AlfredHealth

Annual Report 2018—19

theAlfred
Caulfield HOSPITAL
Sandringham HOSPITAL
MSHC MELBOURNE SEXUAL HEALTH CENTRE

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

Nurse **Lydia D'Lasselle** is part of The Alfred's hard working cardiology team.

Contents

Front cover
Nurse **Marc Marquez** was named 2018 Australasian Emergency Nurse of the Year at the International Conference for Emergency Nursing.

Back cover
Nurse **Grace O'Brien** and doctor **Juan Carlos Mora** are part of The Alfred's ICU team.

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 2018 to 30 June 2019. We value transparency and accountability and aim to have all our reportable data available to the community in the one publication.

There were four relevant Ministers for the period:

The Honourable Jill Hennessy Minister for Health, Minister for Ambulance Services	01/07/2018 – 29/11/2018
The Honourable Jenny Mikakos Minister for Health, Minister for Ambulance Services	29/11/2018 – 30/06/2019
The Honourable Martin Foley Minister for Mental Health	01/07/2018 – 30/06/2019
The Honourable Martin Foley Minister for Housing, Disability and Ageing	01/07/2018 – 29/11/2018
The Honourable Luke Donnellan Minister for Child Protection, Minister for Disability, Ageing and Carers	29/11/2018 – 30/06/2019

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**

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 our community-based clinics, provide lifesaving treatments, specialist care and rehabilitation services.

We provide a comprehensive range of locally based services, caring for a wide range of people from children to the elderly.

A member of

Alfred Research Alliance
New thinking. Real impact.

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 Research Alliance (A+).

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, general surgery, orthopaedics 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

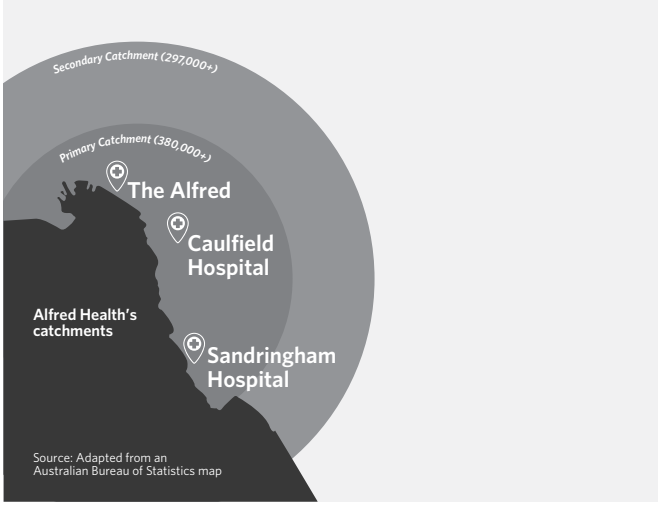
Melbourne Sexual Health has dedicated clinics for men and women, onsite testing for sexually transmitted infections and provides counselling, advice, and health information.

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.

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 covers over 700,000 people and continues to grow rapidly.

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

About Alfred Health (continued)

Alfred Health national service

Paediatric Lung Transplant Service

Alfred Health's statewide services

Bariatric Service

Clinical Haematology Service and Haemophilia Service

Cystic Fibrosis Service

Heart and Lung Transplant Service

Hyperbaric Medicine Service

Major Trauma Service

Malignant Haematology and Stem Cell

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

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 2019.

Michael Gorton AM
Chair

Alfred Health Board
4 September 2019

How expert care saved Petra's life

When 35-year-old Petra Brosch's heart stopped during a routine run on Elwood Beach, it was the start of a journey where The Alfred's specialists would draw on the latest in modern medicine to save her life.

Petra was suffering irreparable heart failure.

"To give her the best chance of survival, we put Petra on ECMO (extracorporeal membrane oxygenation) – a heart-lung bypass that supports vital organs," Intensivist Dr Li Tan said. "We were concerned about the brain, which is vulnerable to damage without oxygen."

Petra also suffered internal bleeding and fluid in her lungs, which a cardiothoracic surgeon relieved through surgery.

A procedure connecting Petra's heart to a mechanical pump on the outside of her chest was performed.

To the surprise of staff, Petra stood up in the ICU – a big step to keeping muscle condition and being eligible for a heart transplant. After two months in ICU, a new heart became available.

"With our heritage of handling heart support and transplant patients, we are prepared for the long haul," said Dr Peter Bergin, Medical Director, Heart Failure and Transplant Service.

Petra is expected to get back to running and work, though she has a long road ahead.

"Her job now is to get strong, and we will help her," said Dr Bergin.

Chair and Chief Executive's year in review

Chair
Michael Gorton AM

Chief Executive
Prof Andrew Way AM

It is a privilege to present this year's annual report, demonstrating how Alfred Health continued to serve Victorians by providing expert care when people needed it most. We also took an enormous stride towards a digital health service, introducing an integrated electronic medical record.

Leading critical care

Increasing emergency presentations and high acuity were the distinguishing features of 2018–19.

More than 9,550 trauma cases were treated and around 7,600 emergency surgeries performed.

Our Intensive Care Unit (ICU) treated the most complex and unwell patients in Victoria as demand for critical care services continued to rise. To address this need in the short term, planning for a second ICU located on Level 3 was well advanced. This new pod, which will open in September 2019, increases the total number of ICU beds to 50.

ECMO cases (Extracorporeal Membrane Oxygenation) continued to grow, with this heart and lung bypass treatment saving the lives of people with catastrophic organ failure. During the year, The Alfred was recognised internationally as an ECMO centre of excellence.

As the state's heart and lung transplantation service, we continued to give people a second chance of life, undertaking 37 heart and 94 lung transplants.

Better care, close to home

Using evidence-based practice, we saw a fall in the average length of stay for our acute patients along with an increase in discharge rates with patients returning home sooner.

The *Better at Home* program at Caulfield Hospital, which provides older patients with an opportunity to receive therapy in their own surroundings, grew by 61 per cent in the year. Meanwhile, telehealth services increased exponentially with 1,395 telehealth appointments covering more than 50 clinical areas including epilepsy, cardiology, cystic fibrosis, and infectious diseases.

At Sandringham Hospital, the opening of a new Day Procedure Centre in August 2018 meant an increase in surgery and more local care.

We increased services to meet demand at our Melbourne Sexual Health Centre as we provided a record 56,892 consultations, an 8 per cent increase on last year.

Community recognition

A highlight of the year was receiving the Premier's Award for Health Service of the Year (Large), a privilege shared with our colleagues at the Peter MacCallum Cancer Centre.

This award recognises the commitment of our frontline staff and the confidence our community has in the quality and leading care we provide.

Staff safety and wellbeing

The inseparable link between patient care and staff wellbeing intensified our focus of ensuring the physical and psychological safety of our staff who often work in challenging work environments.

Our occupational health and safety initiatives focused on manual handling and occupational violence training. We embedded an early intervention program to encourage staff to seek medical treatment as soon as possible after a workplace injury, which saw improved return to work rates.

The Schwartz Rounds provided a forum for staff to discuss the emotional and social aspects of working in healthcare while staff completed mandatory e-learning programs raising awareness about unacceptable and unprofessional behaviour.

Digital transformation

Alfred Health introduced our largest quality initiative ever, over five weeks we introduced an integrated electronic medical record (EMR) to our three hospital campuses.

This was truly a whole-of-health service initiative touching every corner of our operations. A comprehensive training program saw more than 6,000 staff receive training over ten weeks: the culmination of two years of detailed development and planning.

For our patients, the new EMR means their treating team has access to their clinical information anywhere, anytime. It will support decision making, reduce clinical variation, increase visibility of patient risk factors and reduce duplication of administration and data. We are already seeing significant benefits in medication safety.

Importantly, we delivered one of our most significant strategic initiatives outlined in our 2016–20 Strategic Plan. For 2019–20, the focus is to streamline EMR functionality as it becomes more deeply embedded in the way we deliver care, extend the EMR to outpatients and further expand the patient portal.

Building for a better future

This year we experienced some infrastructure challenges and completed essential repair works at The Alfred. We thank our patients and staff for their patience during this time.

The faulty cold water pipes in The Alfred Centre, which continuously affected daily operations, were successfully replaced during the year. Supported by the Victorian Government, this project meant the short-term relocation of our elective surgical program and team to Epworth Health as well as the relocation of outpatients and Radiology within the main hospital.

Extreme wet weather challenged the infrastructure at The Alfred. Before the government-funded roof and sewerage replacement program was complete, water leakage from storms in late 2018 meant the closure of an operating theatre as well as two wards on Level 7, affecting access performance.

In true Alfred Health fashion, we continued to offer quality care to our community during these disruptions either by working with our colleagues in the health sector, or through creating Australian firsts, by using the first mobile theatre for cardiac surgery.

We will continue to work with the Victorian Government to develop facilities that meet the growing population's need for critical care services in the long term.

Research and education

Alfred Health continued to be one of Australia's most research-intense health services. This research activity is largely driven through our relationships with the Alfred Research Alliance (previously known as the Alfred Medical Research and Education Precinct) as well as Monash Partners Academic Health Science Centre, as we worked together to translate research directly into patient benefit.

Of particular note is the increase in neuroscience on the precinct, with The Alfred now home to the only inpatient neuroscience clinical trials unit in the country. Patients have the opportunity to participate in innovative medical trials of new therapies in the safety of a hospital ward with specific expertise in managing patients with neurological conditions.

Announced during the year was a joint Alfred Health and Monash University initiative to establish a new clinical trials network, funded by Federal and Victorian Governments.

The Australian Clinical Trials Network's 'TrialHub' program will give Australians greater access to potentially lifesaving treatments for rare cancers and other diseases through partnerships with regional hospitals. This will make it easier for Australians in regional and rural areas to participate in trials.

Thanks to Board and staff

Thanks go to our directors and executive team for their hard work and continued dedication. We are grateful for their ongoing commitment to delivering safe and timely care. We also said goodbye to one of our longest serving board members – Julian Gardner–who helped guide and support the health service for the past nine years.

To our donors and broader community, we are grateful for your unstinting generosity; through your support Alfred Health can continue to deliver world-leading healthcare.

Given the substantial changes this year to technology (EMR) and extensive building works and improvements, most importantly, our gratitude goes to our outstanding staff who, every day, even in challenging circumstances, make a positive difference to the lives of our community.

Michael Gorton AM
Chair

Alfred Health
4 September 2019

Prof Andrew Way AM
Chief Executive

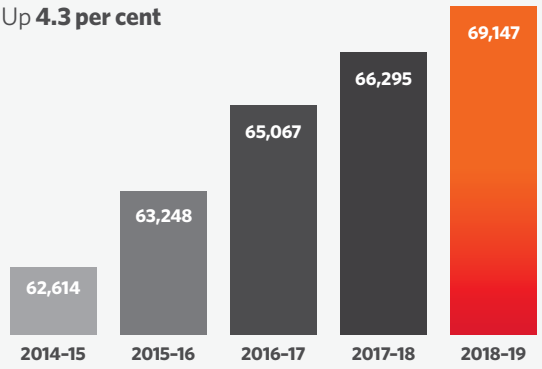
Alfred Health
4 September 2019

Fast facts

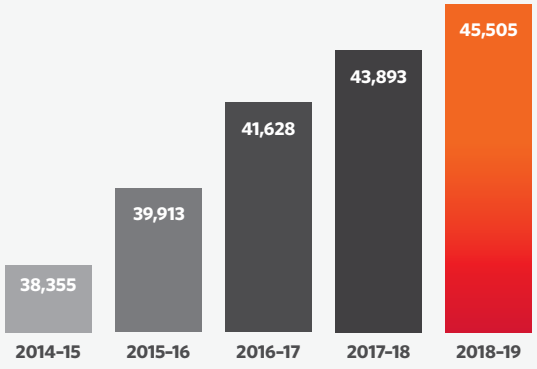
Emergency presentations

114,652

The Alfred
Up **4.3 per cent**



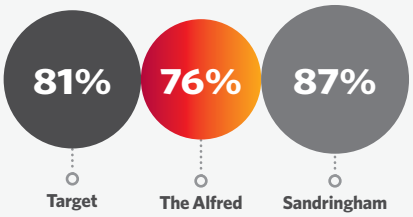
Sandringham Hospital
(includes Sandringham Ambulatory Care Centre)
Up **3.7 per cent**



*There was also an increase in ambulance arrivals at The Alfred, with **23,375** in 2018–19 (**21,545** in 2017–18). Sandringham Hospital also had an increase in ambulance arrivals, with **4,334** in 2018–19 (**4,072** in 2017–18).*

NEAT – National emergency access targets

(Proportion of emergency patients with a length of stay of less than four hours)



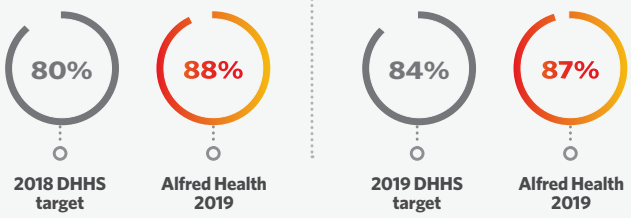
Employees

9,276

Volunteers

520

Staff flu vaccination rates



Alfred Health has exceeded the DHHS target figure since 2013.

Episodes of inpatient care

117,797

Emergency surgeries

9,169

Trauma admissions

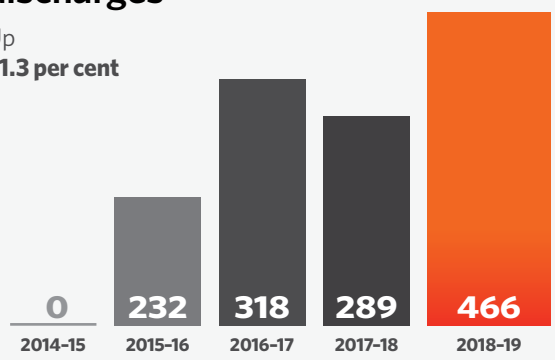
9,554

Clinical trials open as at 30 June 2019

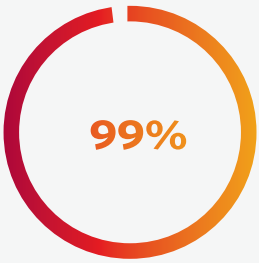
377

Better at home discharges

Up **61.3 per cent**



Elective surgeries performed from waiting list



Patients treated within clinically recommended times

Heart transplants

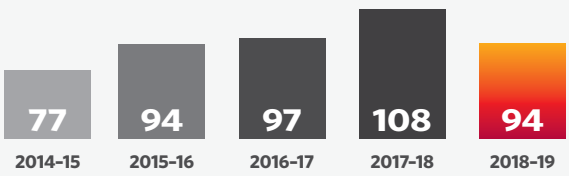
Up **48 per cent**

37

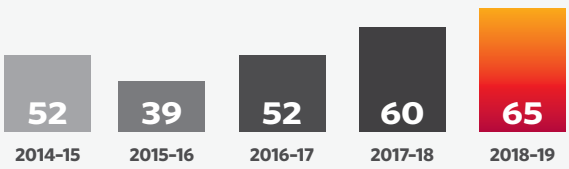
Lung transplants

Down **13 per cent**

94

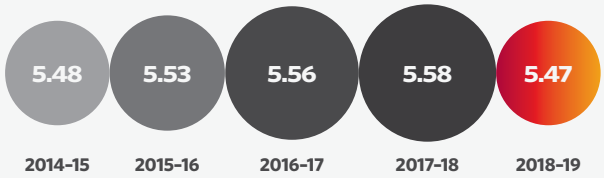


Extracorporeal membrane oxygenation (ECMO) discharges
Up **8.3 per cent**

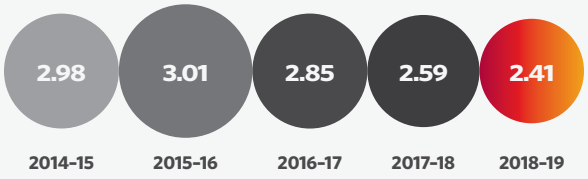


Average length of stay – acute patients

The Alfred
Down **2 per cent**



Sandringham Hospital
Down **7 per cent**



Specialist outpatient appointments

189,453

Our patients

Alfred Health continues to include patients and their families in our care to ensure a quality healthcare experience.

We value the involvement of those who use our services and programs, and help us improve our service planning and delivery.

Patients come first

In this third year of our Patients Come First 2016–20 Strategy, we focused on access, respect, communication, compassion, and leaving our care (discharge).

Patients Come First is our roadmap to supporting the best possible patient experience. It engages current and past patients, carers and family members (consumers) in health service planning, design and improvement. It is built on eight pillars that form the foundation of a good patient experience.

Consumer participation

We continue to have strong engagement with consumers across the health service.

We currently have 82 registered Consumer Advisors who represent our diverse community.

Thirty-four Consumer Advisors are active participants on various committees, such as Board Quality, Community Advisory and Medication Safety.

In addition, Alfred Health has specialist advisory groups to inform service improvement for specific health conditions, with members primarily consisting of consumers with a lived experience. This year, in addition to the HIV Services Advisory Group and CF Advisory Group, the Acquired Brain Injury Advisory Group was established.

Experience pillars

1. Access

2. Respect

3. Team

4. Communication

Vulnerable patient initiative

Alfred Health cares for patients from all backgrounds, including those identified as being vulnerable. We define a vulnerable patient as "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".

Initiatives progressed include:

- a 'vulnerability risk screen' within our electronic medical record to support clinical decision making. This will be trialled on two wards during 2019–20
- collaboration with consumers to capture their stories of vulnerability on video and identify opportunities for service improvement
- a research partnership with University of Technology Sydney trialled training in a communication model (Crucial Conversations™) with two staff groups to support them in having challenging conversations about vulnerable patients.

Work has also continued on projects to support specific vulnerable populations, including those who are culturally and linguistically diverse; Lesbian, Gay, Bisexual, Transsexual, Intersex and Queer; and Aboriginal and Torres Strait Islander peoples.

Access and Inclusion Plan 2019

The Alfred Health Access and Inclusion (Disability) Plan 2019 has been submitted to DHHS and the Office for Disability. Steps taken in its development include:

- a review of previous Disability Action Plans and completion of a gap analysis
- consultation with people with a disability and their carers, staff, and external stakeholders and service providers.

Actions on the draft plan fall within seven priority areas:

1. Continuous policy and systems development
2. Collaborative consumer consultation
3. Accessible built environment
4. Accessible communication
5. Inclusive organisational culture
6. Responsive feedback processes
7. Supportive employment practices

Family violence project

Our family violence project was expanded further this year, with key achievements including:

- training over 1,800 frontline staff to recognise the warning signs of family violence, understand clinical risk indicators and know how to respond sensitively and safely
- commencing a co-trainer model to deliver family violence education, partnering with social workers and nurse educators
- implementing training for managers so they can notice and respond to family violence affecting staff at Alfred Health. Over 140 managers have attended this training
- developing an online education program for frontline clinicians who are unable to attend facilitated sessions
- introducing family violence measures within the EMR
- revising the *Elder Abuse Guideline* and the *Family Violence Guideline*, and also adding a new *Alleged or Suspected Sexual Assault Guideline*.

Funding was received within the Alfred Mental and Addiction Health (AMAH) Program for a Specialist Mental Health Advisor for Family Violence, with the role commencing in November 2018.

Dr Mithu Palit (pictured left) is part of the dedicated team providing quality care at Caulfield Hospital to patients such as **Peter Dixon**.

5. Comfort & environment

6. Compassion

7. Family & friends

8. Leaving our care

Our patients (continued)

Alfred Health is committed to providing high quality care to patients of all backgrounds.

Who are our patients?

Our patients reflect the nature of our specialist and statewide services, and the catchment we care for locally.

Our primary catchment is growing, with an expected annual increase of 1.7 per cent, accounting for 44 per cent of our patients. The remaining 56 per cent of patients are from across Victoria and elsewhere.

Cultural diversity

Our patients come from ***224*** different countries* and speak ***110*** different languages including AUSLAN.

Our top five languages other than English are: Greek, Russian, Mandarin, Arabic and Italian.

54 per cent of all patients in the year who were born outside Australia, were born in non-English speaking (NES) countries.

29 per cent of our patients identify as Christian which is our main religious group followed by Judaism (3 per cent), Islam (1 per cent), Buddhism (1 per cent) and Hinduism (0.5 per cent). 65 per cent of patients did not nominate their religion.

*Countries and territories as identified by patients.

Diversity and inclusion

To support diversity and equitable healthcare, we have developed resources to support staff caring for some of our most vulnerable patients. This includes culturally and linguistically diverse patients, our LGBTIQ community and Aboriginal and Torres Strait Islander patients.

We celebrated Cultural Diversity Week in March with patients and staff sharing their stories of migration and belonging with the theme of "Proud to Belong – Your Generation, Your Stories". Our *Caring for our Cultural and Linguistically Diverse Patients* intranet page was also launched to help staff care for patients and families from culturally and linguistically diverse backgrounds.

We also hosted a first-of-its-kind LGBTIQ Inclusive Practice Health Sector forum in June 2018 with support from DHHS. It identified priorities such as staff education; emergency departments; implementing the Rainbow Tick; and a gap analysis of services and organisations.

Aboriginal health

Reconciliation Action Plan (RAP)

Artwork by Boon Wurrung woman **Jarra Karalinar Steel** was the cover art for the Alfred Health Reconciliation Action Plan.

The RAP acknowledges our journey towards greater understanding and acknowledgement of past truths about our shared history, respect for Aboriginal culture and knowing our local community.

Understanding the specific experience and outcomes of Aboriginal patients accessing care is an important component of our RAP. Key performance indicators aimed at improving health outcomes were developed by the Aboriginal Health Advisory working group in collaboration with the local Aboriginal community.

As part of our commitment to an inclusive workforce, we are continuing to develop our Aboriginal Employment Strategy. Our aim is to increase employment opportunities for Aboriginal people, and provide support to Aboriginal staff including professional development opportunities. We understand that creating a culturally diverse and supportive workplace is important so we can better meet the healthcare needs of our Aboriginal community.

Growing our cultural understanding and sensitivity through Aboriginal cultural awareness training has also been a priority.

During National Reconciliation Week in May, we launched a range of reconciliation resources including a video featuring local Boon Wurrung Elder Parbin-ata Carolyn Briggs AM and Aboriginal Hospital Liaison Officer Alicia Morris. They discussed the importance of asking: "Are you an Aboriginal or Torres Strait Islander?"

Measuring the experience of our patients

We regularly measure our patients' views, integrating surveys, compliments, complaints and other feedback to track their experiences.

The Victorian Healthcare Experience Survey (VHES)

The VHES collects data from users of Victorian public health services.

While results in the second half of 2018 reflected the rollout of the electronic medical record and the relocation of wards at The Alfred, there were improvements in 2019.

The following results were noteworthy:

Community health at Caulfield Community Health Service (July–September 2018)

- 98 per cent of patients rated the care received as Very Good or Good
- 90 per cent of patients said they were Very Likely to recommend the service to a family or friend

Paediatric emergency at Sandringham Hospital (July–September 2018)

- 97 per cent of parents rated the care received as Very Good or Good, 11 per cent higher than the state average

Percentage of patients that rated their care as very good or good (VHES)

Adult inpatient (Alfred, Caulfield, Sandringham)

July to September 2018	October to December 2018	January to March 2019
90%	89%	94%

Adult emergency (Alfred and Sandringham)

July to September 2018	October to December 2018	January to March 2019
91%	90%	91%

Cleanliness

While the VHES reported on patient perceptions on cleanliness, with the age of our facilities a potential contributing factor, we have taken positive steps to improve cleaning outcomes.

These include:

- using fluorescent marker auditing
- implementing cleaning signage and checklists
- working with consumer representatives to understand what is important from a consumer/patient perspective.

