are also issued but not effective for the 2017–18 reporting period. At this stage, the preliminary assessment suggests they may have insignificant impacts on public sector reporting.

- AASB 2016-5 *Amendments to Australian Accounting Standards* – Classification and Measurement of Share based Payment Transactions
- AASB 2016-6 *Amendments to Australian Accounting Standards* – Applying AASB 9 *Financial Instruments* with AASB 4 *Insurance Contracts*
- AASB 2017-1 *Amendments to Australian Accounting Standards* – Transfers of Investment Property, Annual Improvements 2014–2016 Cycle and Other Amendments
- AASB 2017-3 *Amendments to Australian Accounting Standards* – Clarifications to AASB 4
- AASB 2017-4 *Amendments to Australian Accounting Standards* – Uncertainty over Income Tax Treatments
- AASB 2017-5 *Amendments to Australian Accounting Standards* – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections
- AASB 2017-6 *Amendments to Australian Accounting Standards* – Prepayment Features with Negative Compensation
- AASB 2017-7 *Amendments to Australian Accounting Standards* – Long-term Interests in Associates and Joint Ventures
- AASB 2018-1 *Amendments to Australian Accounting Standards* – Annual Improvements 2015–2017 Cycle
- AASB 2018-2 *Amendments to Australian Accounting Standards* – Plan Amendments, Curtailment or Settlement

Notes:

For the current year, given the number of consequential amendments to AASB 9 *Financial Instruments* AASB 15 *Revenue from Contracts with Customers,* and AASB 16 *Leases* the standards/interpretations have been grouped together to provide a more relevant view of the upcoming changes.

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 – Going Concern

Alfred Health is wholly dependent on the continued financial support of the State Government and in particular the Department of Health and Human Services.

The Department of Health and Human Services has provided confirmation that it will continue to provide the Alfred Health adequate cash flow support to meet its current and future obligations as and when they fall due for a period up to September 2019.

Alfred Health reported a negative net result for the year of $33.7million (2017: $28.5million). Alfred Health's current asset ratio (2018: 0.41 and 2017: 0.39) and days available cash (2018: 7.2 days and 2017: 0.9 days) continue to be below an adequate short-term position. A letter confirming adequate cash flow was also provided in the previous financial year.

The financial statements have been prepared on a going concern basis. The State Government and the Department of Health and Human Services have confirmed financial support to settle Alfred Health's financial obligations when they fall due.

Note 8.11 – Alternative Presentation of Comprehensive Operating Statement

	Note	Parent Entity 2018 $'000	Parent Entity 2017 $'000	Consol'd 2018 $'000	Consol'd 2017 $'000
Grants					
Operating	**2.1**	991,051	952,932	991,052	952,932
Capital	**2.1**	16,041	31,390	16,041	31,390
Interest	**2.1**	3,185	2,713	4,378	4,286
Sales of Goods and services	**2.1**	120,598	115,375	120,598	115,399
Other Income	**2.1**	97,314	86,687	97,314	86,687
Revenue from Transactions		**1,228,189**	**1,189,097**	**1,229,383**	**1,190,694**
Employee Expenses	**3.1**	800,601	738,403	800,601	738,403
Operating Expenses					
Supplies and Consumables	**3.1**	247,017	261,135	247,017	261,135
Non-salary Labour Costs	**3.1**	12,105	16,675	12,105	16,675
Finance Costs	**3.3**	1,071	1,122	1,071	1,122
Other	**3.1**	136,538	127,990	137,395	128,819
Non-Operating Expenses					
Interest on Long-Term Borrowings	**3.3**	167	138	167	138
Expenditure for Capital Purpose	**3.1**	208	129	307	872
Depreciation and Amortisation	**4.4**	66,769	67,897	66,769	67,897
Expenses from Transactions		**1,264,476**	**1,213,489**	**1,265,432**	**1,215,061**
Net Results from Transactions – Total		**(36,287)**	**(24,392)**	**(36,049)**	**(24,367)**
Other Economic Flows included in Net Result					
Net Gain/(Loss) on Non-Financial Assets	**7.2**	(515)	(1)	(515)	(1)
Net Gain/(Loss) on Financial Instruments		(4,454)	(4,773)	(4,355)	(4,030)
Revaluation of Long Service Leave		39	649	39	649
Other Gain/(Loss) from Other Economic Flows	**6.1(v)**	7,500	-	7,500	-
Total Other Economic Flows included in Net Result		**2,570**	**(4,125)**	**2,669**	**(3,382)**
NET RESULT FOR THE YEAR		**(33,717)**	**(28,517)**	**(33,380)**	**(27,749)**
Other Comprehensive Income					
Items that will not be Reclassified to Net Result					
Changes in Physical Asset Revaluation Surplus	**8.1**	62,147	26,423	62,147	26,423
Items that may be Reclassified Subsequently to Net Result					
Changes to Financial Assets Available-For-Sale Revaluation Surplus	**8.1**	2,637	1,844	3,054	2,042
Total Other Comprehensive Income	**8.1**	**64,784**	**28,267**	**65,201**	**28,465**
COMPREHENSIVE RESULT		**31,067**	**(250)**	**31,821**	**716**

This alternative presentation reflects the format required for reporting to the Department of Treasury and Finance, which differs to the disclosures of certain transactions, in particular revenue and expenses, in the hospital's annual report.