Our patients (continued)

Patient Experience Survey (PES)

The Patient Experience Survey (PES) captures feedback from patients across the health service about their care and experience. Trained consumers with a lived experience of the health service collect the PES. From July 2018 to June 2019 we surveyed 2,614 inpatients, with 94 per cent of Alfred Health patients rating their care as Very good or Good.

By hospital campus, results were:

Local PES reports help identify positive performance as well as opportunities for improvement. They also demonstrate how wards have responded to patient feedback.

Themes from local areas include: actions to improve the timeliness and communication of discharge information, involving patients in their care at handover and ward rounds, and actions to improve cleanliness and tidiness.

Outpatient experience

This year, we conducted a separate patient experience survey for outpatient and ambulatory services.

Across Alfred Health, it was found that 97.5 per cent of outpatients overall rated their care as very good or good.

Survey highlights include:

How do you feel about the length of time you were waiting before you could access the service you are currently using or needed?

My appointment was as soon as I thought was necessary	87%
I should have been seen a bit sooner	8%
I should have been seen a lot sooner	5%

Were you involved as much as you wanted to be in decisions about your care and treatment?

Yes, definitely	89%
Yes, to some extent	9%
No	2%

Complaints and compliments

We welcome and encourage patients and their families to provide feedback about their experiences. Their opinions are important and helps us know what we are doing well and where we need to improve.

In 2018–19, we:

- received 1,783 complaints, which is an increase of 153 (or 9.8 per cent) from the previous year
- received 1,280 compliments, an increase of 56 compliments (or 4.6 per cent) from the previous year.

Improving patient experiences

Expansion of telehealth

Telehealth is a flexible way for patients to receive care, regardless of location. We have continued to expand the number of clinics that offer consultations through video, as part of our goal to improve access to care for patients and their families.

Over 12 months we:

- held 1,395 telehealth appointments across 50 clinical areas (compared to 564 telehealth appointments across 19 clinical areas the previous year)
- were most active in clinic consultations for epilepsy, cardiology, cystic fibrosis, and the infectious diseases regional service to Mildura
- involved GPs, residential care, and Aboriginal Health services in some consultations, which allowed for additional support and improved coordination of ongoing local care
- decreased travel time and costs, with more than 700,000 kilometres of patient travel saved, also contributing to Alfred Health's environmental sustainability goals.

National Disability Insurance Scheme

The National Disability Scheme (NDIS) is a Federal Government initiative designed to support people with permanent disabilities who need long-term support.

At Alfred Health, we work with our patients to ensure they are provided with the best opportunity to receive the support they need under the NDIS as they return to their lives after hospital or rehabilitation.

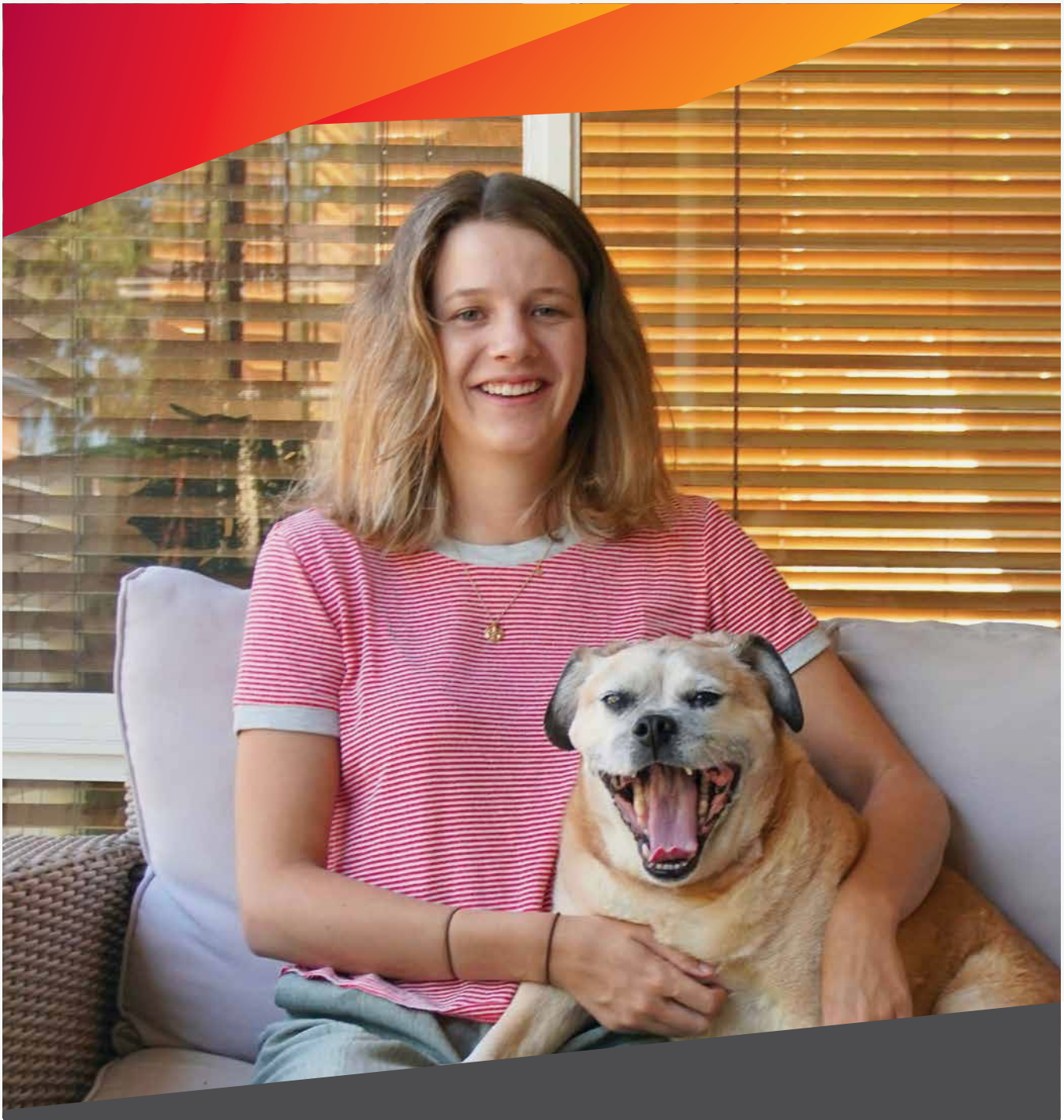
We have supported more than 200 inpatients in our subacute wards on a NDIS pathway since rollout commenced.

We are also working with the Summer Foundation on a Collaborative Discharge Approach Project, which aims to reduce overstays in hospital for patients on an NDIS pathway, and reduce entry to residential aged care for people under 65.

NDIS Service Provider: We are also an NDIS service provider, offering ongoing care and rehabilitation across several areas, including:

- prosthetics
- acquired brain injury rehabilitation
- occupational therapy driving assessments

Patients who select Alfred Health to provide their services can benefit from a coordinated approach, providing comprehensive rehabilitation and care.



Navigating the NDIS while battling the unknown

A rare auto-immune disease unexpectedly plunged Emma O'Kelly (pictured above) into the long-term healthcare system, and needing to apply for the National Disability Insurance Scheme (NDIS).

Emma had no idea how long recovery would take, or if she would enjoy a full recovery.

"I found it confusing to begin with, but staff were great–they collected all the information and applied on my behalf," Emma said.

"They had a booklet with all my info, including quotes and treatment requirements."

Emma said the honest communication from staff, along with hope that she would improve, meant she was comfortable with her assessment.

Emma is now making a strong recovery. While she still requires NDIS-funded visits to an exercise physiologist and a physiotherapist, she is now walking again and is back at university.

Our patients (continued)

Carer involvement and recognition

The Carers Recognition Act 2012 (Vic) promotes the role of people in carer relationships. It recognises the contribution that carers and people in carer relationships make to the social and economic fabric of our community.

A guideline developed in response to the Act continues to advance Alfred Health's commitment to patients and their carers.

It helps staff recognise the role of unpaid carers (friends or family members) in a patient's care plan.

We have taken measures to comply with our obligations under the Act, ensuring 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.

Patient car parking

Alfred Health is working with stakeholders to improve car parking capacity at our sites.

Patient and visitor car parking at our hospital sites is limited, and can cause some frustration for patients, visitors and staff.

To improve car parking experiences at The Alfred, we have introduced:

- car park stackers to house our hospital fleet to open up parking availability
- valet parking for staff to increase parking availability for patients, visitors and staff.

We are also currently progressing a design for an extension of our existing multi-deck car park facility at the Alfred. Where possible, we also encourage the use of public transport.

Alfred Health's car parking policy seeks to reduce the financial burden of vulnerable patients who frequently attend our health service. It is reviewed annually.

We comply 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

Respect and compassion are key values for Alfred Health, with each patient provided with individual care.

Our employees

The professionalism and compassion of our staff remained central to delivering quality care to our community.

Our focus for 2018-19 was supporting a healthy, respectful and safe workplace, for our skilled and engaged workforce.

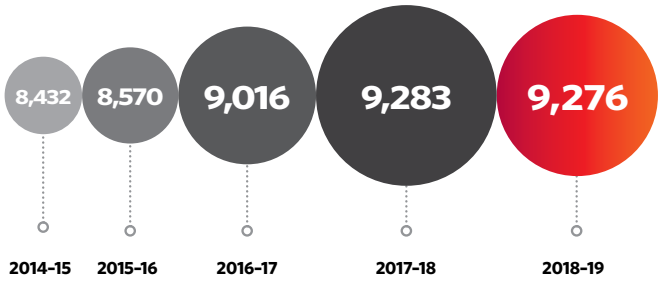
Recruiting and retaining

In 2018–19, Alfred Health had 9,276 staff (6,395 full-time equivalents), including 1,993 new employees who joined us this year.

During the year there was a reduction in casuals and an increase in part-time and full-time employees.

Staff numbers grew by 10 per cent over the last five years, as services expanded and demand increased.

Staff numbers



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

				2019
	Casual	Full Time	Part Time	Grand Total
Caulfield	173	558	749	1,480
Sandringham	62	142	344	548
The Alfred	798	2,921	3,529	7,248
Grand Total	**1,033**	**3,621**	**4,622**	**9,276**

Our employees (continued)

Workforce

	Current Month FTE		YTD FTE	
	2018	**2019**	**2018**	**2019**
Nursing	2,595	2,616	2,532	2,599
Administration and clerical	1,049	1,078	1,009	1,060
Medical support	576	593	558	584
Hotel and allied services	208	212	206	211
Medical officers	218	225	208	219
Hospital medical officers	557	585	554	579
Sessional clinicians	163	165	159	164
Ancillary staff (Allied Health)	978	970	959	979
Grand Total	**6,344**	**6,444**	**6,185**	**6,395**

The average FTE is calculated based on the weighted average of employees in each category in the 2018–19 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.

Commitment to diversity and inclusiveness

The Alfred Pride Network was established in 2018. It is open to all staff to support LGBTIQ employees bring their whole selves to work and to improve the experience of LGBTIQ patients, carers and visitors.

In February 2019, our Pride Network represented Alfred Health at the Midsumma Festival and engaged with the LGBTIQ community about what a LGBTIQ-friendly health service looks like.

This information will inform initiatives to improve the inclusiveness of our health service.

Occupational health and safety

Keeping our staff healthy and supported requires environments that are physically and psychologically safe.

Key priorities this year for the Occupational Health, Safety and Wellbeing (OHSW) Executive Committee included:

- focusing on Manual Handling and OVA training, to build capacity and capability of our team
- embedding the Early Intervention Program, so staff can seek access to medical treatment as soon as possible after a workplace injury
- improving return to work rate for injured employees.

Staff wellbeing and support are key priorities. For example, the Director of Clinical Training and Supervisor of Intern Training oversees prevocational training and provides personal and professional support for our doctors in training. The program also includes mentoring for interns, wellbeing sessions and focus groups, and debrief sessions following critical events.

Overview of health and safety

Measure	2016–17	2017–18	2018–19	Explanation
Number of hazards reported	1,600	1,380	696	
Number of lost time standard claims	87	56	40	A 28% reduction in claims was a significant achievement due to the Early Intervention Program that allows for timely medical treatment reducing lost time.
Average cost per claim (including estimate)	$63,112	$56,215	$63,072	The 10% increase is due to a small proportion of claims that are complex in nature (injury and recovery time)
Fatality	0	0	0	N/A

Injury compensation data

Measure	2016–17	2017–18	2018–19	Commentary
WorkCover Claims	114	78	80	Timely medical support (Early Intervention Program) has reduced WorkCover claims. This is a positive outcome for our staff who may be injured in the workplace and can receive timely medical treatment, without undertaking the process for WorkCover.
Injury support claims	10	27	23	

Main contributors of WorkCover claims

Measure	2016–17	2017–18	2018–19	Commentary
Manual handling	63	27	39	The rise in manual handling injury claims is due to the increase in complex patients presenting to the service. Infrastructure/equipment and tailored training continue to be rolled out to meet the demand.
Occupational violence and aggression (OVA)	13	13	10	Sustained efforts in early intervention of potential OVA has significantly reduced OVA incidents and subsequent claims.
Slips, trips and falls (STF)	26	11	12	Continued focus on STF strategies has ensured that numbers have remained stable.

Occupational violence and aggression (OVA)

In healthcare, OVA continues to be a concern. We have implemented a range of measures to enhance safety for our staff.

These include:

- continued reinforcement that violence towards healthcare workers is not accepted or tolerated by Alfred Health
- establishment of the OVA Steering Committee, with union representation
- AWARE training for all frontline staff and those in high-risk wards.

Occupational violence statistics*	2017–18	2018–19
WorkCover-accepted claims with an occupational violence cause per 100 FTE	0.217	0.156
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0.269	0.153
Number of occupational violence incidents reported	489	473
Number of occupational violence incidents reported per 100 FTE	7.6*	7.4
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	2.7%*	2.1%

*Figures revised from 2017–18 Annual Report.

Definitions are in the glossary on page 125.

Our employees (continued)

Occupational violence statistics	2016–17	2017–18	2018–19
Number of OVA incidents reported	510	489	473
Number of WorkCover claims	13	13	10
OVA claims frequency rate (per million hours worked)	0.7	0.6	0.4
Injury support claims (Early intervention Program)	0	2	0

WorkCover claims

Incident type	2016–17	2017–18	2018–19
Exposure to chemical/substance	3	4	3
Hit or hit by, excluding violence	1	11	7
Mental stress	2	8	2
Occupational violence (physical and/or verbal)	9	4	8
Other	2	7	9
Slip, trip or fall	16	12	12
Manual handling	58	31	39
Grand total	**91**	**77**	**80**

Staff training and workforce initiatives

Alfred Health trains the healthcare professionals of the future and provides staff with a range of developmental opportunities. This enhances the ability of our staff to do their job better and promote a more positive workplace.

Encouraging a constructive and collegial environment remains a strategic priority for the health service. There is zero tolerance for bullying, harassment or occupational violence and aggression (OVA).

The Alfred Health Occupational Violence and Aggression Strategy covers all areas of governance and policy, capital and equipment, and training.

Training targets all staff in high to medium risk areas for training either with the AWARE (Assess, What now, Alert others, Respond, Evaluate) or DAMA (De-escalation and Management of Aggression) programs. AWARE and DAMA are considered leading programs across the state with many colleagues visiting Alfred Health to learn from our experiences.

Improvements in the last 12 months include new duress alarms at Caulfield Hospital and a pilot of body cameras worn by Security in The Alfred Emergency Department.

Governance and systems improvements included:

- an updated guideline for exclusion from treatment
- new Behaviour of Concern (BOC) models
- introduction of early intervention initiatives such as Psychiatric Behaviour of Concern (PsyBOC) in Mental and Addiction Health and DIvERT (De-escalation Intervention Early Response Team)
- implementation of DIvERT in our Trauma and Neurosurgical wards, with scope to introduce it to the General Medical wards.

Other initiatives included:

- continuing our mandatory e-learning program, in line with DHHS workforce violence and bullying indicators;
- promotion of our Code of Conduct, with staff supported to report unacceptable behaviours; and
- continued success of Schwartz Rounds, which provide a forum for clinical and non-clinical staff to discuss the emotional and social aspects of working in healthcare.

Medical education

There are 695 doctors-in-training employed across Alfred Health, including 56 interns in their first postgraduate year, and 171 hospital medical officers (HMOs) (in second and third postgraduate years).

The Postgraduate Medical Council of Victoria (PMCV) accredits Alfred Health to train junior doctors in their first three postgraduate (prevocational years).

Alfred Health is accredited for specialist (vocational) medical training in over 40 specialties including medical and surgical specialties, emergency medicine, intensive care, anaesthesiology, psychiatry, radiology, pathology, aged care and rehabilitation medicine.

Our senior medical staff provide clinical leadership, teaching, supervision, professional support and guidance.

In 2018, Alfred Health had an 88 per cent pass rate for the RACP Clinical Physician Exam (compared with the national average of 70.6 per cent).

Much of the training doctors undertake is in individual units and departments, with specialist training coordinating well with excellent orientation and education.

Education programs co-ordinated by the Medical Education Unit at Alfred Health are also offered.

Alfred Health also has an Interprofessional Education Committee to develop a strategic approach to education across all professional disciplines.

Wellbeing initiatives

We continue to promote active travel for staff, including cycling. Our Active Travel Zone has over 500 members, and over 350 employees are members of our onsite gym.

Our staff health survey results report 67 per cent of staff are meeting recommended physical activity guidelines for good health, an increase of 31 per cent since 2013.

We also support our staff to quit smoking, including funded nicotine replacement therapy and support. To date, 84 staff have participated in the initiative with current (2019) quit rates of close to 40 per cent.

Training a priority for new technology

Training more than 6,000 staff over a 10-week period was a major milestone in introducing Alfred Health's integrated electronic medical record (EMR).

The extensive training program ensured staff were well prepared for the transition, with all clinicians required to complete proficiency assessments before their first work shift after the new system had gone live.

Among the staff to receive training were 650 'SuperUsers', who provided specialised support to their colleagues as well as receiving detailed training themselves.

The SuperUsers offered local support for their team during and after the EMR go-live period. Their role combined their system knowledge as well as local clinical workflow expertise.

The training program familiarised staff with the new record, bringing it into their everyday practice. The EMR means staff can access patients' records at anytime from anywhere.

Teamwork and quality training have been key elements in ensuring staff were ready for our new electronic medical record program.

Our employees (continued)

Staff engagement

Throughout the year we worked to further develop a positive and safe work environment across our health service.

People Matter Survey

The 2019 People Matter Survey, an important tool to canvass the views of staff, was completed by 27 per cent of our staff.

Positives reported from the survey include:

- high levels of employee engagement (70 per cent), above both the Victorian Public Sector Commission (VPSC) and health industry averages, and pleasing levels of job satisfaction
- high levels of advocacy with 81 per cent of our staff saying they would recommend someone to be treated at Alfred Health, 8 per cent above industry standards
- 77 per cent of our staff, 3 per cent more than health averages, would recommend us as a good place to work
- 80 per cent of our staff believe we provide a safe work environment
- we also saw an encouraging reduction in stress levels experienced by our staff, the first reduction in four years.

In addition, we have improved how we manage, communicate and implement change. Overall, our staff saw Alfred Health as scoring well in areas such as Responsiveness, Collaboration, Impartiality, Innovation and Accountability.

The survey also reinforced to Alfred Health leadership the importance of patient safety; the ongoing need to continually work to eradicate bullying, harassment, occupational violence and discrimination in our workplace; and that staff want to feel as though their grievances and issues are heard.

We are working hard to address issues raised by staff. As part of our commitment to ongoing improvement, we are reviewing our education, orientation and development programs, to ensure a safer and better workplace experience for staff.

An extraordinary team

It is through our extraordinary staff that we achieve some extraordinary results. Throughout the year, we celebrate their outstanding contribution in a variety of ways.

Annual excellence awards

The Recognising Excellence Awards are an opportunity for all Alfred Health staff to highlight the outstanding achievements of their colleagues, both as individuals and teams.

Alfred Health's focus for 2018–19 was supporting a healthy, respectful and safe workplace for our skilled and engaged workforce.

2018 winners	Team	Individual
Focusing on patients	GEM at Home	Julie Smith
Diversity and inclusion	Cystic Fibrosis Advisory Working Group	Tori Berquist
Demonstrating safety	Ward 6 West Interdisciplinary Team	Vicki White
Research in healthcare	Pharmacy GenMed Partnered Charting Project Team	Joe Doyle
Fostering education	Interdisciplinary Medical Emergency Team Training	Laila Rotstein
Leading innovation	*Joint winners*: Information Development Division, Electronic Medical Record Team *and* Perioperative Nurse Surgical Assistant Operating Suite – Cardiothoracic Unit	Antony Friedman
Working together	Sepsis Working Group	Kelly Decker

Long-serving staff

Alfred Health values longevity of service, and ceremonies are held at each of our hospitals to acknowledge and reward those with 5, 10, 15 and even up to over 50 years of valued service. The ceremonies provide an opportunity for the health service to show its appreciation for its dedicated employees.

Public awards

Australia Day Honours

Officer (AO) in the General Division of the Order of Australia:

Professor Sharon Lewin

Professor Catriona McLean

Professor John McNeil

Member (AM) of the Order of Australia (General Division):

Professor Andrew Way

Dr Margaret Hellard

Professor Jennifer Hoy

Associate Professor Bill Johnson

Dr Bryan Walpole

Medal (OAM) of the Order of Australia in the General Division:

Mrs Sally Garratt

Dr Donald William Hossack

Mrs Felicity Frederico

Queen's Birthday Honours

Member (AM) of the Order of Australia:

Professor Jayashri Kulkarni

Adjunct Professor Richard Stark

Dr Christine Ball

Dr Robert Gillies

Staff awards

The Alfred's **Emergency Team** was named 2018 Australasian Emergency Department of the Year at the International Conference for Emergency Nursing, with nurse **Marc Marquez** named the 2018 Australasian Emergency Nurse of the Year.

Clinical Nurse Specialist **Dr Judy Moore** won the prestigious Young Investigator Award at Australian Gastroenterology Week for her PhD work: *Prolonged improvement in symptoms and quality of life with transabdominal electrical interferential stimulation in adult women with constipation.*

Occupational Therapist **Anna Kennedy** was awarded for the best poster, on the Targeted Therapy Active Rehabilitation Project at the Victorian Allied Health Research Conference.

The Recognising Excellence Awards highlight the outstanding work of Alfred Health staff. The GEM at Home team (centre, above) were acknowledged in the Focus on Patients category at 2018's event by **Prof Andrew Way AM** (right).

Delivering quality care

Alfred Health uses a range of indicators and standards to monitor and gauge the quality of care we provide our community.

We benchmark our performance nationally and internationally, and strive to ensure everyday care for every patient meets the National Safety and Quality Health Service (NSQHS) Standards. In October 2019, Alfred Health will be accredited against the second edition of these standards.

The introduction of our integrated electronic medical record (EMR) in October was a significant development in monitoring the quality of care provided across our health service.

Infection prevention

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

SAB initiatives

Staphylococcus aureus bloodstream (SAB) infections are serious with significant associated morbidity and mortality. The target benchmark for SAB was reduced from 2/10000 OBDs to 1/10000 OBDs for Victorian hospitals in July 2017. Subsequently, Australian Institute of Health and Welfare (AIHW) major hospitals, which are of comparable size to Alfred Health, have reported rates between 0.4 and 1.49. In 2018–19, Alfred Health reported an annual rate of 1.26.

Multiple initiatives are ongoing to reduce SAB rates, including

- an in-depth case review of every SAB event in tandem with clinical staff providing care, to identify any potentially modifiable practices
- ensuring insertion and maintenance of peripheral venous catheters is performed according to best practice
- ensuring staff are competency-assessed in aseptic technique
- sustained improvements in hand hygiene practices
- promotion of 'scrub the hub' to clean IV access ports prior to injection, to reduce infection risk.

CLABSI decline

We continued to see a sustained reduction in central line–associated bloodstream infections (CLABSIs) in our Intensive Care Unit, monitored against the statewide target of zero.

Multiple interventions include:

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

Despite an increasingly complex patient group, we have sustained a decreased rate of CLABSIs, with zero infections observed in six of the previous 11 months from July 2018–May 2019.

Hand hygiene

With a Victorian State Government target of 80 per cent for hand hygiene, we achieved an average of 83.7 per cent compliance over the year, with:

- 82.9 per cent compliance in the first audit period (June–October 2018)
- 84.2 per cent for period two (November 2018–March 2019)
- 84.2 per cent for period three (April–June 2019).

Key activities included intensive awareness of hand hygiene requirements following the introduction of new electronic mobile devices and ongoing auditor training.

Immunisation

Communications collateral, including screensavers, was used in a staff flu vaccination campaign.

Influenza vaccination: The 2018 influenza campaign, which ended in August 2018, saw 88 per cent of staff vaccinated, exceeding the DHHS target of 80 per cent. As of 30 June, and part-way through the 2019 campaign, 87 per cent of staff had been vaccinated.

We have exceeded the DHHS target since 2013. Influenza vaccination continues to be strongly encouraged for all healthcare workers across the organisation as well as our high-risk patients.

Surgical site infection

We monitor infections related to key surgeries, in line with requirements. In 2018–19, monitoring orthopaedic surgery, hip and knee replacements, demonstrated infection rates were below benchmark rates. We also monitor infections in cardiothoracic surgery.

Last year we implemented intensive initiatives to decrease our rate of infection following coronary artery bypass graft surgery including:

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

As a result, decreased infection rates have been sustained and efforts to reduce this further are continuing.

Multi-resistant organisms

Like many Australian hospitals, our health service has been challenged by cases of multi-resistant bacteria, including multiple cases of Carbapenemase-producing Enterobacteriaceae (CPE). We have worked closely with the DHHS and followed statewide CPE management guidelines to initiate control measures.

Measures that have been implemented are:

- active screening for patients at higher risk of CPE colonisation
- contact tracing and screening for potential inpatient and discharged contacts
- increased cleaning initiatives in ward areas, promotion of hand hygiene and cleaning of shared patient equipment.

Education and auditing of clinical practices also continue across the health service. Recent work internationally has focused on the potential for contaminated sinks to act as reservoirs for multi-resistant organisms. We have successfully implemented a decontamination program in our intensive care unit to reduce the potential for transmission.

Blood management

Alfred Health transfused close to 25,000 fresh blood products in 2018–19.

Wastage of fresh products remain largely below target. When above target, there are follow-up investigations, if appropriate.

A *Patient Blood Management Guideline* (Preoperative Management of Anaemia for Major Elective Surgery) was developed and rolled out to major elective surgical services. This guideline focuses on optimising patient haemoglobin prior to surgery as part of its aim to prevent red cell transfusion intra- and post-operation.

All interns completed BloodSafe eLearning and 77 per cent of all nursing staff have completed mandatory training in the year.

A prospective audit looking at wastage due to incorrect storage of units transferred with patients from other health services was performed.

Medication safety

At Alfred Health, a group of campus-wide clinicians, the Medication Safety Committee (MSC), reviews processes and practices to ensure medication-related activities are as safe as possible. This includes buying, storing, manufacturing, prescribing, dispensing, administering and monitoring the effects of over 20,000 medication doses administered in Alfred Health every month.

As well as education activities, highlights included:

- the introduction of electronic medication management, including electronic prescribing, medical record, medication administration and with decision support
- a decrease in medication-related incidents with harm over the last four years, and a decrease in RiskMan incident reports over the last six months.

Delivering quality care (continued)

Antimicrobial stewardship (AMS)

The EMR implementation enhanced the AMS Program, providing a clear view of all antimicrobials used across the health service. This facilitates targeted review of all patients on selected broad spectrum antibiotics to ensure appropriate use.

A focus on sepsis also continued. Alfred Health participated in a scaling collaboration sponsored by Better Care Victoria, which allowed the adaptation of a standardised sepsis pathway into the electronic medical record. A clinical trial examined the utility of reviewing patients following episodes of sepsis and found an improvement in timely appropriate antibiotic treatments, which has now been incorporated into routine clinical care.

Harm minimisation

Alfred Health takes a coordinated approach to harm minimisation, with all patients screened for their individual risk of harm from falls, delirium, pressure injuries and malnutrition.

To facilitate patient, family and carer engagement we introduced a range of resources over the past year:

- an integrated patient information brochure called Get Involved in Getting Better, which provides patients with strategies to help them stay safe, get better and go home sooner
- the new electronic medical record, which provides a Harm-free Plan of Care, a documentation tool used to develop an individualised, interdisciplinary care plan
- team-based risk rounds, to support and monitor harm minimisation care plans.

Falls and delirium

Over the last two years, the total number of falls have increased. In part, this relates to the growing complexity of our patients. However, it is also the result of a stronger reporting culture, which includes reporting of 'near miss' falls that improves patient safety through better preventative care planning.

In line with an integrated approach to risk, all falls with serious injury are investigated to understand if the patient was also experiencing an active delirium. We know patients in a delirium are at a significant risk of falling and we need to ensure support is provided for this vulnerable group.

	May 2016–Apr 2017	May 2017–Apr 2018	May 2018–Apr 2019
Actual Falls	1,958	2,086	2,216
Actual Serious Injury (ISR1 and 2)	31	22	25

Other initiatives included:

- participation in the Safer Care Victoria Delirium Point Prevalence Survey to improve our understanding of the proportion of our patients at risk of delirium and the subsequent Safer Care Victoria Delirium Collaborative
- launch of a staff education package on delirium identification, prevention and management.

Getting active for better outcomes

In collaboration with Safer Care Victoria, we are participating in the End PJ Paralysis Project, which aims to reduce functional decline of patients while in hospital.

Running at a ward at Caulfield Hospital, it has been renamed Get Dressed, Get Moving, Get Better to more clearly promote the goals of the project to staff, patients, families and carers.

Staff and volunteers, such as Thelma (left) and Lisa (right) have worked together to deliver the program.

Pressure injury prevention

All full-thickness pressure injuries that are acquired or worsened in care are reviewed by the Wound Clinical Nurse Consultants to assist assessment and understanding about where further education and support is required. The Wound Clinical Nurse Consultants work with local wards and provide education on skin assessment, pressure prevention strategies including pressure-relieving equipment.

The positive relationship shared by the Wound Clinical Nurse Consultants and local wards is reflected in our Pressure Ulcer Point Prevalence Survey (PUPPS), with patients at high risk better identified. The annual PUPPS results are used to provide direction for improvement each year.

Pressure Ulcer Point Prevalence Survey results:

	2015	2016	2017	2018	2019
Prevalence of patients with pressure injuries	16.6	13.5	18.3	9.6	11.6
Prevalence of patients with newly developed pressure injuries	11.8	9.9	12.9	7.2	7.5

Significant initiatives include:

- reviewing equipment requirements and availability including pressure relieving mattresses in ICU and pressure-relieving seating/cushions
- introducing a new Incontinence Associated Dermatitis Poster to help staff identify this skin damage including prevention and management strategies.

Malnutrition

An annual body mass index (BMI) audit of patients is conducted in conjunction with the annual Pressure Ulcer Point Prevalence Survey. Data is collected on malnutrition risk and each patient is assessed against the criteria for malnutrition diagnosis. Patients can be admitted with malnutrition or become malnourished as part of their illness. Alfred Health's process is for all inpatients to be screened for malnutrition, weighed on admission and then weighed weekly.

During the year, 27 per cent of inpatients were found to be malnourished and on some wards more than 40 per cent are malnourished.

The reasons for a patient being malnourished varies: a consequence of long-term illness; side effects of illness or treatment such as a poor appetite; and reduced oral intake among our elderly population. Wards with lower rates of malnutrition typically have younger patients with healthy weights prior to their injury or admission.

Over the past 18 months, we have implemented the MedPass Program, which allows dietitians to prescribe at-risk patients high-energy, high-protein oral nutrition supplement. Evaluation of this program is now underway.

Advance care planning

The Advance Care Planning Team ensures families and healthcare teams understand what is important to a patient; and how the patient wants to be treated if they become unable to make decisions or communicate their wishes.

Referral numbers for 2018–19 are slightly up from 2017–18, by about 3 per cent. However, we have seen a 35 per cent increase in the number of appointments made with our service to assist with the completion of an Advance Care Plan.

This year, the service focused on patients with a chronic illness to provide education, information and assistance with advance care planning (ACP). Partnerships with services such as Renal and the Hospital Admission Risk Program (HARP) have been key to this work. The team continues to build partnerships with services across the organisation to support them and their patients.

The past 12 months has seen the ACP Program expand promotional and educational activities both within the organisation and at a community level, including involvement in Dying to Know Day and Advance Care Planning Week.

Voluntary assisted dying

The Voluntary Assisted Dying Act, which came into effect on 19 June 2019, is a significant change to end-of-life care. The Act will affect a small number of Victorians who are at the end of their lives, suffering and meet the strict eligibility criteria for access to voluntary assisted dying.

Alfred Health's response to voluntary assisted dying is to partner with general practitioners, who in the main, will coordinate care for patients who are found eligible.

Where appropriate, we will provide specialist opinion.

Statewide Pharmacy Service

Following a request from the Victorian State Government, Alfred Health took on the role of the Statewide Pharmacy Service to support the implementation of the Voluntary Assisted Dying legislation and add further safeguards for the scheme.

The service is responsible for importing, storing, preparing and dispensing medications for Victorians who make the decision to access Voluntary Assisted Dying. This role includes:

- Developing patient and healthcare provider information.
- Educating medical practitioners regarding prescribing and administration of medications.
- Reviewing prescribed medications.
- Dispensing voluntary assisted dying medications and other supportive medications.
- Going to patients (wherever they are in Victoria) to provide face-to-face information regarding medications and their administration.
- Supporting medical practitioners, patients, families and carers throughout the process.

Operational highlights

The year was characterised by growing demand for critical and complex care, as the health service cared for the state's most acutely unwell patients.

Frontline operations rose to the challenge of implementing the integrated electronic medical record.

The introduction of the electronic medical record touched every part of the health service.

Integrated electronic medical record

In October, we delivered on our strategic vision of a digital health service, implementing an integrated electronic medical record (EMR) across our three hospitals over five weeks.

This is Alfred Health's largest-ever investment in technology. It included the customisation of Cerner software as well as the introduction of new hardware to frontline operations including 425 bedside mobile workstations, 250 bedside vital sign monitors, upgraded ECG carts and 500 new tablet computers.

The implementation took years of detailed planning and development, involving staff at all levels. More than 6,000 clinical staff received extensive training over 10 weeks and our frontline was supported by more than 650 Superusers, who were expert in the new record.

Substantial system upgrades that had been undertaken in previous years to human resource information systems (HRIS) and the patient administration system, as well as improving network resilience, were essential steps in the successful EMR implementation.

In an Australian first, we deployed the Cerner Care Aware Connect mobile app to nursing staff in our Mental Health Service as part of the implementation. This enables nurses to perform advanced clinical interactions that connect through to the EMR from handheld devices. In another first, Capture Connect was launched later in 2018–19 enabling wound nurses and other clinicians to capture and upload clinical images directly into the EMR.

The integrated EMR supports clinical decision making, reduces clinical variation, increases visibility of patient risk factors and reduces duplication of administration and data.

Importantly for patients, this means their treating team has easy access to up-to-date clinical information which is stored safely in one place.

We are already seeing benefits, particularly in terms of managing medications which are now prescribed, administered and documented in the EMR. This brings greater transparency and reduces medication safety risk, with dosage and allergy alerts.

Alfred Health's EMR implementation was recognised at the Australian Healthcare Week Awards, where we were awarded the Digital Transformation Award.

In 2019–20, we will further streamline the EMR, introducing new functionality including a patient portal that gives patients access to their own records.

Extending services across Victoria

Beyond our services in Melbourne, Alfred Health continued to provide care to people in regional and rural Victoria through a combination of local service provision, quick and easy referral pathways and telehealth. We are proud to support regional and rural health services provide specialist care to their local communities.

For example, our radiation oncology service runs outpatient clinics in Gippsland, offering a radiation oncologist doctor to discuss treatment plans and monitor a patient's progress. Locations include Traralgon, Warragul and Sale. In addition to The Alfred, we offer radiation therapy at Latrobe Regional Hospital.

Our ICU specialists support intensive care units at Mildura and Bairnsdale Base Hospitals through regular training, consultations and discussions through telehealth.

There was substantial growth in referrals from regional GPs into our cardiac and neuro services. Telehealth services with patients also continued to grow; giving patients an opportunity to see, hear and speak with their specialist, almost as if they were there in person.

The Alfred

The Alfred is home to many statewide services, providing comprehensive care for the most complex patients. We also train the next generation of healthcare professionals through our education and learning programs, while working to discover breakthroughs in clinical care through translational research.

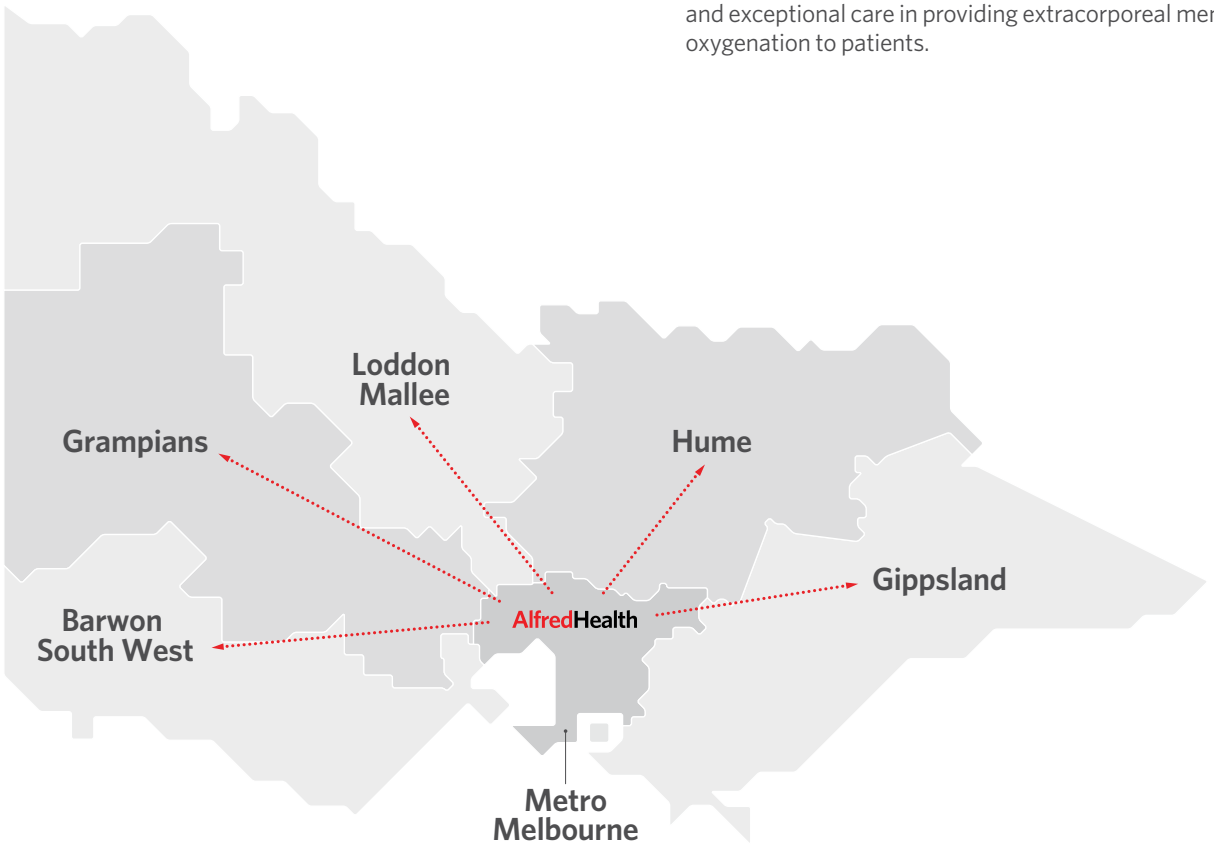
The year saw the demand for critical care remain strong, through growing emergency presentations. We managed 9,554 trauma admissions and there were 2,842 inpatient episodes involving an ICU stay.

Critical care: During the year, around 60 per cent of our ICU patients came from areas in Victoria and Australia that were outside our local catchment, which is a direct result of our statewide services that care for the most acute patients.

Our ICU now regularly operates at close to 100 per cent occupancy with the highest rate of invasive life support in Australia (that is, ventilated patients). The average length of stay for a patient in our ICU in 2018–19 was 1.78 days (an increase from 1.66 in 2017–18), reflecting the complexity of cases and patients.

We are a centre of excellence for Extracorporeal membrane oxygenation (ECMO) a heart and lung bypass treatment that saves the lives of up to 60 per cent of people with organ failure who would have died without this treatment. This service grew by over 8 per cent in the year to 65 cases.

In May 2019 Alfred Health's ICU received a *Platinum Level* ELSO Award for Excellence in Life Support; international recognition of processes, procedures and systems that promote excellence and exceptional care in providing extracorporeal membrane oxygenation to patients.



In partnership with local health providers, Alfred Health offers a broad range of specialist care across Victoria, including radiation oncology and ICU support.

ICU patient's dream realised

The Alfred's ICU staff were honoured to help fulfil patient Toni Carroll's dream of getting married to her partner and father of her two children, Jesse Welsh.

One of Toni's doctors, Intensivist Dashiell Gantner, said it was a special day to watch Toni and Jesse say their vows in the hospital's chapel, especially given her critical condition.

At The Alfred, Toni's life was saved using a heart-lung bypass machine called ECMO, along with a heart pump (VAD). The team are continuing to manage both her heart condition and the need for chemotherapy treatment.

The wedding was a success, with Toni and Jesse's children present along with family members and staff.

Staff did their best to ensure it was a special day for the couple. They organised homemade cakes, a hair and makeup artist, flowers and decorations.

"Everybody got involved, the team was creative and organised, and we worked together well," Nurse and ECMO specialist Jayne Sheldrake said.

"Everyone wanted to make the day special for them."

"I thought it was going to be small and then it exploded with all this love from everyone. It was perfect," said Toni.

Toni Carroll (pictured right) and **Jesse Welsh** celebrate their wedding day.

Operational highlights (continued)

Maintaining access

Extreme wet weather events challenged hospital operations at The Alfred during the year. While we continued to provide patients with the same level of access to quality care through innovative and pragmatic solutions the infrastructure failures did affect access performance through the year.

Heavy rains in late 2018, caused the roof of Main Ward Block and operating theatres to leak, before the government-funded roof replacement project was completed in mid–2019. Cardiac surgery was temporarily relocated along with one of our surgical teams to Cabrini Malvern until March 2019, when the mobile theatre was commissioned to support our surgical program (see story).

The Alfred Centre's Pipeworks Replacement Project (see Projects and Infrastructure chapter) required the relocation of our elective surgical program to Epworth Health from January to March 2019 as well as some our outpatient clinics to the new Alfred Lane House. This relocation program, which saw Alfred surgical staff undertake elective surgery at the Epworth facilities, was successful due to detailed planning and the support and commitment of staff.

Specialty care

In 2018–19, we reorganised our specialist services as we continued to develop cutting-edge treatment for Australians with the most difficult to treat conditions, creating:

- Alfred Brain
- Alfred Cancer
- Alfred Heart and Lung
- Alfred Specialty Medicine
- Alfred Mental Health and Addiction

Alfred Brain

Alfred Brain brings together the surgical and medical neuroscience units of Neurosurgery, Neurology, Stroke, Epilepsy and Multiple Sclerosis Neuroimmunology (MSNI). It is focused on implementing new thinking and advancements in biomedical science and engineering, to bring about smart innovations to advance patient care.

During the year, the program established:

- Functional Neurosurgery – DBS, Epilepsy Surgery, Vagal Nerve Stimulation
- MSNI and Neuro-ophthalmology Service
- Epilepsy Monitoring Unit (six beds)
- Neurosciences Clinical Trial Unit.

Inpatient and outpatient services grew substantially, especially through the expansion of epilepsy, movement disorders, headache, neuromuscular, otoneurology and neurophysiology services. There was also significant growth of telehealth outpatient services, the development of new neurophysiology services, and in clinical trial activities.

New self-contained operating theatre an Australian first

A new self-contained operating theatre was installed in the car park, next to the Emergency and Trauma Centre.

This Australian first supported our elective cardiac surgical program and Theatre 12, which had sustained water damage in late 2018.

The mobile theatre, which started operating in March 2019, was an innovative approach to ensuring patients continued to receive timely care, delivered at the same rigorous quality and safety standards as other operating suites.

An innovative mobile theatre provided support to patients during roofing works.

Operational highlights (continued)

Alfred Cancer

Alfred Cancer offers one of the most extensive cancer services in Victoria. During the year, our Cancer Service* cared for 5,116 patients in inpatient and outpatient settings, including trials. This is a 5.6 per cent increase from 2017–18.

The program also continued to engage with partners on a broad range of research projects. This includes medical oncology (MONC) studies where we are combining novel therapies to a standard immunotherapy.

We are also advancing personalised medicine through genomics, co-investing with Monash University in the latest next generation sequencing (NGS) technology, and obtained research grants to advance clinical genomics for patients at The Alfred Hospital.

*These figures exclude Radiation Oncology outpatients

Alfred Heart and Lung

Alfred's Heart and Lung Program is at the forefront of heart disease. It offers one of the largest public transcatheter aortic valve implantation (TAVI) programs in Australia, with 116 cases in 2018–19 (a 25 per cent increase on 2017–18, when 93 cases were recorded). It was involved with the recent low-risk TAVI trial published in *New England Journal of Medicine*, which showed TAVI may be suitable for a younger group of patients with severe aortic stenosis.

The Alfred is now part of the ACE registry (Alfred, Cabrini and Epworth) performing over 350 TAVIs and will be able to perform large trials and registry studies.

A standout was the increase in heart transplants undertaken this year from 25 to 37 in 2018–19, offering many people a second chance of life. In fact, over the past 30 years we have performed 1,500 heart transplants.

Our Lung Transplant Service performed its highest number of transplants during a calendar year – 105 (102 for 2017). Recently celebrating its 30th anniversary, this service remains world leading, with the lowest waiting mortality and greatest expertise in donation after circulatory death (DCD) lung transplantation, making up 25–30 per cent of all transplants.

The Lung Transplant Service has extensive clinical and research collaborations. This includes clinical trials in new diagnostic systems to characterise infection and rejection, and a partnership with the Australian Red Cross to roll out a new organ cross-matching platform.

Alfred Specialty Medicine

Alfred Specialty Medicine offers a comprehensive range of services. This includes Infectious Diseases and Sexual Heath, Rheumatology, Endocrinology and Diabetes, Dermatology, Gastroenterology and Renal Medicine.

Among the services offered is a new streamlined multidisciplinary standalone Renal Transplant Clinic, which cares for and treats people who have had a kidney transplant. In the first year of operation, the clinic has looked after 2,500 visitations by transplant patients. Patients have access in the clinic to renal transplant physicians, a pharmacist, a nutritionist and a phlebotomist for immediate blood sampling. A dedicated clerical team skilfully oversees the clinic bookings.

Alfred Mental and Addiction Health

Opening in May 2018, the low stimulation pod in The Alfred's Emergency and Trauma Centre was purpose-built for the assessment and management of mental health and addiction patients including Brief Intervention Short Stay Unit (BISSU) admissions. Commonly referred to as 'the West Wing', Code Grey Standbys (aggressive behaviours) have reduced from 422 episodes since it opened to a low of 215 episodes in April 2019.

Contributing factors include the physical environment, the proximity of the Security Base, and the employment of registered psychiatric nurses (RPNs) working in this area alongside emergency clinical staff, with specialist input from the Emergency Psychiatry Service.