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)

(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*

(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.

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.

Note 8.12 – Glossary of terms and style conventions (cont'd)

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 (for example, 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 (for example, water and port authorities). In general, PNFCs are legally distinguishable from the governments that own them.

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 (for example, 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.

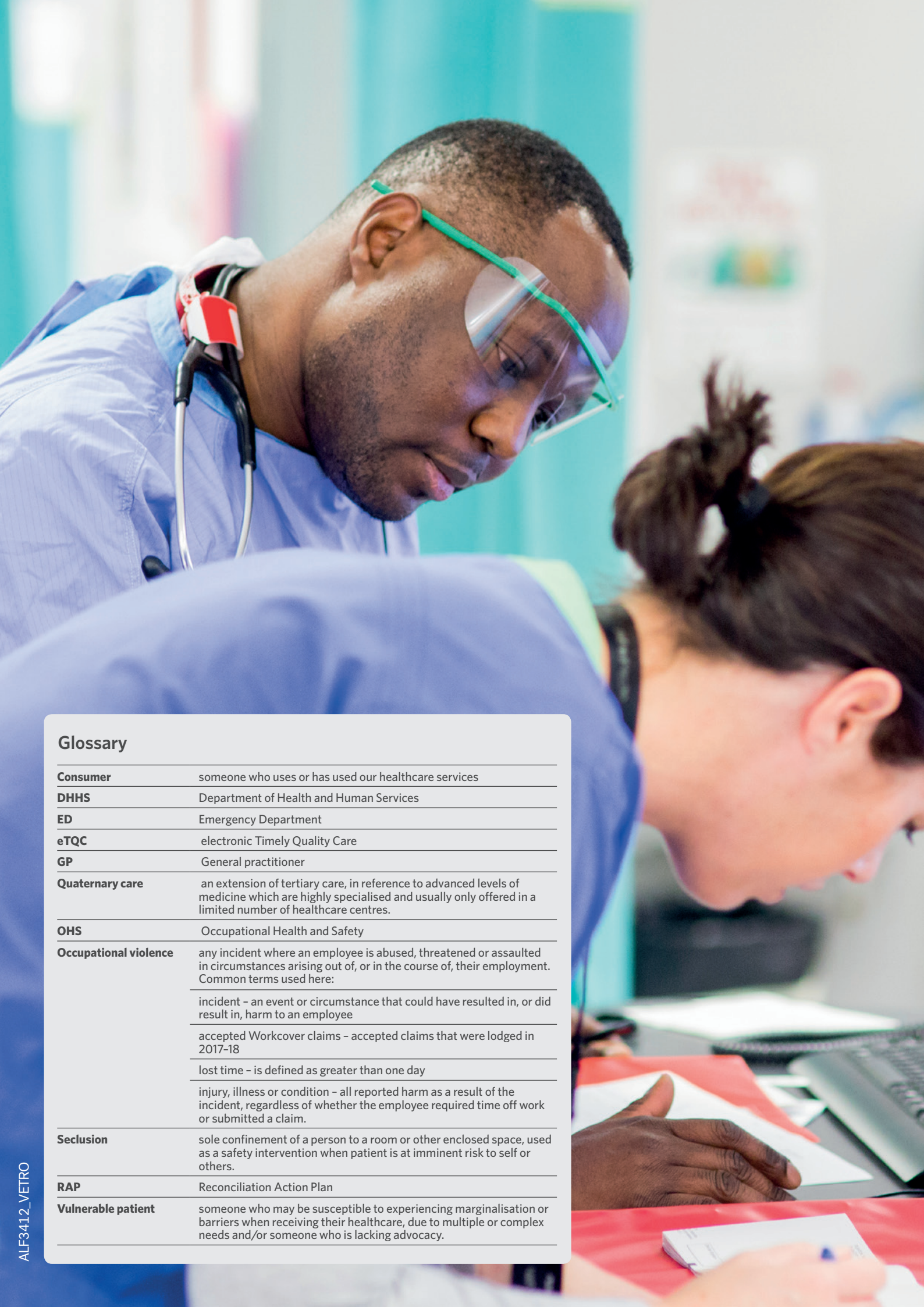
The notation used in the tables is as follows:

zero, or rounded to zero

(000) negative numbers

2018 - year period

2017 - prior year period



Glossary

Consumer	someone who uses or has used our healthcare services
DHHS	Department of Health and Human Services
ED	Emergency Department
eTQC	electronic Timely Quality Care
GP	General practitioner
Quaternary care	an extension of tertiary care, in reference to advanced levels of medicine which are highly specialised and usually only offered in a limited number of healthcare centres.
OHS	Occupational Health and Safety
Occupational violence	any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of, their employment. Common terms used here:
	incident – an event or circumstance that could have resulted in, or did result in, harm to an employee
	accepted Workcover claims – accepted claims that were lodged in 2017–18
	lost time – is defined as greater than one day
	injury, illness or condition – all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.
Seclusion	sole confinement of a person to a room or other enclosed space, used as a safety intervention when patient is at imminent risk to self or others.
RAP	Reconciliation Action Plan
Vulnerable patient	someone who may be susceptible to experiencing marginalisation or barriers when receiving their healthcare, due to multiple or complex needs and/or someone who is lacking advocacy.

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