Meanwhile, our Adult Community Mental Health Program has developed a Navigations Team which focuses on helping clients and families access the appropriate mental health service. We have also introduced a Transitions Team, which assists in linking patients back to their GP or private provider as part of their discharge planning.

Mental health performance

We continued to take a proactive approach to calm distressed or agitated patients early, preventing escalating behaviours. This has allowed us to manage rates of restraint and seclusion, which are only used as a final measure.

	Adult psychiatry inpatients	
	Target	**2018–19**
Seclusion rate	Less than 15	4.6
Physical restraints	No set target	3.6
Mechanical restraint	No set target	0.76

	Aged psychiatry inpatients	
	Target	**2018–19**
Seclusion rate	Less than 15	0.2
Physical restraints	No set target	5.9
Mechanical restraint	No set target	0

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

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.

Better at Home

Better at Home provides a personalised home-based model of inpatient care for older adults, designed to avoid or shorten the need for hospital admission and lower the odds of developing a hospital-acquired complication.

An expanded inpatient home-based model for rehabilitation patients was trialled for three months from August 2018.

During the trial, 53 patients were managed at home, many referred directly from The Alfred and Sandringham Hospital. This provided the opportunity to receive therapy in their own surroundings and return to meaningful real life activities sooner, rather than being admitted to Caulfield Hospital for rehabilitation.

Feedback received from patients and their families was overwhelmingly positive, with the partner of one patient stating:

"Being at home allowed us to get back to normal as much as possible. It was music to our ears to hear this program was available."

Post-trial, the program has continued to provide inpatient care to rehabilitation patients and older adults, and has been rebadged. Overall, Alfred Health recorded 466 Better at Home discharges in 2018–19, compared to 289 in 2017–18; an increase of 61 per cent.

Working with Safer Care Victoria

Following a Safety System Review, we have successfully implemented all 26 recommendations from Safer Care Victoria to further improve the experience of care for our patients, staff and visitors.

The review was prompted when concerns were raised in January 2018 about the care of a Caulfield Hospital patient in our Acquired Brain Injury Unit.

The improvements were presented to Safer Care Victoria in April 2019. Insights gained throughout the process will be shared with other healthcare providers.

Cardiac Rehabilitation patient **Ursula Haymes** is supported by physiotherapist **Josh Jekot** at Caulfield Hospital.

Operational highlights (continued)

Sandringham Hospital

Sandringham Hospital is community-focused, providing hospital healthcare needs for the local area through emergency, paediatrics, general medicine, general surgery, orthopaedics and outpatient services. It works with Royal Women's Hospital onsite, partnering to provide maternal and gynaecological services.

Emergency

Demand for the service continues to increase, with 45,505 presentations in 2018–19 compared to 43,893 in 2017–18.

The paediatric population forms a large part of Emergency Department (ED) presentations requiring a tailored approach to care, with an average of 920 paediatric presentations every month, a 12 per cent increase from 2017–18, largely due to minor illnesses or injuries. Around 25 per cent of these patients were seen in the co-located Sandringham Ambulatory Care Centre (SACC).

The SACC is a partner of Alfred Health, seeing on average a third of Sandringham's overall emergency presentations. In total, SACC recorded 11,806 presentations in 2018–19.

The SACC treats streamed non-urgent patients, allowing our ED staff to care for higher-acuity patients.

The ED also supports the birthing suite at Sandringham Hospital and neonatal resuscitations are common.

	Presentations to Emergency
2016–17:	41,628
2017–18:	43,893
2018–19:	**45,505**

Saving hearts at Sandringham

Echocardiograms have been introduced to Sandringham Hospital, after The Alfred expanded its services to Bayside.

They allow cardiologists to look at the heart using ultrasound. It is used for people with a wide range of heart conditions. The new service was created in response to high demand for appointments at The Alfred. Head of Echocardiography Dr Angeline Leet said 15 per cent of patients were having to travel across from the Sandringham area already, so it made sense to move the service to them.

Day Procedure Centre opens

The $2.5 million Sandringham Community Bank® Day Procedure Centre opened in August 2018, thanks to support from the local community and the Victorian State Government.

The dedicated, purpose-built facility provides a modern, bright space for patients, treating more than 2,000 same-day surgery cases since it opened.

In the last five years, same-day cases, which include the use of theatres for gynaecological cases for the Womens@Sandringham initiative, have remained consistently high.

	Same-day surgical cases
2014–15:	2,155
2015–16:	2,035
2016–17:	2,076
2017–18:	2,145
2018–19:	**2,190**

Sandringham Community Bank® Day Procedure Centre opened by then-Minister for Health, **Jill Hennessy**.

Melbourne Sexual Health Centre

Melbourne Sexual Health Centre (MSHC) celebrated 100 years of service on 20 July 2018. It has been the only publicly funded clinic providing care for sexually transmitted infections (STI) over this time.

Demand remains unprecedented

Victoria's growing population has seen increased demand for our services. In 2018–19, we provided a record 56,892 consultations; an 8 per cent increase on 2017–18. We diagnosed a record of 3,540 cases of chlamydia (a 7 per cent increase on 2017–18) and 2,339 cases of gonorrhoea (a 7 per cent increase). A further 408 services were provided to outreach clients.

Research

This year our research focus was on exploring interventions for STI control that don't rely solely on condoms. Following detailed analysis of gonorrhoea transmission, we realised that the throat was important from a transmission perspective. This led to testing mouthwash for gonorrhoea prevention; with research led by Dr Eric Chow due at the end of 2019. We are also exploring ways to detect syphilis earlier and dramatically shorten the duration of undiagnosed infections, with work led by Dr Catriona Bradshaw.

The number of publications in peer-reviewed journals have increased from six in 2002 to 120 in 2017, with 112 in 2018.

Community care

Hospital Outreach Post-suicidal Engagement (HOPE)

The Alfred's Hospital Outreach Post-suicidal Engagement (HOPE) Team provides practical support and follow-up for people leaving hospital after a suicide attempt. Outreach workers also work with families, friends and carers so they can better support their loved ones during this critical time.

In its first two years, HOPE received 277 referrals of which 203 resulted in an episode of care. In the first 12 months of operation, active care commenced rapidly, within one day for 61 per cent of clients and within seven days for 97 per cent of episodes.

Clients varied in age, from 15 to 85 years. However, 60 per cent were aged 15–34 years and 72 per cent were referred after a suicide attempt or incident involving self-harm. Clients who present expressing serious suicidal ideation, planning and intent are also offered support by HOPE.

An evaluation also found that clients had significantly fewer presentations to The Alfred's Emergency and Trauma Centre since the establishment of HOPE.

Only 13 per cent of HOPE Team clients attended The Alfred's Emergency in 28 days after commencing, whereas a 2015 study found that 26 per cent of clients attending The Alfred's Emergency after a suicide attempt, re-presented within 28 days. This showed that access to the HOPE Team improved the aftercare following a suicide attempt or period with severe suicidal ideation.

Discovery College

Discovery College, currently funded through the headspace Youth Early Psychosis Program (YEPP), is based on principles of recovery.

Courses are co-produced by those with lived experience of mental health, those who have professional expertise, as well as family, friends and the broader community.

We recently completed a project to determine our strategic direction for the next three years, with expansion a key part of that strategy.

Recent highlights have included:

- 442 individual student enrolments since launching in 2016, including parents, young people, mental health professionals and community members
- 73 courses run over seven different service and community-based locations
- new courses exploring relationships between mental and physical health
- two articles published in 2018 in the *Journal of Mental Health and Social Inclusion*
- exploring how a Discovery College model may work in an adult setting.

Hospital Admission Risk Program (HARP)

Working closely with the General Medicine program, HARP proactively identifies patients across the health service who are at risk of avoidable hospital readmission, and can benefit from additional support in the community.

Among the key projects it is leading is the DHHS HealthLinks Chronic Care initiative, which focuses on integrated healthcare for people with chronic and complex health conditions. A recent DHHS grant enabled the commencement of a project to develop a HealthLinks data dashboard to enable better targeting of care to meet the needs of people with chronic and complex health conditions.

Hospital in the Home

Hospital in the Home (HITH) is a leading provider in acute home-based healthcare.

It also has established relationships with many outsourced providers for patients who fall outside catchment areas, working in partnership with these services to provide care.

Interfacing with teams across Alfred Health, HITH coordinates and treats in excess of 45 inpatients daily. In 2018–19, we provided 1,350 episodes of care. HITH forms an integral part of Alfred Health's bed capacity by ensuring flow from inpatient areas to the community setting in a safe and timely way.

HITH has developed the capacity and expertise to deliver diverse and complex care.

Key highlights for the past year include:

- successful home immunotherapy trial for patients with metastatic melanoma
- chemotherapy credentialing of HITH staff to undertake new cancer treatments
- upgrade to ambulatory pump with specialised drug library for patients with cystic fibrosis
- utilising Bluetooth technologies to create safer patient specimen collection.

Performance

Part A: Statement of Priorities

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

DHHS strategies	Alfred Health deliverables	Progress update as of 30 June 2019	Status
Better health			
Reduce statewide risks Build healthy neighbourhoods Help people to stay healthy Target health gaps	**Develop systems** to improve the integration and coordination of care for people with chronic conditions through the **Victorian Integrated Care Model**, supporting the boarder Commonwealth Health Care Homes initiative.	Initiative is embedded within General Practice Liaison Service to foster improved working relationships with GPs coordinating care of people with chronic and complex care. Key achievements include: • developing notification system from within electronic medical records of patients enrolled in healthcare homes to GPs of patient attendance at Alfred Health; and • expansion of e-referral system to facilitate timely and accurate referrals to specialist clinics underway.	**Good Progress**
	HIV strategy – alignment of the Victorian HIV Service to the **Victorian HIV Strategy 2017–2020** and enhance Alfred Health's role as a centre of excellence in HIV leadership, clinical expertise, sexual health, education and research.	Progressed agreed priority actions including: • strategies to expand access and promotion of PrEPX/PEP • promotional video for HIV testing completed and available online • screening and management of *HIV-associated Comorbidity Guideline* completed and adopted by National Guidelines • pathway to link newly diagnosed patients and HIV specialists established (GP Connect Service).	**Completed** ✓

Part A: Statement of Priorities (continued)

DHHS strategies	Alfred Health deliverables	Progress update as of 30 June 2019	Status
Better health (continued)			
	Implement the **Strengthening Hospital Responses to Family Violence (SHRFV)** initiative, • embed SHRFV whole-of-hospital model for identifying and responding to family violence internally • implement a Family Violence Workplace Support Program to support staff experiencing family violence	Project initiatives continue to be embedded with the following: • progressing staff training with 25% staff trained since commencement of the program and over 120 managers trained in workplace support • inter-professional family violence education plan developed to support sustainability of training • alignment of organisational policies and guidelines, including family violence, sexual assault and elder abuse, updated and available to staff • appropriate referral pathways established for staff making referrals related to family violence and online resources available • family violence Tier 1 alert and plan of care incorporated into electronic medical record	**Completed**
Better access			
Plan and invest Unlock innovation Provide easier access Ensure fair access	***Strategic project*** Progress detailed service and capital planning, and finalise the business case, for The Alfred Hospital Redevelopment Project to ensure Alfred Health can continue to provide state-of-the-art statewide specialist critical healthcare and general acute healthcare services to Victorians.	The Alfred Redevelopment Business Case has been finalised and submitted to Victorian Health and Human Services Building Authority. The business case highlights the need for the redevelopment, given the increasing demand facing The Alfred.	**Completed**
	Strategic Project **Innovation and Education Hub** – develop a capital and operating business case for the implementation of a self-funded, new vision/brand for education and innovation at Alfred Health.	Business case completed and approved. Detailed planning and consultation underway for project to be tendered in August 2019 and completion by mid-2020.	**Completed**
	Recommissioning of Ward 5 West to provide additional capacity and enhanced acute rehabilitation for trauma patients to ensure The Alfred can continue to meet the growing demand for emergency and trauma care.	All major decant works completed including new ID Clinic, Sleep Laboratory and respiratory clinics and offices enabling works on Ward 5 West underway. Detailed design of Ward 5 West completed with consumer representation; construction underway with operational commissioning by October 2019.	
Better care			
Put quality first Join up care Partner with patients Strengthen the workforce Embed evidence Ensure equal care	***Strategic Project*** Implementation of eTQC (electronic timely quality care) phase 1 – an integrated electronic clinical information system, to reduce variation in clinical care and improved access to data to support clinical teams and effective patient management.	Phase 1 eTQC Go Live successfully completed in November 2018. Post- implementation review and benefits realisation will be reported. Planning underway for optimisation and Phase 2.	**Completed**

Part A: Statement of Priorities (continued)

DHHS strategies	Alfred Health deliverables	Progress update as of 30 June 2019	Status
Better care (continued)			
Put quality first Join up care Partner with patients Strengthen the workforce Embed evidence Ensure equal care	Build **capacity and capability in clinical trials** for the translation of research into practice.	Alfred Health has committed to a capital investment to refurbish a designated area on level 1 South Block Building, which will provide additional cancer and clinical trial capacity. Construction of refurbishment to commence July 2019. Secured funding to support large-scale investment to establish Australian Clinical Trials Hub for patients across Australia.	**Completed**
Specific 2018–19 priorities mandatory			
Disability action plans Preparation for implementation of disability action plans is completed in 2018–19.	Submit a draft disability action plan to the department by 30 June 2019. The draft plan needs to outline the approach to full implementation within three years of publication.	Draft completed in consultation with consumer groups. The draft Alfred Health Access and Inclusion (Disability) Plan endorsed/supported by Alfred Health Board and submitted to DHHS.	**Completed**
Volunteer engagement Ensure that the health service executives have appropriate measures to engage and recognise volunteers.	Implement reporting to Executive Committee on volunteer activities to raise the awareness of the volunteer's contribution across Alfred Health.	Implementation of electronic management and reporting system 'better impact' to assist with the coordination and tracking of volunteer activities. End-of-year events held to celebrate and acknowledge the contribution of volunteers and consumers.	**Completed**
Bullying and harassment Actively promote positive workplace behaviours and encourage reporting. Utilise staff surveys, incident reporting data, outcomes of investigations and claims to regularly monitor and identify risks related to bullying and harassment, in particular include as a regular item in Board and executive meetings. Appropriately investigate all reports of bullying and harassment and ensure there is a feedback mechanism to staff involved and the broader health service staff.	Use People Matter Survey feedback to identify cross-organisational and group-specific issues related to bullying and harassment. Highlight areas where bullying instances have reduced or been eradicated and use as champions of good behaviour. Target areas where bullying continues with all staff presentations. Conduct a Grand Round in 2019 on interpersonal behaviour. Highlight claims and investigation progress to Board and People and Culture Sub-committee.	People Matter Survey results have been shared with their teams. Many teams have reviewed results and conducted conversations to identify areas to improve. Initiatives from survey results include: • free text comments being considered as part of a broader organisational strategy • areas of poor engagement and high stress have been identified as potential for organisational development • Human Resources continue to conduct internal and, where indicated, external investigations into bullying and harassment claims • bullying and harassment claims now form part of HR KPI dashboard.	**Completed**
Occupational violence Ensure all staff who have contact with patients and visitors have undertaken core occupational violence training, annually. Ensure the department's occupational violence and aggression training principles are implemented.	Continue to embed the principles, skills and learnings from the two key training programs (DARMA and AWARE) developed and delivered to highlight and address instances of OVA in the workplace. This is done though face-to-face coaching and mentoring on the 'ward'. Conduct continuous assessment of course content and usefulness by doing post-course assessments on wards. Design shorter version of AWARE and refresher courses.	Expanded resources to continue occupational violence training through the AWARE and DARMA programs. Key achievements include: • training tailored to specific areas and needs; • refresher courses ongoing, with online refresher package now implemented; and • development of Super Users.	**Completed**

DHHS strategies	Alfred Health deliverables	Progress update as of 30 June 2019	Status
Specific 2018–19 priorities mandatory (continued)			
Environmental sustainability Actively contribute to the development of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measurable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Alfred Health's Environmental Sustainability Strategy and Action Plan 2017–21, with key deliverables in 2018, to include: the adoption of local sustainability action plans; DHHS environmental reporting and measures expanded; and increased staff engagement.	Green teams established across multiple work units at Alfred Health, responsible for local sustainability action plans. This has been supported by: • development of a monthly environmental sustainability newsletter to promote staff engagement • a review of Alfred Health's asset structure against the DHHS environmental data management • extensive consultation and involvement into capital improvements across the site to ensure the new areas align to the Environment Sustainability Strategy.	**Completed**
LGBTIQ* Develop and promulgate service level policies and protocols, in partnership with LGBTIQ communities, to avoid discrimination against LGBTIQ patients. Ensure appropriate data collection, and actively promote rights to free expression of gender and sexuality in healthcare settings. Where relevant, services should offer leading practice approaches to trans- and intersex-related interventions. Note: deliverables should be in accordance with the DHHS Rainbow eQuality Guide (**www2.health.vic.gov.au/rainbowequality**) and the *Rainbow Tick Accreditation Guide* (see at **glhv.org.au**).	Aligned to Alfred Health's broader initiative to improve access and care for all vulnerable persons, specific initiatives are to be developed in partnership with the LGBTIQ community. These include: • convene a consumer forum • develop family violence training content relevant to the needs of LGBTIQ communities • workforce sensitive inquiry training.	Community forum convened and preliminary analysis of survey feedback currently completed and delivered to DHHS. Currently working with DHHS to develop actions arising from survey feedback – DHHS to lead this work. Resources and tools developed using the sensitive enquiry framework to support staff caring for people who identify as LGBTIQ available on the intranet. Scoping project for LGBTIQ FV has been completed and will be tabled at the Vulnerable Persons Committee to finalise actions.	**Completed**

* Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex, Queer and questioning

Performance (continued)

Part B: Performance priorities

High-quality and safe care

Key performance indicator	Target	2018–19 actuals
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Accredited	Achieved
Infection prevention and control		
Compliance with the Hand Hygiene Australia	80%	83.8%
Percentage of healthcare workers immunised for influenza	80%	88%
Patient experience		
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – quarter 1	95%	90%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – quarter 2	95%	89%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – quarter 3	95%	94%
Victorian Healthcare Experience Survey – transition of care – quarter 1	75%	72%
Victorian Healthcare Experience Survey – transition of care – quarter 2	75%	75%
Victorian Healthcare Experience Survey – transition of care – quarter 3	75%	74%
Victorian Healthcare Experience Survey – patients' perception of cleanliness – quarter 1	70%	56%
Victorian Healthcare Experience Survey – patients' perception of cleanliness – quarter 2	70%	62%
Victorian Healthcare Experience Survey – patients' perception of cleanliness – quarter 3	70%	55%
Healthcare-associated infections (HAIs)		
Number of patients with surgical site infection	No outliers	No outliers
Number of patients with ICU central line-associated bloodstream infection (CLABSI)	Nil	5 ICU CLABSIs (rate of 0.48)
Rate of patients with SAB[1] per occupied bed day	≤1/10,000	1.26/10,000
Adverse events		
Sentinel events – root cause analysis (RCA) reporting	All RCA reports submitted within 30 business days	1 sentinel event[2]
Unplanned re-admission hip replacement[3]	Annual rate ≤2.5%	The Alfred 2.9% / Sandringham Hospital 2.5%
Mental health		
Percentage of adult acute mental health inpatients who are re-admitted within 28 days of discharge	14%	10%
Rate of seclusion events relating to an adult acute mental health admission	≤15/1,000	5
Rate of seclusion events relating to an aged acute mental health admission	≤15/1,000	0
Percentage of adult acute mental health inpatients who have a post-discharge follow-up within seven days	80%	82%
Percentage of aged acute mental health inpatients who have a post-discharge follow-up within seven days	80%	95%
Continuing care		
Functional independence gain from an episode of rehabilitation admission to discharge relative to length of stay	≥0.645	0.692

1 SAB is *Staphylococcus aureus bacteraemia.*
2 Not submitted within 30 days but done so within extension period granted.
3 Based on data available at publication. Figures for Q4, 2017–18 and Q1, Q2 and Q3, 2018–19.

Strong governance, leadership and culture

Key performance indicator	Target (%)	2018–19 actuals (%)
Organisational culture		
People Matter Survey – percentage of staff with an overall positive response to safety and culture questions	80	72
People Matter Survey – percentage of staff with a positive response to the question: "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 question: "Patient care errors are handled appropriately in my work area."	80	75
People Matter Survey – percentage of staff with a positive response to the question: "My suggestions about patient safety would be acted upon if I expressed them to my manager."	80	72
People Matter Survey – percentage of staff with a positive response to the question: "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 question: "Management is driving us to be a safety-centred organisation."	80	69
People Matter Survey – percentage of staff with a positive response to the question: "This health service does a good job of training new and existing staff."	80	65
People Matter Survey – percentage of staff with a positive response to the question: "Trainees in my discipline are adequately supervised."	80	66
People Matter Survey – percentage of staff with a positive response to the question: "I would recommend a friend or relative to be treated as a patient here."	80	81

Timely access to care

Key performance indicator	Target	2018–19 actuals	
Emergency care		The Alfred	Sandringham Hospital
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%	78%	84%
Percentage of emergency patients with a length of stay in the Emergency Department of less than four hours (NEAT)	81%	76%	87%
Number of patients with a length of stay in the Emergency Department greater than 24 hours	0	1	0
Elective surgery			**Alfred Health**
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%		99%
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	1,950		1,943
Number of hospital initiated postponements per 100 scheduled elective surgery admissions	≤7 /100		4
Number of patients admitted from the elective surgery waiting list[4]	11,500		11,060
Specialist clinics			
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%		N/A[5]
Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%		N/A[6]

4 The target shown is the number of patients on the elective surgery waiting list as at 30 June 2019.
5 Not currently measured due to Victorian Integrated Non-Admitted Health (VINAH) compliance issues.
6 Not currently measured due to Victorian Integrated Non-Admitted Health (VINAH) compliance issues.

Part B: Performance priorities (continued)

Effective financial management

Key performance indicator	Target	2018–19 actuals
Finance		
Operating result	0	$0.19 million
Average number of days to paying trade creditors	60 days	51 days
Average number of days to receiving patient fee debtors	60 days	68 days
Public and Private WIES[7] activity performance to target	100%	102.3%
Adjusted current asset ratio	0.64	0.67
Actual number of days a health service can maintain its operations with unrestricted available cash, measured on the last day of each month	14 days	16.6 days
Measures the accuracy of forecasting the net result from transactions (NRFT) for the current financial year ending 30 June	Variance ≤$250,000	$2.33 million

7 WIES is a Weighted Inlier Equivalent Separation.

Rehabilitation is among the key services offered at Caulfield Hospital.

Part C: Activity and funding

High-quality and safe care

	2018–19 activity achievement
Acute admitted	
WIES public	86,258
WIES private	16,931
WIES DVA	687
WIES TAC	6,483
Acute non-admitted	
Emergency services	102,843
Home enteral nutrition	953
Home renal dialysis	99
Radiotherapy WAUs public	77,393
Radiotherapy WAUs DVA	984
Specialist clinics (inc DVA)	219,661
Subacute and non-acute admitted	
Subacute WIES – rehabilitation public	1,298
Subacute WIES – rehabilitation private	440
Subacute WIES – rehab DVA	9
Subacute WIES – GEM public	1,990
Subacute WIES – GEM private	595
Subacute WIES – GEM DVA	47
Transition care – bed days	25,905
Transition care – home days	4,788
Subacute non-admitted	
Health Independence Program – public inc DVA	94,444
Victorian Artificial Limb Program	2,578
Aged care	
HACC	19,943
Mental Health and Drug Services	
Mental health ambulatory	83,372
Mental health inpatient – available bed days	24,805
Mental health subacute (inc CCU and PARC)	8,678
Drug Services	151
Primary health	
Community health/primary care programs	18,186
Other	
NFC – paediatric lung transplantation	3
Health workforce[+]	333

+ Includes staff in various training positions, such as trainee and graduate workforce.

WIES Weighted Inlier Equivalent Separation
HACC Home and Community Care
DVA Department of Veterans' Affairs
CCU Community Care Units
TAC Transport Accident Commission
PARC Prevention and Recovery Care
WAUs Weighted Activity Units
NFC National Funded Centres
GEM Geriatric Evaluation and Management

Financial summary 2018–19

The operating result for 2018–19 was a $0.19 million surplus. The result is in line with the operating result target in the Statement of Priorities.

Total revenue and expenditure increased in the year, largely due to activity growth throughout the health service.

Net assets increased by $268.82 million in 2018–19, largely due to land and building revaluation of $313.66 million.

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 to achieve savings targets through efficiency programs and close monitoring of the costs of growing activity.

	2015 $'000	2016 $'000	2017 $'000	2018 $'000	2019 $'000
Operating result*	(115)	4,325	203	240	193
Total revenue	1,008,163	1,104,793	1,189,097	1,228,190	1,314,925
Total expenses	(1,042,141)	(1,124,590)	(1,213,489)	(1,264,477)	(1,352,319)
Net result from transactions	**(33,978)**	**(19,797)**	**(24,392)**	**(36,287)**	**(37,394)**
Total other economic flows	3,012	(4,545)	(4,125)	2,570	(6,938)
Net result	**(30,966)**	**(24,342)**	**(28,517)**	**(33,717)**	**(44,332)**
Total assets	1,056,838	1,085,146	1,096,904	1,160,112	1,446,645
Total liabilities	279,390	294,174	306,182	338,323	356,039
Net assets / Total equity	**777,448**	**790,972**	**790,722**	**821,789**	**1,090,606**
	2015 $'000	**2016 $'000**	**2017 $'000**	**2018 $'000**	**2019 $'000**
Net operating result	(115)	4,325	203	240	193
Capital and specific items					
Capital purpose income	32,103	42,442	43,569	30,617	41,374
Capital expenses	0	(139)	(129)	(208)	(1,210)
Depreciation and amortisation	(65,477)	(66,088)	(67,897)	(66,769)	(77,714)
Finance costs (other)	(489)	(337)	(138)	(167)	(37)
Net result from transactions	**(33,978)**	**(19,797)**	**(24,392)**	**(36,287)**	**(37,394)**

* 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.
Years described in this table refer to financial years ended 30 June of the relevant year.

Information and communication technology (ICT) expenditure

The total ICT expenditure incurred during 2018–19 is $44.2 million (excluding GST):

Business as usual (BAU) ICT expenditure ($m)	Non-business as usual (on-BAU) ICT expenditure ($m)	Operational expenditure ($m)	Capital expenditure ($m)	Year
31.2	13.0	2.9	10.0	30-Jun-19

Research

Across our health network, research is undertaken to bring major benefits to our patients. Alfred Health continues to be one of the most research-intense health services in Australia.

All our research is translational – meaning patients receive the direct benefit of clinicians' and scientists' work.

Major research highlights

New trial provides hope for incurable disease

The Alfred has launched a world-first clinical trial to investigate whether a new experimental medication can be used to treat people with Rett syndrome – a rare and catastrophic neurodevelopmental disease that currently has no cure.

ANAVEX®2-73 is currently in clinical development to treat people with Alzheimer's disease. This new trial is being led by Program Director of Alfred Brain and Deputy Director of Research Professor Terry O'Brien.

The Alfred is home to the only inpatient neuroscience clinical trials unit in the country, where it can offer patients the opportunity to participate in innovative medical trials of new therapies in the safety of a hospital ward with specific expertise in managing patients with neurological conditions.

***Other research highlights include*:**

- Doctors at The Alfred were involved in an international randomised trial that has shown patients live significantly longer when stereotactic ablative radiotherapy (SABR) is used to target all of their tumours. It noted that with SABR there was a potentially curative treatment for patients with up to five tumours, with the trial showing SABR resulted in almost half the patients surviving five years or more – at least one year longer than with current therapies. Stereotactic Radiation Oncologist Associate Professor Sasha Senthi is lead investigator for the study.
- Researchers at The Alfred trialled nitrous oxide (also known as laughing gas) to treat patients with depression after studies overseas showed promising results. Researchers believe it could target a different type of neural pathway to that of existing antidepressant medications, which could alleviate symptoms for patients with treatment-resistant depression. The trial is a collaboration between Monash Alfred Psychiatry Research Centre (MapRC) Director Jayashri Kulkarni, and Director of Anaesthesiology and Perioperative Medicine Paul Myles.

Alfred Research Alliance
New thinking. Real impact.

Alfred Research Alliance

Alfred Health was a founding member of Alfred Medical Research and Education Precinct (AMREP) together with Monash University, Baker Heart and Diabetes Institute and Burnet Institute. Later joined by La Trobe University and Deakin University, this six-way partnership cemented the Alfred precinct as a centre of research excellence.

The past year has seen a transformation, with the collaboration now known as the Alfred Research Alliance. Its focus is improving understanding of some of the world's most critical health problems through research and translation through health services. The complete translational research loop, helps make the Alfred Research Alliance unique in the biomedical research space.

The Alfred Research Alliance was officially launched in September, with a special presentation from Alliance researchers about their collaborative research projects; and more than 400 Conversations in the Courtyard run by our engagement partner, the Conversation Caravan, discussing the value of working as part of the Alliance.

In 2018, the Alliance:

- secured more than **$112 million** in external research funding
- published a total of **2,295 publications**, including journal articles, reviews, book chapters and books
- saw **219 students** complete their masters and doctoral degrees.

Research (continued)

Alfred Health Week

In June 2019, nearly 130 posters showcased the latest research from across the Alfred Research Alliance in the corridors of The Alfred.

Prizes were awarded for the posters judged best in categories such as infectious diseases, cardiovascular disease, mental health, nursing and allied health.

We also celebrated Alfred Health Week Research Day in June with Professor Ricky Johnstone from the Peter MacCallum Cancer Centre delivering the keynote address.

Research Day also saw the presentation of the annual Alliance Research Prizes, which recognise the excellence of published research articles by researchers at the Alfred Research Alliance.

2019 Alfred Research Alliance Research Prize in Basic Research:

Dr Dragana Dragoljevic | Baker Heart and Diabetes Institute

'Defective Cholesterol Metabolism in Haematopoietic Stem Cells Promotes Monocyte-Driven Atherosclerosis in Rheumatoid Arthritis' – *European Heart Journal*.

Dr Melanie Ziegler | Baker Heart and Diabetes Institute

'A Single-Chain Antibody-CD39 Fusion Protein Targeting Activated Platelets Protects from Cardiac Ischaemia/ Reperfusion Injury' – *European Heart Journal*.

***2019 Alfred Research Alliance Research Prize in Clinical Research*:**

Professor Paul Myles | The Alfred and Monash University

'Restrictive versus Liberal Fluid Therapy for Major Abdominal Surgery' – *New England Journal of Medicine*.

Professor John McNeil AM | Monash Public Health and Preventive Medicine

'Effect of Aspirin on Disability-Free Survival in the Healthy Elderly'; 'Effect of Aspirin on Cardiovascular Events and Bleeding in the Healthy Elderly' and 'Effect of Aspirin on All-Cause Mortality in the Healthy Elderly' – *New England Journal of Medicine*.

Research funding

Alfred Health researchers were lead investigators of several new NHMRC (National Health and Medical Research Council) grants commencing in 2019.

Project grants

- Professor Stephen Bernard: Pre-hospital anti-fibrinolytics for traumatic coagulopathy and haemorrhage-2 (The PATCH2 Study). $656,155
- Dr Narelle Cox: Early home-based pulmonary rehabilitation after hospitalisation in chronic obstructive pulmonary disease. $1,022,292
- Associate Professor David Curtis: Targeted therapies for chemo-resistant leukaemia cells. $727,087
- Dr Ingrid Hopper: The STAREE Heart Study. $1,470,583
- Professor Paul Komesaroff: A new direction in end of life care? Assessing the impact and outcomes of the Victorian Voluntary Assisted Dying Act. $1,210,400
- Dr Zoe McQuilten: Clonal haematopoiesis of indeterminate potential (CHIP) and its consequences for blood cancers, cardiovascular disease and stroke – the ASPREE-CHIP sub-study. $1,416,603
- Professor Robert Medcalf: Improving the safety and predictable efficacy of thrombolytic therapy in acute ischaemic stroke. $1,371,900
- Dr Andrew Stewardson: Understanding patient movement networks to better prevent dissemination of antimicrobial resistance. $409,717
- Professor Andrew Udy: Brain Oxygen Neuromonitoring In Australia And New Zealand Assessment (BONANZA) Trial. $2,703,830
- Associate Professor Andrew Wei: Transforming the treatment landscape in elderly acute myeloid leukaemia. $1,071,166

Medical Research Future Fund (MRFF) – Rare Cancers and Unmet Need Clinical Trials Program

- Professor David Pilcher: Linking routinely collected cardiac surgical and Intensive care registry data to provide near real time monitoring of cardiac surgical performance. A local pilot for a national system. $104,000
- Professor Andrew Udy: Brain Oxygen Neuromonitoring In Australia And New Zealand Assessment (BONANZA) Trial. $1,084,852
- Associate Professor Andrew Wei: Novel venetoclax combinations to improve outcomes in unfit older patients with acute myeloid leukaemia. $1,380,298

Practitioner Fellowship

- Professor John Zalcberg (2019–2023)

Career Development Fellowships

- Dr Joseph Doyle (2019–2022)
- Associate Professor Natasha Lannin (2019 – 2022) – MRFF Next Generation Clinical Research Program
- Associate Professor Jake Shortt (2019–2022) – MRFF Next Generation Clinical Research Program

Translating Research Into Practice (TRIP) Fellowships

- Dr Joseph Doyle (2019–2022)

Research (continued)

Monash Partners Academic Health Science Centre

Alfred Health continued to be a lead partner in the NHMRC-accredited Monash Partners Academic Health Science Centre.

During the year Monash Partners completed its strategic plan and refined its purpose to connect researchers, health professionals and the community to innovate for better health. It also contributed to developing a national strategy for data-driven healthcare improvements across similar centres in Australia.

Importantly 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.

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, and
- strengthened national collaboration through the national alliance.

Research awards

Trisha Peel from our Infectious Diseases Unit was a recipient of a National Health and Medical Research Council (NHMRC) Research Excellence Award. She received a Career Development Fellowship Award for being the highest-ranked candidate in the level one clinical category for her work on surgical wound infections – the costliest and leading cause of infections.

Dr Vincent Cornelisse from Melbourne Sexual Health Centre received the Victorian Premier's Prize for Best Public Health Researcher Award for his work in the prevention of HIV and other sexually transmitted infections.

Trainee physician **Dr Jessica Fairley** won the Victorian 2018 RACP Trainee Research Award for Adult Medicine. As part of the prize, Jessica will be heading to New Zealand next year to present her abstract at the RACP Congress.

Events such as this year's Surgical Research Forum provide staff with an opportunity to increase their knowledge and broaden their skill base.

Projects and infrastructure

2018–19 saw one of the largest infrastructure programs in the history of the health service. We resolved some infrastructure challenges and created new facilities to address growing community needs for inpatient care.

The resilience of staff and the support of our patient community was essential in the success of this program.

Alfred Centre Pipeworks Replacement Project

This year we successfully replaced the faulty cold water pipes at The Alfred Centre. An ongoing issue, due to faulty workmanship at the time of construction, had significantly affected service delivery as well as staff conditions. The project was funded by the Victorian Government.

The Alfred Centre maintained operations while initial enabling works were completed between September 2018 to Christmas 2018. While the centre closed between late December and April 2019 for the project to be completed, we maintained services for patients.

Specialist clinics (outpatients) were temporarily relocated to the newly refurbished Alfred Lane House; the Radiology Service relocated to the main hospital; and elective surgery relocated to Epworth Private Hospital.

The Alfred Centre returned to full service on 1 April 2019 with no further infrastructure issues reported. The project was delivered on time and within budget.

New trauma ward

Works on a new state-of-the-art trauma ward are currently underway. To be located on Ward 5 West, it will feature a range of speciality functions. Construction on the new ward has been a major exercise, with the demolition and removal of hazardous materials, including over 32 tonnes of brickwork removed from the site. The project is proceeding to program and budget, with the ward set to open in late 2019.

Previous services located on Level 5 were relocated:

- the Bronchoscopy Suite was transferred to a new facility within The Alfred Centre;
- the Sleep Laboratory was relocated to a new purpose-designed facility, also within The Alfred Centre;
- specialist respiratory clinics moved to a purpose-designed area within the East and Philip Blocks.

Projects and infrastructure (continued)

Roof replacement works and sewer replacement

Roof and sewer replacement works addressed the history of water leaks at The Alfred. South Block (Cancer Services) and the Main Ward Block (theatre suite and wards) were among those areas most affected.

The works included the replacement of roof sheeting, downpipes, stormwater infrastructure and guttering. Sewer and grease trap systems were also replaced.

The $8 million project was due to be completed in mid-2019.

Main Ward Block Urgent Infrastructure Upgrade Project

Planning started for the $69.5 million Main Ward Block Upgrade Project that will modernise infrastructure across a number of wards; particularly, 2 East, 2 West, 4 East, 6 East and 7 West.

The project involves the relocation of services to create accommodation for decant ward spaces, the creation of decant ward accommodation to enable the vacation of existing ward areas for the redevelopment, and the redevelopment of five existing wards.

The works will take place over a three- to four-year period.

Other maintenance and repairs

Recent projects conducted over the past year include:

- the installation of a computerised building automation system to monitor and control key air-conditioning infrastructure
- the creation of a dedicated fire ring main to ensure a separate and independent fire system for hydrant and sprinkler systems
- the installation of new chiller and associated infrastructure to improve the performance and efficiency of air-conditioning systems throughout The Alfred Hospital site.

Maintenance costs

Description	2015 $'000	2016 $'000	2017 $'000	2018 $'000	2019 $'000
Plant and non-medical equipment	1,598	2,018	1,771	959	1,225
Buildings	3,475	4,368	6,593	7,496	8,084
Grand total	**5,073**	**6,386**	**8,364**	**8,455**	**9,309**

* Years described in this table refer to financial years ended 30 June of the relevant year

High-value equipment and infrastructure funding

In 2018–19, we were allocated $5.61 million in funding from DHHS's High-value Statewide Replacement and Violence Prevention Funds.

The funded projects consisted of:

Medical equipment

- Cardiac SPECT Imaging System (Nuclear Medicine) $670,000
- CT-Upgrade (Emergency Department) $490,000
- Echocardiography System (Intensive Care Unit) $330,000
- Tandem Mass Spectrometer (Pathology) $500,000
- Angiography Fluoroscopy System (Radiology) $1,150,000

Infrastructure works

- Air Handling Units (Main Ward Block) $900,000
- nurse call/duress system $700,000
- fire services upgrade (Sandringham) $590,000

Violence prevention

- Improved visibility and zoning (Acquired Brain Injury Unit) $149,000
- CCTV cameras and monitors for safety zones (Ward 5) $130,000

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

- Neurology (Epilepsy Service) development
- Respiratory Medicine – Clinics
- Sleep Laboratory
- Vascular Laboratory
- Anatomical Pathology Laboratory upgrade
- Fire Ring Main upgrade
- Specialist Outpatients Clinics – Alfred Lane House

Sandringham Hospital

- Day Procedure Unit
- Staff accommodation

Projects with building permits under construction

The Alfred

- Sewer and roofing upgrade works
- Administrative offices – The Stables
- Clinical trials – South Block
- Fire and infrastructure – Decant Works
- Ward 5 West – Trauma Ward redevelopment

Sandringham

- Pathology and kitchen redevelopment
- Behaviours of Concern Area – Emergency Department

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 being 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

Community health

Prevention through health services

Alfred Health was again funded to support Victorian public health services in preventive health, with a focus on healthy eating and reducing harm from tobacco. Since 2016, we have supported 55 other Victorian health services in prevention activities to improve the health of the Victorian community.

Healthy eating

We continued to exceed the Victorian Government's Healthy Choices: policy guidelines for hospital and health services in our retail, catering and vending environments.

Sandringham Hospital Kiosk Manager Carol Anderson and Lead for Population Health Healthy Living Kia Noble (both pictured above) have been part of the team working hard to ensure healthier options are available at the Sandringham Hospital Kiosk.

Primary Care and Population Health Strategy 2018–2023

Our community and stakeholders helped shape our Primary Care and Population Health Strategy 2018–2023.

It focuses on actions related to our environment, clinical interaction and workforce, including:

- reducing the harm from tobacco
- healthy living (healthy eating and physical activity)
- reducing the harm from alcohol
- improving mental health
- vaccinations and prevention of blood-borne viruses.

Alfred Health formalised a Population Health partnership with the Burnet Institute to facilitate the implementation of the strategy.

Alfred Health volunteers

Alfred Health volunteers add to the quality of healthcare provided by supporting patients, their families, staff, visitors and the general hospital community.

The volunteer program offers a diverse range of opportunities, including:

- tea and coffee trolley service to outpatients
- shop trolley service for inpatients
- social visiting and
- a concierge service supporting patients when accessing the hospital.

Each individual volunteer makes an important contribution; including Sandringham Hospital volunteer Joan McLean, who was announced as Bayside's Citizen of the Year as part of the Australia Day Awards.

Supporting capital projects

In early 2019, The Alfred underwent major capital project works.

With the relocation of some services on-site, a separate intake of 16 new 'concierge' volunteers were added, creating a greater presence to our existing volunteer wayfinding team.

This ensured the smooth flow of patients, families and friends throughout the hospital and created the best experience possible for patients to reach their appointments on time.

Number of volunteers at Alfred Health	
The Alfred	255
Caulfield	145
Sandringham	120
Total	**520**

Ward 2E and 2W Host Volunteer Program

Volunteer Kate Pointon knows what it's like to be a patient on the Neurosurgery Ward at The Alfred – it's where she spent three months last year recovering from a brain aneurysm.

Now, she's one of our first 'Host Volunteers', providing patients on the Neurosurgery and Trauma wards with companionship and conversation.

"Patients really appreciate it and are comforted when they can share what they are going through with someone who's had a similar experience," Kate said.

Volunteer **Kate Pointon** provides a helping hand to patient Anne.

Community and environment (continued)

The Alfred Foundation

The Alfred Foundation plays a fundamental role in improving the lives of our patients, families and community.

In 2018–19, donors made more than 38,400 donations, contributing $12.5 million to support the work of The Alfred.

Thanks must be extended to all donors who supported the work of The Alfred in 2018–19. Their ongoing support means we can continue to provide exceptional patient care.

Father's Day Appeal

This year we saw the best result ever for our annual Father's Day Appeal, with the continuing generosity of our presenting partner, Bulla Family Dairy. The campaign raised more than $1.1 million, funding projects such as a technology upgrade supporting the transitioning from paper-based patient medical records to electronic records. Special thanks to our broadcasting partner Radio 3AW.

Lifesaving Equipment Fund

In May 2018, the $5 million Lifesaving Equipment Fund was launched. It was established to give the hospital the flexibility to purchase innovative equipment as soon as it is needed, allowing for greater patient impact, faster.

Nursing Scholarship Lunch

The Nursing Scholarship Lunch supports an annual international travel scholarship. It is awarded to an emerging nurse leader in clinical practice, research, education or management to learn from world-leading services first-hand. The lunch raised close to $50,000, with the scholarship awarded to Belinda Bourne and Rebecca Brereton.

The Alfred Foundation Board

In 2018-19, The Alfred Foundation Board comprised:

- Sir Rod Eddington AO (Chair)
- Mr Ian Cootes AM (Deputy Chair) – retired 2018
- Mr Patrick Baker (Director, The Alfred Foundation)
- Mr Ravi Bhatia
- Ms Greta Bradman
- Mr Anthony Charles
- Mr Didier Elzinga – retired 2019
- Mr Allan Hood
- Ms Meg Landrigan
- Mr Eddie McGuire AM
- 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@The Alfred Chair)
- Professor Andrew Way AM (Chief Executive, Alfred Health)
- Mr Alan Williams
- Sir Donald Trescowthick AC KBE (Patron)

The Alfred has made technology upgrades a key fundraising priority. **Dr Michelle Anada-Rajah**, a physician in General Medicine and Infectious Diseases, said it was exciting to have such transformative technology in the hospital.

Sandringham Hospital fundraising

The community once again showed its support for Sandringham Hospital, helping it purchase much needed equipment and update facilities.

Day Procedure Centre opens

On 14 August 2018, then-Minister for Health, Jill Hennessy, officially opened the $2.5 million Sandringham Community Bank® Day Procedure Centre at Sandringham Hospital.

Funded through the generosity of local organisations, residents and a significant contribution from the Sandringham Community Bank, the purpose-built centre was established in response to a 50 per cent increase in demand for same-day surgeries at Sandringham Hospital.

Community support

Major fundraising events held in support of the hospital Sandringham Hospital included the Bayside Charity Golf Day at Royal Melbourne Golf Club hosted by the Black Rock Sports Auxiliary and the Rotary Club of Beaumaris, the Oaks Day Ladies Luncheon at Sandringham Yacht Club and Lunch by the Bay fundraising luncheon.

With the support of Bayside Companion Dog Training School, the therapy dog program has continued to bring enjoyment to patients and staff at Sandringham Hospital.

Community support ensured we could purchase a broad range of medical equipment.

Significant support was received from:

- All Souls Opportunity Shop
- Black Rock Sports Auxiliary
- Collier Charitable Fund
- Dr Steven Gaff
- Ethel Herman Charitable Trust
- Isobel Hill Brown Charitable Trust
- F and M Hofmann
- Humpty Dumpty Foundation
- Lions Club of Beaumaris
- Rotary Club of Beaumaris
- Rotary Club of Sandringham
- Sandringham Hospital Kiosk volunteers
- Sandringham Yacht Club
- The Alfred and Jean Dickson Foundation
- The Estate of Eric Ernest Henry Dyster Trust
- The J and Hope Knell Trust Fund
- TR and RB Ditchfield Med Res Endowment Fund
- Donald Weir
- anonymous supporters.

Caulfield Hospital fundraising

Fundraising and philanthropic support continues to be important for Caulfield Hospital.

We secured a number of grants related to care of older people, which allowed us to furnish the new activities space in our Delirium and Dementia Unit. Several grants were also secured for specialised equipment to enhance patient care and facilitate a safer working environment.

Grants were received from the following philanthropic organisations:

- Joe White Bequest
- Caulfield RSL
- William Angliss Charitable Fund
- Collier Charitable Fund
- Aged Person Welfare Fund.

Funds were also raised through the Melbourne Racing Club Foundation Race Day at Caulfield Racecourse.

It was another successful year for our Helmsman Kiosk staff with volunteers raising funds for our ward and service equipment replacements and upgrades.

Work is continuing on upgrades for the hydrotherapy pool, with fundraising around Caulfield Hospital's centenary celebrations.

Community and environment (continued)

Environmental performance

Our *Environmental Sustainability Strategy 2017–21* supports resource prioritisation and management decisions that will minimise environmental impacts and deliver balanced economic, social and environmental benefits to our community.

We aim to engage, educate and empower staff to create an environmentally sustainable workplace.

The environmental data management system (EDMS) records our environmental performance data. The EDMS generates reports related to our greenhouse gas emissions, waste generation, and energy and water consumption.

Alfred Health is part of a pilot program to reduce how much waste it produces,including recycling stainless steel single use instruments. It is the first stage of an audit to see how we can continue to reduce our environmental impact.

Greenhouse gas emissions (CO2-e)

Year	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19
Scope 1	3,107	3,099	3,039	3,065	3,329	3,104
Scope 2	49,647	49,152	49,105	48,324	47,629	47,295
TOTAL (tonnes CO2-e)	**52,754**	**52,251**	**52,144**	**51,389**	**50,958**	**50,399**

Water consumption

Year	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19
Class A recycled water	0	0	0	0	0	0
Potable water	261,846	211,231	270,606	191,355	245,233	234,016
Reclaimed water	0	0	0	0	0	0
TOTAL (kL)	**261,846**	**211,231**	**270,606**	**191,355**	**245,233**	**234,016**

At the time of publication, estimated data was used to produce the environmental performance results. A standalone environmental sustainability report will be published on the Alfred Health website when actual environmental performance data for 2018–19 is available.

Building automation and control for the chiller and cooling tower infrastructure at The Alfred was completed during the year. It will enable site infrastructure to be more integrated, and produce positive outcomes regarding chemical usage and energy consumption. At Caulfield Hospital, we made significant energy savings by upgrading infrastructure associated with the hydrotherapy pool.

We were awarded a $15,000 Sustainability in Healthcare Innovation Grant by the DHHS to develop a project toolkit for developing outdoor meeting spaces.

In partnership with South East Water, drinking water dispensers will be installed at each of our hospital sites in 2019–20, as part of their Choose Tap campaign to encourage users to drink tap water. Paper straws will also be made available to wards looking for an environmentally friendly alternative to plastic. Old thermal hand dryers and paper towel dispensers in public areas are being replaced with jet air hand dryers, to improve energy efficiency and reduce paper towel use.

At Sandringham Hospital, we started our 'War on Waste' trial, centred around a clear and consistent waste management system to make responsible waste disposal easy for staff and our community.

Our suture package recycling program in operating suites was presented at the ANMF 2019 Health and Environmental Sustainability Conference.

We changed our Environmental Sustainability Committee terms of reference to include representatives from our 'Green Teams' in committee membership to gain perspective from frontline staff and to improve transparency.

Alfred Health also participated in 'Waste education in healthcare', a Department of Health and Human Services project which aims to achieve environmental and financial benefits in public health waste management.

Key projects included being a pilot health service for single-use metal instrument recycling. This has reduced sharps container use by up to 25 per cent at other health services, with a potential $100,000 annual saving.

Governance

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

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

The Board comprises up to nine independent non-executive directors who are elected for a period of up to three years and can be re-elected to serve for up to nine years. The Board had nine directors in 2018–19.

Objectives, functions, power and duties

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

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

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

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

Governance (continued)

Board of Directors as at 30 June 2019

Mr Michael Gorton AM (Chair) 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 Committee

Mr Gardner is a lawyer whose consultancy has included law reform, advance care planning and public administration. He is the Chair of the Board of Mind Australia Ltd, an NGO providing community mental health services and 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
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 LIV's 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 newsletter of the Australian Infant Mental Health Association and served as the registrar representative on the Faculty of Child and Adolescent Psychiatry within the Royal Australian and New Zealand College of Psychiatrists.

Ms Miriam Suss OAM BA MSW

Chair: Community Advisory Committee
Member: 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, Master of Health Management

Chair: Quality Committee
Member: Finance and Remuneration committees

Dr Victoria Atkinson is a cardiac surgeon and former Chief Medical Officer at St Vincent's Health Australia. In 2018 she became the national Chief Medical Officer of Healthscope Ltd.

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 focussed and harm-free care.

Dr Atkinson is the Deputy Chair of the Board for Better Care Victoria and a Board Member of the Royal Flying Doctor Service (Victoria). She holds an MBBS, FRACS, AFRACMA and a Masters of Health Management, 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 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 consulting 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, a Director and Committee 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).

Mrs Sally Campbell

LLB/BA

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

Mrs Campbell is an experienced business leader with extensive executive experience gained in commercial and government industries in Australia, New Zealand and the United Kingdom. Mrs Campbell's background includes working in health, 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 operational performance and managing change in large, complex and politically sensitive organisations. Mrs 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, Mrs Campbell retired from Melbourne Health (as the Executive Director of Corporate and Information Services) and also concluded an executive role managing strategy and planning at Barwon Health at the end of June. Mrs Campbell is also a director of Forensicare.

Mrs Campbell has degrees in law and arts and is a graduate of the AICD.

Governance (continued)

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

Finance Committee

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

Primary Care and Population Health Advisory Committee

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

- the health service 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

The People and Culture Committee assists 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 the health service 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 2019

Audit Committee

Mrs Sally Campbell (Chair)
Ms Kaye McNaught
Ms Anne Howells
Mr Michael Gorton AM (ex officio)

Finance Committee

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

Community Advisory Committee

Ms Miriam Suss (Chair)
Dr Benjamin Goodfellow
Mr Keven Boyce
Ms Kay Currie
Ms Carol Gordon
Mr John Hawker
Mr Stuart Martin
Mr Barry Westhorpe
Ms Irene Havryluk-Davies
Ms Judith Carruthers

Primary Care and Population Health Advisory Committee

Dr Benjamin Goodfellow (Chair)
Mrs Sally Campbell
Ms Melanie Eagle
Professor Andrew Way AM
Associate Professor Peter Hunter
Associate Professor Simon Stafrace
Dr Elizabeth Deveny
Ms Tracey Limpens
Mr Damian Ferrie

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 AM
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)
Dr Victoria Atkinson
Ms Melanie Eagle
Mr Julian Gardner

Governance (continued)

Risk management

Alfred Health has an integrated clinical and enterprise risk register which consisted of 33 open risks at 30 June 2019.

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 Victorian Health Incident Management System's data set, is an integral component of our risk management framework. Regular training, information and support is provided for staff on the use of the incident reporting database 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 is 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 Comprehensive Care 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 AM RN BSc (Hons) MBA FAICD FCHSM

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, Professor Way had an extensive career in the NHS in the United Kingdom, latterly as CEO of the Royal Free Hampstead NHS Trust.

Chief Operating Officer

Ms Simone Alexander MHAdmin, MClinNurs, BN

Ms Alexander has more than 20 years' experience in the healthcare sector and has served as Alfred Health's Chief Operating Officer role since December 2017.

Ms Alexander is responsible for the management and performance of the health services' clinical operations. She has spent the last eight years as a Clinical Service Director at Alfred Health, most recently in the Emergency and Acute Medicine program. In this role, she was responsible for meeting national emergency access targets and service development. She has also taken part in advising on trauma centre development in other countries, including Saudi Arabia.

Ms Alexander has master's 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 Allied Health Services, Non-Clinical Support Services and provides professional leadership to the Alfred Health nursing workforce. She also provides leadership for Alfred Health's corporate social responsibility program including consumer participation, patient experience, population health and environmental sustainability. Ms Weir-Phyland also oversees site coordination of Sandringham and Caulfield hospitals.

She has worked in a number of management and senior management positions in both Canada and Australia in areas of education, clinical governance, acute, subacute and residential care services.

Ms Weir-Phyland's external appointments include Adjunct Professor School of Nursing and Midwifery, Faculty of Health Deakin University and board member of the Australian Commission on Safety and Quality in Healthcare.

Deputy Chief Executive Officer and 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.

He 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 Government. He 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 (AHSC).

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

Executive Director, Finance

Mr Peter Joyce BCom FCPA

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 seven 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 Amy McKimm BAppSc (Hons)
ProfCert Health Systems Management

As Executive Director of Information Development (IDD), Ms McKimm is responsible for supporting Alfred Health through its digital transformation. This includes the strategic use of data and systems so clinical care at the bedside is performed with all the information required for excellence.

IDD covers all aspects of IT infrastructure and support, projects, applications development, security, privacy, and the ongoing development of the electronic medical record which is a strategic focus for the organisation. Ms McKimm recently led Alfred Health's electronic Timely Quality Care (eTQC) Program which went live in October 2018.

She has worked in a number of clinical and operational roles in health services in Australia and the United Kingdom. Throughout her career Ms McKimm's interest has been in using technology, data and digital platforms to support healthcare to adapt and change, to better meet the needs of patients and the broader community. In 2018, she completed Leadership Victoria's Williamson Leadership Program.

General Counsel

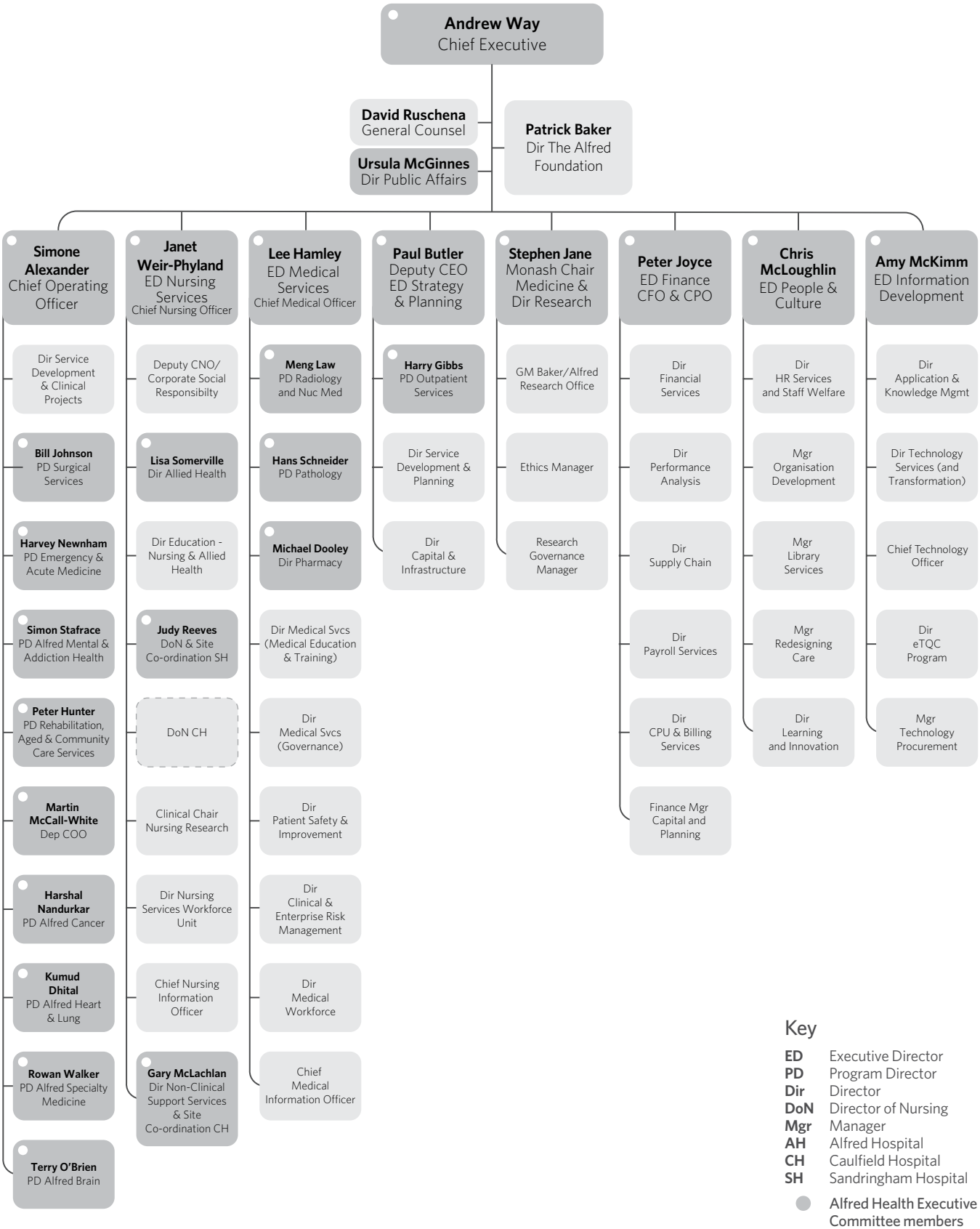
Mr David Ruschena PhD LLB (Hons)/BSc (Hons)

Responsible for providing legal advice across Alfred Health.

Governance (continued)

Organisational structure

June 2019



Legislation change

The Voluntary Assisted Dying Act commenced operation on 19 June 2019. The Act creates a pathway that eligible patients can utilise if they wish to gain access to a medication that will allow them to end their life at a time they choose. The legislation is aimed at ensuring that patients can control their life journey, and therefore complements the Medical Treatment Planning and Decisions Act, which commenced operation on 12 March 2018.

Eligibility for voluntary assisted dying is limited to competent, adult patients who have been living in Victoria for 12 months or more, and who have an advanced disease that is:

- incurable
- advanced, progressive and terminal
- likely to cause their death within six months (or within 12 months for neurodegenerative diseases like motor neurone disease)
- causing the person suffering that cannot be relieved in a manner that is tolerable to them.

Patients' eligibility and competence is assessed by two independent and experienced medical practitioners. Each practitioner must confirm the patient's eligibility and competence, and that the patient's decision to access voluntary assisted dying is continuing.

In consultation with staff, we have:

- undertaken an extensive education campaign to maximise staff familiarity with the legislation
- created Alfred Health–specific guidelines to assist staff to deliver quality care to patients in this area
- formalised referral pathways for our stakeholders in the broader community.

General information

Directions of the Assistant Treasurer

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

Statement on National Competition Policy

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).

In addition, we are rolling out a series of animated e-learning modules to assist our people to apply these principles more easily in their day-to-day working lives.

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 2018–2019

	2018–19
Applications received	2,521
Applications granted (full)	2,154
Applications granted (part)	12
Access denied	3
No documents	7
Other	12
Not finalised	333

Not finalised 2017–2018	169
Access granted in full	165
Access granted in part	0
Access denied	0
Other	4

Governance (continued)

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
Destravis Australia Pty Ltd	Subacute mental health masterplan and feasibility assessment	73,660	67,188	6,472
Johnstaff Projects (Vic) Pty Ltd	Construction procurement framework project	31,000	29,775	1,225
Lyons Architects	Masterplan and feasibility study	403,220	403,220	–
Mercer Consulting (Australia) Pty Ltd	Business manager review	50,120	50,120	–
Safetyworks Group Pty Ltd	Safety and wellbeing behaviour change program	67,200	67,200	–
Top Anderson and Associates	Professional financial services	44,245	44,245	–
Total		**669,445**	**665,248**	**7,697**

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 accurately reflects actual performance. Alfred Health has critically reviewed these controls and processes during the year.

Professor Andrew Way AM
Chief Executive

Melbourne
4 September 2019

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 AM
Chair

Melbourne
4 September 2019

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 AM
Chief Executive

Melbourne
4 September 2019

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 AM
Chief Executive

Melbourne
4 September 2019

Integrity, fraud and corruption

I, Andrew Way, certify that Alfred Health has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at Alfred Health during the year.

Professor Andrew Way AM
Chief Executive

Melbourne
4 September 2019

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 Assistant Treasurer under the *Financial Management Act 1994*, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2019 and the financial position of Alfred Health and the Consolidated Entity at 30 June 2019.

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 4 September 2019.

Mr Michael Gorton AM
Board Chair

Melbourne
4 September 2019

Prof Andrew Way AM
Accountable Officer

Melbourne
4 September 2019

Mr Peter Joyce
Chief Finance & Accounting Officer

Melbourne
4 September 2019

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.

Audit report

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 sheets as at 30 June 2019 • consolidated entity and health service comprehensive operating statements for the year then ended • consolidated entity and health service statements of changes in equity for the year then ended • consolidated entity and health service cash flow statements for the year then ended • notes to the financial statements, including 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 2019 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.
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
5 September 2019

Travis Derricott
as delegate for the Auditor-General of Victoria

Comprehensive operating statement

for the financial year ended 30 June 2019

	Note	Parent entity 2019 $'000	Parent entity 2018 $'000	Consolidated 2019 $'000	Consolidated 2018 $'000
Income from transactions					
Operating activities	2.1	1,311,215	1,224,668	1,310,012	1,225,005
Non-operating activities	2.1	3,710	3,522	5,018	4,379
Total income form transactions		**1,314,925**	**1,228,190**	**1,315,030**	**1,229,384**
Expenses from transactions					
Employee expenses	3.1	(872,229)	(812,695)	(872,229)	(812,695)
Supplies and consumables	3.1	(290,220)	(280,556)	(290,220)	(280,556)
Finance costs	3.1	(1,188)	(1,474)	(1,188)	(1,474)
Other operating expenses	3.1	(110,968)	(102,983)	(112,371)	(103,938)
Depreciation and amortisation	3.1	(77,714)	(66,769)	(77,714)	(66,769)
Total expenses from transactions		**(1,352,319)**	**(1,264,477)**	**(1,353,722)**	**(1,265,432)**
Net result from transactions - net operating balance		**(37,394)**	**(36,287)**	**(38,692)**	**(36,048)**
Other economic flows included in net result					
Net gain/(loss) on sale of non-financial assets	3.2	(126)	(515)	(126)	(515)
Net gain/(loss) on financial instruments at fair value	3.2	(5,130)	3,046	(4,971)	3,145
Other gain/(loss) from other economic flows	3.2	(1,682)	39	(1,682)	39
Total other economic flows included in net result		**(6,938)**	**2,570**	**(6,779)**	**2,668**
Net result for the year		**(44,332)**	**(33,717)**	**(45,471)**	**(33,380)**
Other comprehensive income					
Items that will not be reclassified to net result					
Changes in property, plant and equipment revaluation surplus	4.3(b)	313,658	62,147	313,658	62,147
Items that may be reclassified subsequently to net result					
Changes to financial assets available-for-sale revaluation surplus		-	2,637	-	3,054
Total other comprehensive income		**313,658**	**64,784**	**313,658**	**65,201**
Comprehensive result for the year		**269,326**	**31,067**	**268,187**	**31,821**

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

Balance sheet

as at 30 June 2019

	Note	Parent entity 2019 $'000	Parent entity 2018 $'000	Consolidated 2019 $'000	Consolidated 2018 $'000
Current assets					
Cash and cash equivalents	6.2	15,468	54,825	15,707	54,880
Receivables	5.1	51,650	49,600	52,020	49,755
Inventories		10,150	10,177	10,150	10,177
Other assets		3,353	2,682	3,368	2,682
Total current assets		**80,621**	**117,284**	**81,245**	**117,494**
Non-current assets					
Receivables	5.1	23,376	16,291	23,376	16,291
Investments and other financial assets	4.1	45,840	46,613	59,634	61,963
Property, plant & equipment	4.3(a)	1,279,018	968,951	1,279,018	968,951
Intangible assets	4.5	17,790	10,973	17,790	10,973
Total non-current assets		**1,366,024**	**1,042,828**	**1,379,818**	**1,058,178**
Total assets		**1,446,645**	**1,160,112**	**1,461,063**	**1,175,672**
Current liabilities					
Payables	5.2	106,600	108,503	106,717	108,622
Borrowings	6.1	2,701	2,597	2,701	2,597
Provisions	3.4	195,677	178,407	195,677	178,407
Other liabilities	5.3	69	76	69	76
Total current liabilities		**305,047**	**289,583**	**305,164**	**289,702**
Non-current liabilities					
Borrowings	6.1	12,518	15,182	12,518	15,182
Provisions	3.4	38,474	33,558	38,474	33,558
Total non-current liabilities		**50,992**	**48,740**	**50,992**	**48,740**
Total liabilities		**356,039**	**338,323**	**356,156**	**338,442**
Net assets		**1,090,606**	**821,789**	**1,104,907**	**837,230**
Equity					
Property, plant & equipment revaluation surplus	4.3(f)	949,526	635,868	949,526	635,868
Financial assets available for sale revaluation surplus		-	25,382	-	26,333
General purpose surplus		63,804	77,741	63,804	77,741
Restricted specific purpose surplus		50,096	48,636	64,397	62,833
Contributed capital		324,134	324,134	324,134	324,134
Accumulated deficits		(296,954)	(289,972)	(296,954)	(289,679)
Total equity		**1,090,606**	**821,789**	**1,104,907**	**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 2019

Consolidated	Note	Property, plant & equipment revaluation surplus $'000	Financial assets available for sale revaluation surplus $'000	General purpose surplus $'000	Restricted specific purpose surplus $'000	Contributed capital $'000	Accumulated (deficits)	Total $'000
Balance at 1 July 2017		**573,721**	**23,279**	**70,991**	**63,521**	**324,134**	**(250,237)**	**805,409**
Net result for the year		-	-	-	-	-	(33,380)	(33,380)
Other comprehensive income for the year		62,147	3,054	-	-	-	-	65,201
Transfer from accumulated surplus		-	-	6,750	(688)	-	(6,062)	-
Balance at 30 June 2018		**635,868**	**26,333**	**77,741**	**62,833**	**324,134**	**(289,679)**	**837,230**
Opening balance adjustment on adoption of AASB9	8.10	-	(26,333)	-	-	-	25,823	(510)
Restated balance at 1 July 2018		**635,868**	**-**	**77,741**	**62,833**	**324,134**	**(263,856)**	**836,720**
Net result for the year		-	-	-	-	-	(45,471)	(45,471)
Other comprehensive income for the year		313,658	-	-	-	-	-	313,658
Transfer from accumulated surplus		-	-	(13,937)	1,564	-	12,373	-
Balance at 30 June 2019		**949,526**	**-**	**63,804**	**64,397**	**324,134**	**(296,954)**	**1,104,907**

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

Parent	Note	Property, plant & 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 (deficits)	Total $'000
Balance at 1 July 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**
Opening balance adjustment on adoption of AASB9	8.10	-	(25,382)	-	-	-	24,872	(510)
Restated balance at 1 July 2018		**635,868**	**-**	**77,741**	**48,636**	**324,134**	**(265,099)**	**821,280**
Net result for the year		-	-	-	-	-	(44,332)	(44,332)
Other comprehensive income for the year		313,658	-	-	-	-	-	313,658
Transfer from accumulated surplus		-	-	(13,937)	1,460	-	12,477	-
Balance at 30 June 2019		**949,526**	**-**	**63,804**	**50,096**	**324,134**	**(296,954)**	**1,090,606**

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

Cash flow statement

for the financial year ended 30 June 2019

	Note	Parent entity 2019 $'000	Parent entity 2018 $'000	Consolidated 2019 $'000	Consolidated 2018 $'000
Cash flows from operating activities					
Operating grants from government		1,053,242	1,008,776	1,053,242	1,008,776
Capital grants from government		25,114	16,041	25,114	16,041
Patient fees received		46,224	46,787	46,224	46,787
Private practice fees received		65,725	58,698	65,725	58,698
Donations and bequests received		14,965	14,505	13,271	14,505
GST received from / (paid to) ATO		31,324	33,210	31,324	32,553
Interest received		764	1,155	764	1,155
Car park income received		10,702	10,178	10,702	10,178
Other capital receipts		4,208	3,297	4,208	3,297
Other receipts		71,650	66,277	71,863	66,602
Total receipts		**1,323,918**	**1,258,924**	**1,322,437**	**1,258,592**
Employee expenses paid		(842,834)	(768,896)	(842,834)	(768,896)
Non salary labour costs		(11,143)	(12,105)	(11,143)	(12,105)
Payments for supplies and consumables		(398,598)	(391,812)	(399,519)	(391,858)
Payments for repairs and maintenance		(29,390)	(27,039)	(29,390)	(27,039)
Finance costs		(1,054)	(1,293)	(1,054)	(1,293)
Total payments		**(1,283,019)**	**(1,201,145)**	**(1,283,940)**	**(1,201,191)**
Net cash flow from operating activities	8.1	**40,899**	**57,779**	**38,497**	**57,401**
Cash flows from investing activities					
Purchase of non-financial assets		(81,065)	(42,302)	(81,066)	(42,302)
Proceeds from disposal of investments		3,406	2,167	5,993	2,362
Net cash flows (used in) investing activities		**(77,659)**	**(40,135)**	**(75,073)**	**(39,940)**
Cash flows from financing activities					
Proceeds from borrowings		-	2,000	-	2,000
Repayment of borrowings		(2,597)	(1,277)	(2,597)	(1,277)
Net cash flows from/ (used in) financing activities		**(2,597)**	**723**	**(2,597)**	**723**
Net increase/(decrease) in cash and cash equivalents held		**(39,357)**	**18,367**	**(39,173)**	**18,184**
Cash and cash equivalents at beginning of financial year		**54,825**	**36,458**	**54,880**	**36,696**
Cash and cash equivalents at end of financial year	6.2	**15,468**	**54,825**	**15,707**	**54,880**

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

Notes to the financial statements

30 June 2019

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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 2019. The purpose of the report is to provide users with information about Alfred Health's stewardship of resources entrusted to it.

(a) Basis of preparation

The financial statements are prepared in accordance with Australian Accounting Standards (AASs) and relevant Financial Reporting Directions (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.

(b) 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 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 FRDs issued by the Department of Treasury and Finance, and relevant Standing Directions (SDs) authorised by the Assistant Treasurer.

Alfred Health is a not-for-profit entity and therefore applies the additional Australian (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 4 September 2019.

(c) 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.

(d) 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 2019, and the comparative information presented in these financial statements for the year ended 30 June 2018.

The financial statements are prepared on a going concern basis (refer to note 8.9 economic dependency).

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 underlying assumptions are reviewed on an ongoing basis. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

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

- The fair value of land, buildings and plant and equipment (refer to note 4.3 property, plant and equipment);
- Defined benefit superannuation expense (refer to note 3.5 superannuation); and
- Employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to note 3.4 employee benefits in the balance sheet).

Note 1 – Summary of significant accounting policies (continued)

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.

(e) 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 2019.
- Control exists when Alfred Health has the power to govern the financial and operating policies of an organisation 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 8.8.
- The parent entity is not shown separately in the notes except where stated.

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.

Intersegment transactions

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

(f) Equity

Contributed capital

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 Alfred Health.

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.

Property, plant and equipment revaluation surplus

The property, plant and equipment revaluation surplus arises on the revaluation of infrastructure, land and buildings. The revaluation surplus is not normally transferred to accumulated surpluses/(deficits) on de-recognition of the relevant asset.

Financial assets available-for-sale revaluation surplus

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

Financial assets classified as available-for-sale in accordance with AASB 139 *Financial Instruments: Recognition and Measurement* have been reclassified at 1 July 2018 in accordance with AASB 9 *Financial Instruments*. As a result, the financial assets available-for-sale revaluation surplus has been transferred to accumulated surpluses/(deficits). Refer to note 8.10 changes in accounting policy.

General purpose surplus

The general purpose surplus is established where Alfred Health has generated funds internally for a specific purpose.

Restricted specific purpose surplus

The restricted specific 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.

(g) Comparatives

Where applicable, the comparative figures have been restated to align with the presentation in the current year. Figures have been restated at notes 2.1, 3.1, 3.2, 3.4, 4.3 and 5.2.

Note 2 – Funding delivery of our services account

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

To enable Alfred Health to fulfil its objective it receives income based on parliamentary appropriations, and is predominately funded by accrual based grant funding for the provision of outputs. Alfred Health also receives income from the supply of services.

Structure

2.1 Income from transactions

Note 2.1 – Income from transactions

	Consolidated 2019 $'000	Consolidated 2018 $'000
Government grants–operating	1,071,957	1,008,937
Government grants–capital	25,114	16,041
Other capital purpose income (including capital donations)	15,057	14,913
Patient fees	46,210	43,980
Private practice fees	60,003	58,001
Commercial activities	12,774	11,822
Other revenue from operating activities (including non-capital donations)	78,897	71,311
Total income from operating activities	**1,310,012**	**1,225,005**
Other interest and investment income	5,018	4,379
Total income from non-operating activities	**5,018**	**4,379**
Total Income from transactions	**1,315,030**	**1,229,384**

Note 2.1 – Income from transactions (continued)

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 on the balance sheet.

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

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

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.

Non-cash contributions from the Department of Health and Human Services

The Department of Health and Human Services makes some payments on behalf of health services as follows:

- The Victorian Managed Insurance Authority non-medical indemnity insurance payments are 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 long service leave funding arrangements set out in the relevant Department of Health and Human Services Hospital Circular.

Patient fees

Patient fees are recognised as revenue on an accrual basis.

Private practice fees

Private practice fees are recognised as revenue on an accrual basis.

Revenue from commercial activities

Revenue from commercial activities is recognised on an accrual basis. Commercial activity revenue includes car park revenue, ethics review fees to recover associated costs, 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. Dividends represent the income arising from Alfred Health and its controlled entities' investments in financial assets.

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.

Note 3 – The cost of delivering services

This section provides an account of the expenses incurred by Alfred Health 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

3.1 Expenses from transactions
3.2 Other economic flows included in net result
3.3 Analysis of expense and revenue by internally managed and restricted specific purpose funds
3.4 Employee benefits in the balance sheet
3.5 Superannuation

Note 3.1 – Expenses from transactions

	Consolidated 2019 $'000	Consolidated 2018 $'000
Employee expenses		
Salaries and wages	678,521	633,290
On-costs	175,088	159,717
Agency expenses	7,806	8,378
Fee for service medical officer expenses	3,337	3,746
Workcover premium	7,477	7,564
Total employee expenses	**872,229**	**812,695**
Supplies and consumables		
Drug supplies	136,400	138,416
Medical and surgical supplies (including prostheses)	62,529	63,113
Diagnostic and radiology supplies	13,260	12,585
Other supplies and consumables	78,031	66,442
Total supplies and consumables	**290,220**	**280,556**
Finance costs		
Finance costs	1,188	1,474
Total finance costs	**1,188**	**1,474**
Other operating expenses		
Fuel, light, power and water	9,774	8,791
Repairs and maintenance	17,057	16,060
Maintenance contracts	17,860	16,135
Medical indemnity insurance	10,336	10,131
Other administrative expenses	56,134	52,613
Expenditure for capital purposes	1,210	208
Total other operating expenses	**112,371**	**103,938**
Other non-operating expenses		
Depreciation and amortisation (refer note 4.4)	77,714	66,769
Total other non-operating expenses	**77,714**	**66,769**
Total expenses from transactions	**1,353,722**	**1,265,432**

Note 3.1 – Expenses from transactions (continued)

Expense recognition

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

Employee expenses

Employee expenses include:

- Salaries and wages (including fringe benefits tax, leave entitlements, terminations payments);
- On-costs (including superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans);
- Agency expenses;
- Fee for service medical officer expenses; and
- WorkCover premiums.

Supplies and consumables

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.

Finance costs

Finance costs include:

- Interest on bank overdrafts and short-term and long-term borrowings (interest expense is recognised in the period in which it is incurred);
- Amortisation of discounts or premiums relating to borrowings;
- Amortisation of ancillary costs incurred in connection with the arrangement of borrowings; and
- Finance charges in respect of finance leases which are recognised in accordance with AASB 117 *Leases*.

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.

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 costs such as:

- Fuel, light and power
- Repairs and maintenance
- Other administrative expenses
- Expenditure for capital purposes (represents expenditure related to the purchase of assets that are below the capitalisation threshold); and
- The Department of Health and Human Services also makes certain payments on behalf of Alfred Health. These amounts have been brought to account as grants in determining the operating result for the year by recording them as revenue and also recording the related expense.

Non-operating expenses

Other non-operating expenses generally represent costs incurred outside the normal operations such as depreciation and amortisation, and assets and services provided free of charge or for nominal consideration.

Note 3.2 – Other economic flows included in net result

	Consolidated 2019 $'000	Consolidated 2018 $'000
Net (loss) on non-financial assets		
Net (loss) on disposal of property plant and equipment	(126)	(515)
Total (loss) on non-financial assets	**(126)**	**(515)**
Net gain/(loss) on financial instruments at fair value		
Allowance for impairment losses of contractual receivables	(5,117)	(4,454)
Net gain on disposal of financial instruments	146	99
Other gains from other economic flows on financial instruments	-	7,500
Total net gain/(loss) on financial instruments at fair value	**(4,971)**	**3,145**
Other gain/(loss) from other economic flows		
Net gain/(loss) arising from revaluation of long service liability	(1,682)	39
Total other gain/(loss) from other economic flows	**(1,682)**	**39**
Total gain/(loss) from economic flows included in net result	**(6,779)**	**2,668**

Other economic flows are changes in the volume or value of assets or liabilities that do not result from transactions. Other gain/(loss) from other economic flows include the gain or loss from:

- The revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- Reclassified amounts relating to available-for-sale financial instruments from the reserves to net result due to a disposal or derecognition of the financial instrument. This does not include reclassification between equity accounts due to machinery of government changes or 'other transfers' of assets.

Net gain/(loss) on non-financial assets

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

- Impairment of non-financial physical assets (refer to note 4.3 property, plant and equipment);
- Net gain/(loss) on disposal of non-financial assets; and
- 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 at fair value

Net gain/(loss) on financial instruments at fair value includes:

- Realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- Impairment and reversal of impairment for financial instruments at amortised cost (refer to note 4.1 investments and other financial assets); and
- Disposals of financial assets and derecognition of financial liabilities.

Other gain/(loss) from other economic flows

Other gain/(loss) 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.

Note 3.3 – Analysis of expense and revenue by internally managed and restricted specific purpose funds

	Expense		Revenue	
	Consolidated 2019 $'000	Consolidated 2018 $'000	Consolidated 2019 $'000	Consolidated 2018 $'000
Commercial activities				
Private practice and other patient activities	5,660	3,881	6,628	5,030
Car park	3,385	3,215	10,673	10,274
Property expense/revenue	184	117	228	229
Other activities				
Fundraising and community support	2,790	3,031	13,271	14,667
Research and scholarship	26,284	27,376	25,356	24,827
Other	15,144	12,480	18,746	18,456
Total expenses and revenue	**53,447**	**50,100**	**74,902**	**73,483**

Note 3.4 – Employee benefits in the balance sheet

	Consolidated 2019 $'000	Consolidated 2018 $'000
Current provisions		
Employee benefits [i]		
Accrued days off		
- Unconditional and expected to be settled wholly within 12 months [ii]	2,073	1,908
Annual leave		
- Unconditional and expected to be settled wholly within 12 months [ii]	63,274	56,888
- Unconditional and expected to be settled after 12 months [iii]	7,293	7,279
Long service leave		
- Unconditional and expected to be settled wholly within 12 months [ii]	10,868	8,585
- Unconditional and expected to be settled after 12 months [iii]	93,912	87,174
	177,420	161,834
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months [ii]	7,532	6,600
- Unconditional and expected to be settled after 12 months [iii]	10,725	9,973
	18,257	16,573
Total current provisions	**195,677**	**178,407**
Non-current provisions		
Conditional long service leave [iii]	34,766	30,315
Provisions related to employee benefit on-costs [iii]	3,708	3,243
Total non-current provisions	**38,474**	**33,558**
Total provisions	**234,151**	**211,965**

(a) Employee benefits and related on-costs

Current employee benefits and related on-costs		
Unconditional long service leave entitlements	115,956	105,858
Annual leave entitlements	77,427	70,437
Accrued days off	2,294	2,112
Non-current employee benefits and related on-costs		
Conditional long service leave entitlements (ii)	38,474	33,558
Total employee benefits and related on-costs	**234,151**	**211,965**

(b) Movement in provisions

Movement in long service leave:		
Balance at start of year	**139,416**	**124,359**
Provision made during the year	26,690	24,270
Settlement made during the year	(11,677)	(9,213)
Balance at end of year	**154,429**	**139,416**

(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 nominal amounts
(iii) The amounts disclosed are discounted to present values.

Note 3.4 – Employee benefits in the balance sheet (continued)

(c) Movement in on-costs provision

	Consolidated 2019 $'000	Consolidated 2018 $'000
Balance at start of year	**19,815**	**17,545**
Additional provisions recognised	1,972	2,277
Unwinding of discount and effect of changes in the discount rate	177	(7)
Balance at end of year	**21,964**	**19,815**

Employee benefit recognition

Provision is made for benefits accruing to employees in respect of 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.

Annual leave and accrued days off

Liabilities for 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 annual leave, and accrued days off are measured at:

- Nominal 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:

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

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

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

On-costs related to employee expenses
Provisions for on-costs such workers compensation and superannuation are recognised separately from provisions for employee benefits.

Note 3.5 – Superannuation

	Contribution paid or payable for the year		Contribution outstanding at year end	
	Consolidated 2019 $'000	Consolidated 2018 $'000	Consolidated 2019 $'000	Consolidated 2018 $'000
Defined benefit plans [i]:				
Health Super	704	727	108	120
Defined contribution plans:				
First State	33,139	31,481	2,474	2,408
Vic Super	184	163	12	15
Hesta	23,387	21,174	1,901	1,695
Other	10,477	8,031	2,945	2,397
Total superannuation	**67,891**	**61,576**	**7,440**	**6,635**

(i) The basis 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 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.

Defined contribution superannuation plans

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

Note 4 – Key assets to support service delivery

Alfred Health 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	
	2019 $'000	**2018 $'000**
Non-current assets		
Financial assets at fair value through the net result		
Managed investment schemes	59,634	-
Available-for-sale		
Managed investment schemes	-	61,963
Total investments and other financial assets	**59,634**	**61,963**
Represented by:		
Investments held in trust	59,634	61,963
Total investments and other financial assets	**59,634**	**61,963**

Alfred Health measures its managed investment schemes at fair value through net result in 2019. Unless such assets are part of a disposal group held for sale, all managed investment schemes are classified as non-current. Accounting policies for investments and other financial assets are disclosed in note 7.1 financial instruments.

Note 4.2 – Interests in subsidiary

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

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

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

(a) The investor has power over the investee;

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

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

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

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

At 30 June 2019, the Trust had net assets of $14.301m (2018: $15.440m) 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

	Consolidated 2019 $'000	Consolidated 2018 $'000
Land		
Crown land at fair value	273,216	237,347
Total land	**273,216**	**237,347**
Buildings		
Buildings under construction at cost	11,241	4,644
Buildings at fair value	901,055	638,910
Total buildings	**912,296**	**643,554**
Leasehold improvements at cost		
Leasehold improvements	5,031	5,025
Less accumulated amortisation	(1,549)	(1,388)
Total leasehold improvements	**3,482**	**3,637**
Plant & equipment, furniture & fittings		
Medical equipment at fair value	181,988	161,098
Less accumulated depreciation	(122,344)	(113,413)
Total medical equipment	59,644	47,685
Computers & communication equipment at fair value	57,934	53,345
Less accumulated depreciation	(52,933)	(49,841)
Total computers & communication equipment	5,001	3,504
Furniture & fittings at fair value	7,307	7,234
Less accumulated depreciation	(6,601)	(6,386)
Total furniture & fittings	706	848
Other plant and equipment at fair value	55,099	53,326
Less accumulated depreciation	(41,488)	(38,912)
Total other plant and equipment	13,611	14,413
Plant & equipment – work in progress at cost	11,062	17,963
Total plant & equipment and furniture & fittings	**90,024**	**84,413**
Motor vehicles		
Motor vehicles at fair value	60	60
Less accumulated depreciation	(60)	(60)
Total motor vehicles	**-**	**-**
Total property, plant and equipment	**1,279,018**	**968,951**

Note 4.3 – Property, plant and equipment (continued)

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

Consolidated	Land $'000	Buildings $'000	Leasehold improvements $'000	Medical equipment $'000	Computers and communication equipment $'000	Furniture and fittings $'000	Other plant and equipment $'000	Total $'000
Balance at 1 July 2017	**237,347**	**600,782**	**3,148**	**40,798**	**4,754**	**1,111**	**42,135**	**930,075**
Additions / (transfers)		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 1 July 2018	**237,347**	**643,554**	**3,637**	**47,685**	**3,504**	**848**	**32,376**	**968,951**
Additions / (transfers)	-	44,923	6	22,232	4,588	72	(5,027)	66,794
Disposals (WDV)	-		-	(126)	-	-	-	(126)
Revaluation increments	35,869	277,789	-	-	-	-	-	313,658
Depreciation (note 4.4)	-	(53,970)	(160)	(10,147)	(3,091)	(215)	(2,676)	(70,259)
Balance at 30 June 2019	**273,216**	**912,296**	**3,482**	**59,644**	**5,001**	**706**	**24,673**	**1,279,018**

Land and buildings carried at valuation

The Valuer-General Victoria undertook a valuation of all Alfred Health-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 2019. The fair value of buildings was adjusted by a managerial revaluation in 2018. The revaluation was based on the latest Valuer-General Victoria indices provided by the Department of Treasury and Finance.

(c) Fair value measurement hierarchy for assets as at 30 June 2019

		Fair value measurement at end of reporting period using:		
	Consolidated carrying amount $'000	Level 1 $'000	Level 2 $'000	Level 3 $'000
Land at fair value				
Specialised land	273,216	-	-	273,216
Total land at fair value	**273,216**	**-**	**-**	**273,216**
Buildings at fair value				
Specialised buildings	901,055	-	-	901,055
Total buildings at fair value	**901,055**	**-**	**-**	**901,055**
Plant & equipment, furniture & fittings at fair value				
Medical equipment	59,644	-	-	59,644
Computers & communication equipment	5,001	-	-	5,001
Furniture & fittings	706	-	-	706
Other equipment	13,611	-	-	13,611
Total plant & equipment and furniture & fittings at fair value	**78,962**	**-**	**-**	**78,962**
Total assets at fair value	**1,253,233**	**-**	**-**	**1,253,233**

There have been no transfers between levels during the period.

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

		Fair value measurement at end of reporting period using:		
	Consolidated carrying amount $'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	638,910	-	-	638,910
Total buildings at fair value	**638,910**	**-**	**-**	**638,910**
Plant & equipment, furniture & fittings at fair value				
Medical equipment	47,685	-	-	47,685
Computers & communication equipment	3,504	-	-	3,504
Furniture & fittings	848	-	-	848
Other equipment	14,413	-	-	14,413
Total plant & equipment and furniture & fittings at fair value	**66,450**	**-**	**-**	**66,450**
Total assets at fair value	**942,707**	**-**	**-**	**942,707**

There have been no transfers between levels during the period.

Note 4.3 – Property, plant and equipment (continued)

(d) Reconciliation of level 3 fair value

30 June 2019	Land $'000	Buildings $'000	Plant & equipment, furniture & fittings $'000	Totals $'000
Opening balance	**237,347**	**638,910**	**66,450**	**942,707**
Additions/(disposals)	-	38,326	28,767	67,093
Gains or losses recognised in net result	-	-	(126)	(126)
- Depreciation	-	(53,970)	(16,129)	(70,099)
Subtotal	**237,347**	**623,266**	**78,962**	**939,575**
Items recognised in other comprehensive income				
- Revaluation	35,869	277,789	-	313,658
Subtotal	**35,869**	**277,789**	**-**	**313,658**
Closing balance	**273,216**	**901,055**	**78,962**	**1,253,233**

There have been no transfers between levels during the period.

30 June 2018	Land $'000	Buildings $'000	Plant & equipment, furniture & fittings $'000	Totals $'000
Opening balance	**237,347**	**599,733**	**75,370**	**912,450**
Additions / (disposals)	-	24,569	5,914	30,483
- Depreciation	-	(47,539)	(14,834)	(62,373)
Subtotal	**237,347**	**576,763**	**66,450**	**880,560**
Items recognised in other comprehensive income				
- Revaluation	-	62,147	-	62,147
Subtotal	**-**	**62,147**	**-**	**62,147**
Closing balance	**237,347**	**638,910**	**66,450**	**942,707**

There have been no transfers between levels during the period.

(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 unit Useful life
Vehicles	If there is an active resale market available;	Level 2	Market approach	N/A
	If there is no active resale market available	Level 3	Depreciated replacement cost approach	Cost per unit Useful life

(i) Newly built/acquired assets could be categorised as level 2 assets as depreciation would not be a significant unobservable input (based on the 10% materiality threshold).

(ii) CSO adjustment of 20% to 50% 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 2019.

(f) Property, plant and equipment revaluation surplus

	Consolidated 2019 $'000	Consolidated 2018 $'000
Property, plant and equipment revaluation surplus		
Balance at the beginning of the reporting period	635,868	573,721
Revaluation increment		
- Land (refer note 4.3(b))	35,869	-
- Buildings (refer note 4.3(b))	277,789	62,147
Balance at the end of the reporting period*	**949,526**	**635,868**
* Represented by:		
- Land	223,952	188,083
- Buildings	725,574	447,785
	949,526	**635,868**

Note 4.3 – Property, plant and equipment (continued)

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. 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* and FRD 103H *Non-financial physical assets*, 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.

Revaluations of non-current physical assets

Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103H *Non-current physical assets*. This revaluation process normally occurs at least every five years, based upon the asset's classification of the functions of government categories, 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 103H, Alfred Health's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Fair value measurement

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

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.

Valuation hierarchy

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

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

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.

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.

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 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 Urbis Valuations as agent for the Valuer-General Victoria 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 2019.

In accordance with FRD 103H 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.

There were no changes in valuation techniques throughout the period to 30 June 2019.

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

Motor vehicles

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

Note 4.4 – Depreciation and amortisation

	Consolidated 2019 $'000	Consolidated 2018 $'000
Depreciation		
Buildings	53,970	47,539
Medical equipment	10,147	9,197
Computers and communication equipment	3,091	2,424
Furniture and fittings	215	262
Other plant and equipment	2,676	2,951
Leasehold improvements	160	152
Total depreciation	**70,259**	**62,525**
Amortisation		
Computer software	7,455	4,244
Total amortisation	**7,455**	**4,244**
Total depreciation and amortisation	**77,714**	**66,769**

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.

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.

	2018/19	2017/18
Buildings	25 – 56 years	25 – 56 years
Plant & 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

Note 4.5 – Intangible assets

	Consolidated 2019 $'000	Consolidated 2018 $'000
Computer software at cost	48,145	33,874
Less accumulated amortisation	(30,355)	(22,901)
Total intangible assets	**17,790**	**10,973**

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 2017	**12,686**
Additions	3,324
Disposals	(793)
Amortisation (note 4.4)	(4,244)
Balance at 1 July 2018	**10,973**
Additions	14,272
Disposals	-
Amortisation (note 4.4)	(7,455)
Balance at 30 June 2019	**17,790**

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.

Note 5 – Other assets and liabilities

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

Structure

5.1 Receivables

5.2 Payables

5.3 Other liabilities

Note 5.1 – Receivables

	Consolidated 2019 $'000	Consolidated 2018 $'000
Current		
Contractual		
Inter hospital debtors	2,326	1,834
Trade debtors	9,090	7,893
Patient fees receivable	20,025	19,091
Accrued revenue – other	16,563	20,551
Total	**48,004**	**49,369**
Less allowance for impairment losses of contractual receivables (a)		
Trade debtors	(283)	(215)
Patient fees	(4,442)	(3,683)
Total	**(4,725)**	**(3,898)**
Subtotal	**43,279**	**45,471**
Statutory		
GST receivable	5,865	3,099
Accrued revenue - Department of Health and Human Services	2,876	1,185
Total current receivables	**52,020**	**49,755**
Non-current		
Statutory		
Long service leave–Department of Health and Human Services	23,376	16,291
Total non-current receivables	**23,376**	**16,291**
Total receivables	**75,396**	**66,046**
(a) Movement in the allowance for impairment losses of contractual receivables		
Balance at beginning of year	(3,898)	(3,730)
Opening retained earnings adjustment on adoption of AASB 9	(510)	-
Opening loss allowance	(4,408)	(3,730)
Amounts written off/(on) during the year	5,041	4,285
Increase in allowance recognised in net result	(5,358)	(4,453)
Balance at end of year	**(4,725)**	**(3,898)**

Note 5.1 – Receivables (continued)

Receivables consist of:

- Contractual receivables, which includes mainly debtors in relation to goods and services, and accrued income. These receivables are classified as financial instruments and categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. Alfred Health holds the contractual receivables with the objective to collect the contractual cash flows and therefore subsequently measured at amortised cost using the effective interest method, less any impairment.
- Statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. Alfred Health applies AASB 9 for initial measurement of the statutory receivables and as a result statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition.

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*.

Alfred Health is not exposed to any significant credit risk exposure to any single counterparty or any group of counterparties having similar characteristics. Trade receivables consist of a large number of customers in various geographical areas. Based on historical information about customer default rates, management consider the credit quality of trade receivables that are not past due or impaired to be good.

Impairment losses of contractual receivables

Refer to note 7.1(c) contractual receivables at amortised costs for Alfred Health's contractual impairment losses.

Note 5.2 – Payables

	Consolidated 2019 $'000	Consolidated 2018 $'000
Current		
Contractual		
Trade creditors [(i)]	33,153	27,308
Accrued expenses	40,867	35,364
Accrued salaries and wages	20,934	24,521
Salary packaging	4,323	4,855
Superannuation	7,440	6,635
Total current payables	**106,717**	**98,683**
Statutory		
Department of Health and Human Services [(ii)]	-	9,939
Total statutory payables	**-**	**9,939**
Total payables	**106,717**	**108,622**

(i) The average credit period is 51 days (2018: 50 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.

Note 5.2 – Payables (continued)

Payables consist of:

- Contractual payables classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages represent liabilities for goods and services provided to Alfred Health prior to the end of the financial year that are unpaid; and
- 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.

Maturity analysis of payables

Please refer to note 7.1(b) for the ageing analysis of payables.

Note 5.3 – Other liabilities

	Consolidated 2019 $'000	Consolidated 2018 $'000
Current		
Patient monies held in trust	69	76
Total other liabilities	**69**	**76**
Total monies held in trust represented by the following assets:		
Cash assets (Note 6.2)	69	76

Note 6 – How we finance our operations

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

This section includes disclosures of balances that are financial instruments (such as borrowings and cash balances).

Note: 7.1 provides additional, specific financial instrument disclosure.

Structure

6.1 Borrowings

6.2 Cash and cash equivalents

6.3 Commitments for expenditure

Note 6.1 – Borrowings

	Consolidated 2019 $'000	Consolidated 2018 $'000
Current		
Australian dollar borrowings		
- Department of Health and Human Services [v]	1,000	1,000
- Treasury Corporation Victoria loans [i-iv]	1,701	1,597
Total current borrowings	**2,701**	**2,597**
Non – current		
Australian dollar borrowings		
- Department of Health and Human Services [v]	-	963
- Treasury Corporation Victoria loans [i-iv]	12,518	14,219
Total non-current borrowings	**12,518**	**15,182**
Total borrowings	**15,219**	**17,779**

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 2019 is $3.4m.

(ii) Average interest rate applied during 2018–19 was 6.33% (2018/19: 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 2019 is $10.8m.

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

Department of Health & Human Services

(v) In June 2018, the Department of Health and Human Services provided Alfred Health with an interest free loan of $2m to be repaid by 30 June 2020. Alfred Health made a repayment of $1m in 2019 with an outstanding amount of $1m as at 30 June 2019.

(a) **Maturity analysis of borrowings** – refer to note 7.1(b) for the ageing analysis of borrowings.

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

Borrowings 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.

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.

Note 6.2 – Cash and cash equivalents

	Consolidated 2019 $'000	Consolidated 2018 $'000
Cash on hand	26	33
Cash at bank	15,681	54,847
Total cash and cash equivalents	**15,707**	**54,880**
Represented by		
Cash held for:		
Health service operations	(2,452)	22,857
Pre-funded capital projects	15,466	31,410
Employee salary packaging	2,624	537
Total cash excluding funds held in trust	**15,638**	**54,804**
Monies held in trust on behalf of patients	69	76
Total	**69**	**76**
Total cash and cash equivalents	**15,707**	**54,880**

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and in banks, deposits at call and highly liquid investments with an original maturity date 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. The cash flow statement includes monies held in trust.

Cash for health service operations, which forms part of total cash and cash equivalents, was ($2,452k) (2018: $22,857k). This was primarily due to amounts owed by DHHS, which will be paid in the following financial year, and the timing of GST refunds.

Note 6.3 – Commitments for expenditure

	Consolidated 2019 $'000	Consolidated 2018 $'000
Capital expenditure commitments:		
Not later than one year	24,524	15,543
Total capital expenditure commitments	**24,524**	**15,543**
Other expenditure commitments:		
Not later than one year	50,736	62,116
Later than one year but not later than five years	78,532	125,343
Later than five years	5,415	5,351
Total other expenditure commitments	**134,683**	**192,810**
Non-cancellable operating leases commitments:		
Not later than one year	8,887	5,681
Later than one year but not later than five years	16,145	11,031
Later than five years	5,193	25
Total non-cancellable operating leases commitments	**30,225**	**16,737**
Total commitments for expenditure (inclusive of GST)	**189,432**	**225,090**
Less GST recoverable from the Australian Tax Office	**(17,221)**	**(20,463)**
Total commitments for expenditure (exclusive of GST)	**172,211**	**204,627**

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.

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed at their nominal value and are inclusive of the GST payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant 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 & valuation uncertainties

Alfred Health 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 Alfred Health is related mainly to fair value determination.

Structure

7.1 Financial instruments

7.2 Contingent assets and contingent liabilities

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	Financial assets at amortised cost 2019 $'000	Financial assets at fair value through net result 2019 $'000	Financial liabilities at amortised cost 2019 $'000	Total
Financial assets					
Cash and cash equivalents	6.2	15,707	-	-	15,707
Receivables					
- Trade debtors	5.1	8,807	-	-	8,807
- Other receivables	5.1	34,472	-	-	34,472
Investments and other financial assets					
- Managed investment schemes	4.1	-	59,634	-	59,634
Total financial assets [(i)]		**58,986**	**59,634**	**-**	**118,620**
Financial liabilities					
Payables	5.2	-	-	106,717	106,717
Borrowings	6.1	-	-	15,219	15,219
Other liabilities	5.3	-	-	69	69
Total financial liabilities [(ii)]		**-**	**-**	**122,005**	**122,005**

Note 7.1 – Financial instruments (continued)

(a) Financial instruments: categorisation (continued)

	Note	Contractual financial assets – loans and receivables [iii] 2018 $'000	Contractual financial assets available-for-sale 2018 $'000	Contractual financial liabilities at amortised cost 2018 $'000	Total
Financial assets					
Cash and cash equivalents	6.2	54,880	-	-	54,880
Receivables					
- Trade debtors	5.1	7,678	-	-	7,678
- Other receivables	5.1	37,793	-	-	37,793
Investments and other financial assets					
- Managed investment schemes	4.1	-	61,963	-	61,963
Total financial assets [i]		**100,351**	**61,963**	**-**	**162,314**
Financial liabilities					
Payables	5.2	-	-	98,683	98,683
Borrowings	6.1	-	-	17,779	17,779
Other liabilities	5.3	-	-	76	76
Total financial liabilities [ii]		**-**	**-**	**116,538**	**116,538**

(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).
(iii) In 2019 financial assets and liabilities are classified under AASB 9. In 2018 comparatives are classified under AASB 139.

From 1 July 2018, Alfred Health applied AASB 9 and classified all of its financial assets based on the business model for managing the assets and the asset's contractual terms.

Categories of financial assets under AASB 9

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

- the assets are held by Alfred Health to collect the contractual cash flows, and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interest.

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

Alfred Health recognises the following assets in this category:

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

Financial assets at fair value through net result
Equity instruments that are held for trading as well as derivative instruments are classified as fair value through net result. Other financial assets are required to be measured at fair value through net result unless they are measured at amortised cost or fair value through other comprehensive income.

However, as an exception to those rules above, Alfred Health may, at initial recognition, irrevocably designate financial assets as measured at fair value through net result if doing so eliminates or significantly reduces a measurement or recognition inconsistency ('accounting mismatch') that would otherwise arise from measuring assets or liabilities or recognising the gains and losses on them on different bases.

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

Note 7.1 – Financial instruments (continued)

Categories of financial assets and liabilities previously under AASB 139

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 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. Alfred Health recognises investments in equities and managed investment schemes in this category.

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.

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*.

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.

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 7.1 (b) 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				
2019	**Note**	**Consolidated carrying amount $'000**	**Consolidated 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**
Financial liabilities								
Payables	5.2	106,717	106,717	102,230	2,124	2,363	-	-
Borrowings	6.1	15,219	15,219	-	1,415	1,286	7,785	4,733
Other financial liabilities	5.3	69	69	69	-	-	-	-
Total financial liabilities		**122,005**	**122,005**	**102,299**	**3,539**	**3,649**	**7,785**	**4,733**

2018	**Note**	**Consolidated carrying amount $'000**	**Consolidated 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**
Financial liabilities								
Payables	5.2	98,683	98,683	96,375	1,988	320	-	-
Borrowings	6.1	17,779	17,779	-	390	2,207	8,464	6,718
Other financial liabilities	5.3	76	76	76	-	-	-	-
Total financial liabilities		**116,538**	**116,538**	**96,451**	**2,378**	**2,527**	**8,464**	**6,718**

Note 7.1 (c) Contractual receivables at amortised cost

1-Jul-18	**Current**	**Less than 1 month**	**1–3 months**	**3 months –1 year**	**1–5 years**	**Total**
Expected loss rate	1.0%	5.6%	15.1%	40.5%	40.5%	
Gross carrying amount of contractual receivables ($'000)	32,072	5,023	4,539	4,641	3,094	**49,369**
Loss allowance	**305**	**283**	**685**	**1,881**	**1,254**	**4,408**

30-Jun-19	**Current**	**Less than 1 month**	**1–3 months**	**3 months –1 year**	**1–5 years**	**Total**
Expected loss rate	1.3%	7.3%	18.0%	32.6%	32.6%	
Gross carrying amount of contractual receivables ($'000)	28,938	5,037	4,134	5,937	3,958	**48,004**
Loss allowance	**386**	**367**	**745**	**1,936**	**1,291**	**4,725**

Note 7.1 – Financial instruments (continued)

Impairment of financial assets under AASB 9 – applicable from 1 July 2018

From 1 July 2018, Alfred Health has been recording the allowance for expected credit loss for the relevant financial instruments, replacing AASB 139's incurred loss approach with AASB 9's expected credit loss approach. Subject to AASB 9 impairment assessment are Alfred Health's contractual receivables, statutory receivables and its investment in debt instruments.

Equity instruments are not subject to impairment under AASB 9. Other financial assets mandatorily measured or designated at fair value through net result are not subject to impairment assessment under AASB 9. While cash and cash equivalents are also subject to the impairment requirements of AASB 9, the identified impairment loss was immaterial.

Contractual receivables at amortised cost

Alfred Health applies AASB 9's simplified approach for all contractual receivables to measure expected credit losses using a lifetime expected loss allowance based on the assumptions about risk of default and expected loss rates. Alfred Health has grouped contractual receivables on shared credit risk characteristics and days past due and selects the expected credit loss rate based on the past history, existing market conditions, as well as forward looking estimates at the end of the financial year.

On this basis, Alfred Health determines the opening loss allowance on initial application date of AASB 9 and the closing loss allowance at end of the financial year as disclosed above.

Reconciliation of the movement in the loss allowance for contractual receivables

	Consolidated 2019	Consolidated 2018
Balance at beginning of the year	**(3,898)**	**(3,730)**
Opening retained earnings adjustment on adoption of AASB 9	(510)	-
Opening loss allowance	**(4,408)**	**(3,730)**
Modification of contractual cash flows on financial assets	4,800	4,285
Increase in provision recognised in the net result	(5,117)	(4,453)
Balance at end of the year	**(4,725)**	**(3,898)**

Credit loss allowance is classified as other economic flows in the net result. Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

In prior years, a provision for doubtful debts was recognised when there was objective evidence that the debts may not be collected and bad debts were written off when identified. A provision is made for estimated irrecoverable amounts from the sale of goods when there is objective evidence that an individual receivable is impaired. Bad debts are considered as written off by mutual consent. Bad debts not written off by mutual consent and the allowance for doubtful debts are classified as other economic flows in the net result.

Statutory receivables and debt investments at amortised cost

Alfred Health's non-contractual receivables arising from statutory requirements are not financial instruments. However, they are nevertheless recognised and measured in accordance with AASB 9 requirements as if those receivables are financial instruments.

Both the statutory receivables and investments in debt instruments are considered to have low credit risk, taking into account the counterparty's credit rating, risk of default and capacity to meet contractual cash flow obligations in the near term. As the result, the loss allowance recognised for these financial assets during the period was limited to 12 months expected losses. No loss allowance was recognised at 30 June 2018 under AASB 139. No additional loss allowance was required upon transition into AASB 9 on 1 July 2018.

Note 7.2 – Contingent assets and contingent liabilities

No contingent assets or liabilities are present for the year ended 30 June 2019 (2018: 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 – Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities

	Consolidated 2019 $'000	Consolidated 2018 $'000
Net result for the year	**(45,471)**	**(33,380)**
Non-cash movements:		
Depreciation	70,259	62,525
Amortisation of intangible non-produced assets	7,455	4,244
Provision for doubtful debts	317	168
Department of Heath and Human Services loan discount	37	167
Department of Health and Human Services loan forgiveness	-	(7,500)
Non-cash investment income	(3,663)	(3,413)
Movements included in investing and financing activities		
Net loss from disposal of non-financial physical assets	126	515
Movements in assets & liabilities		
- Increase in employee benefits	22,185	31,667
- Increase/(decrease) in payables	(1,905)	7,384
- (Decrease) in other liabilities	(7)	(76)
- (Increase) in receivables	(10,177)	(4,434)
- Decrease/(increase) in prepayments	(686)	216
- (Increase)/decrease in inventories	27	(682)
Net cash inflows/(outflows) from operating activities	**38,497**	**57,401**

Note 8.2 – Responsible persons disclosures

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

	Period
Responsible Ministers	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2018 – 29/11/2018
The Honourable Jenny Mikakos, Minister for Health, Minister for Ambulance Services	29/11/2018 – 30/06/2019
The Honourable Martin Foley, Minister for Mental Health	01/07/2018 – 30/06/2019
The Honourable Martin Foley, Minister for Housing, Disability and Ageing	01/07/2018 – 29/11/2018
The Honourable Luke Donnellan, Minister for Child Protection, Minister for Disability, Ageing and Carers	29/11/2018 – 30/06/2019
Governing Boards	
Mr Michael Gorton AM (Chair), BCom LLB	01/07/2018 – 30/06/2019
Mr Julian Gardner AM, BA LLB, FIPAA	01/07/2018 – 30/06/2019
Ms Kaye McNaught BA (PSYCH, CRIM) LLB (MELB)	01/07/2018 – 30/06/2019
Dr Benjamin Goodfellow FRANZCP, MBBS MPM, CAPC	01/07/2018 – 30/06/2019
Ms Miriam Suss OAM, BA MSW	01/07/2018 – 30/06/2019
Ms Melanie Eagle BA BSW LLB, GAICD, Post GradDip (International Development)	01/07/2018 – 30/06/2019
Dr Victoria Atkinson MBBS, FRACS, AFRACMA, Masters of Health Management	01/07/2018 – 30/06/2019
Ms Sally Campbell BA LLB, GAID	01/07/2018 – 30/06/2019
Ms Anne Howells BCom CA, MB (Corporate Governance), GAICD, FGIA	01/07/2018 – 30/06/2019
Accountable Officer	
Prof Andrew Way AM (Chief Executive) RN, BSc (Hons) ,MBA, FAICD, FACHSM	01/07/2018 – 30/06/2019

Remuneration of responsible persons

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

Income band	Consolidated 2019 $'000	Consolidated 2018 $'000
$20,000 – $29,999	-	2
$30,000 – $39,999	-	6
$50,000 – $59,999	8	-
$70,000 – $79,999	-	1
$100,000 – $109,999	1	-
$500,000 – $509,999	1	-
$550,000 – $559,999	-	1
Total number	**10**	**10**
Total remuneration received or due and receivable by responsible persons from the reporting entity amounted to:	**$1,045,172**	**$912,921**

Amounts relating to responsible ministers are reported within the 'Department of Parliamentary Services' financial report as disclosed in note 8.4 related parties, and are not included in the above table.

Note 8.3 – Executive officer disclosures

Remuneration of executives

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

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

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

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

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

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

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 during 2018–19. This has had an impact on total remuneration figures due to the inclusion of annual leave and long service leave payments.

	Consolidated 2019 $	Consolidated 2018 $
Remuneration of executive officers (including key management personnel disclosed in note 8.4)		
Short term employee benefits	2,244,588	2,011,307
Post-employment benefits	171,866	159,463
Other long-term benefits	74,802	100,550
Total remuneration [(i) (ii)]	**2,491,256**	**2,271,320**
Total number of executives	**8**	**8**
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 8.4).
(ii) The remuneration of executive officers disclosed includes pro-rata remuneration of employees whilst acting in the Executive's roles.
(iii) Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

Note 8.4 – Related parties

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

- All key management personnel (KMP) and their close family members;
- Cabinet ministers (where applicable) and their close family members; and
- 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 and its controlled entities are deemed to be KMPs.

Entity	KPMs	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	Ms Simone Alexander	Chief Operating Officer
Alfred Health	Dr Lee Hamley	Executive Director, Medical Services & Chief Medical Officer
Alfred Health	Ms Janet Weir	Executive Director, Nursing Services & 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 (resigned 11 January 2019)
Alfred Health	Ms Amy McKimm	Executive Director, Information Development (appointed 2 May 2019)
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	Ms Jennifer Williams	Trustee
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	Mr John Brown	Trustee
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	Prof Duncan Topliss	Trustee

Note 8.4 – Related parties (continued)

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 is reported within the Department of Parliamentary Services' financial report.

Compensation - KMPs	Consolidated 2019 $'000	Consolidated 2018 $'000
Short term employee benefits	3,203	2,832
Post-employment benefits	244	215
Other long-term benefits	90	137
Total	**3,537**	**3,184**

KMPs are also reported in Note 8.2 responsible person's disclosures or note 8.3 executive officer's disclosures.

Significant transactions with government-related entities

Alfred Health received funding from the Department of Health and Human Services of $928.9 million (2018: $888.4 million) and indirect contributions of $8.5m (2018: $8m).

Alfred Health also provided services to other government related entities that were not individually significant totaling $11.8 million (2018: $12.1 million), and received services that were not individually significant totaling $9.3 million (2018: $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 the Victorian Managed Insurance Authority.

The Standing Directions of the Assistant Treasurer require Alfred Health to hold cash (in excess of working capital) in accordance with the state's centralised banking arrangements. All borrowings are required to be sourced from Treasury Corporation Victorian unless an exemption has been approved by the Minister for Health and Human Services and the Treasurer.

Transactions with key management personnel and other related parties

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

Outside of normal citizen type transactions with Alfred Health, 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 2019 (2018: nil).

There were no related party transactions required to be disclosed for Alfred Health's Board of directors and executive directors in 2019 (2018: 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 8.4.

Note 8.5 – Remuneration of auditors

	Consolidated 2019 $'000	Consolidated 2018 $'000
Victorian Auditor-General's Office		
Audit of financial statements	257	247
TOTAL REMUNERATION OF AUDITORS	**257**	**247**

Note 8.6 – 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 2019 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 2019, 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.

Leases

AASB 16 *Leases* replaces AASB 117 *Leases*, AASB Interpretation 4 *Determining whether an Arrangement contains a Lease*, AASB Interpretation 115 *Operating Leases–Incentives* and AASB Interpretation 127 *Evaluating the Substance of Transactions Involving the Legal Form of a Lease*.

AASB 16 sets out the principles for the recognition, measurement, presentation and disclosure of leases and requires lessees to account for all leases on the balance sheet by recording a Right-Of-Use (RoU) asset and a lease liability except for leases that are shorter than 12 months and leases where the underlying asset is of low value (deemed to be below $10,000).

AASB 16 also requires the lessees to separately recognise the interest expense on the lease liability and the depreciation expense on the right-of-use asset, and remeasure the lease liability upon the occurrence of certain events (e.g. a change in the lease term, a change in future lease payments resulting from a change in an index or rate used to determine those payments). The amount of the remeasurement of the lease liability will generally be recognised as an adjustment to the RoU asset.

Lessor accounting under AASB 16 is substantially unchanged from AASB 117. Lessors will continue to classify all leases using the same classification principle as in AASB 117 and distinguish between two types of leases: operating and finance leases.

The effective date is for annual reporting periods beginning on or after 1 January 2019. Alfred Health intends to adopt AASB 16 in 2019–20 financial year when it becomes effective.

Alfred Health will apply the standard using a modified retrospective approach with the cumulative effect of initial application recognised as an adjustment to the opening balance of accumulated surplus at 1 July 2019, with no restatement of comparative information.

Various practical expedients are available on adoption to account for leases previously classified by a lessee as operating leases under AASB 117. Alfred Health will elect to use the exemptions for all short-term leases (lease term less than 12 months) and low value leases (deemed to be below $10,000).

In addition, AASB 2018-8 – *Amendments to Australian Accounting Standards* – Right-of-Use Assets (RoU) of not-for-profit entities allows a temporary option for not-for-profit entities to not measure RoU assets at initial recognition at fair value in respect of leases that have significantly below-market terms, since further guidance is expected to be developed to assist not-for-profit entities in measuring RoU assets at fair value. The Standard requires an entity that elects to apply the option (i.e. measures a class or classes of such RoU assets at cost rather than fair value) to include additional disclosures. Alfred Health intends to choose the temporary relief to value the RoU asset at the present value of the payments required (at cost).

Note 8.6 – Australian accounting standards issued that are not yet effective (continued)

Alfred Health has performed a detailed impact assessment of AASB 16 and the potential impact in the initial year of application has been estimated as follows:

- increase in RoU ($26,700k)
- increase in related depreciation ($6,400k)
- increase in lease liability ($26,700k)
- increase in related interest ($800k) calculated using effective interest method, and
- decrease in rental expense ($5,700k).

Revenue and income

AASB 15 supersedes AASB 118 *Revenue*, AASB 111 *Construction Contracts* and related Interpretations and it applies, with limited exceptions, to all revenue arising from contracts with its customers.

AASB 15 establishes a five-step model to account for revenue arising from an enforceable contract that imposes a sufficiently specific performance obligation on an entity to transfer goods or services. AASB 15 requires entities to only recognise revenue upon the fulfilment of the performance obligation. Therefore, entities need to allocate the transaction price to each performance obligation in a contract and recognise the revenue only when the related obligation is satisfied.

To address specific concerns from the 'not-for-profit' sector in Australia, the AASB also released the following standards and guidance:

- AASB 2016-8 *Amendments to Australian Accounting Standards – Australian implementation guidance for NFP entities* (AASB 2016-8), to provide guidance on application of revenue recognition principles under AASB 15 in the not-for-profit sector.
- AASB 2018-4 *Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Public-Sector Licensors* (2018-4), to provide guidance on how to distinguish payments received in connection with the access to an asset (or other resource) or to enable other parties to perform activities as tax and non-IP licence. It also provides guidance on timing of revenue recognition for non-IP licence payments.
- AASB 1058 *Income of Not-for-Profit Entities*, to supplement AASB 15 and provide criteria to be applied by not-for-profit entities in establishing the timing of recognising income for government grants and other types of contributions previously contained within AASB 1004 *Contributions*.

AASB 15, AASB 1058 and the related guidance will come into effect for not-for-profit entities for annual reporting periods beginning on or after 1 January 2019. Alfred Health intends to adopt these standards in 2019–20 financial year when it becomes effective.

Alfred Health will apply the standard using a modified retrospective approach with the cumulative effect of initial application recognised as an adjustment to the opening balance of accumulated surplus at 1 July 2019, with no restatement of comparative information.

Alfred Health has performed a detailed impact assessment of AASB 15 and AASB 1058 and the potential impact for each major class of revenue and income in the initial year of application has been estimated as follows:

- Capital grants will reduce by an estimated $4,000k. Capital grants revenue will be deferred and recognised in line with the construction of the asset
- Increase in revenue deferral on balance sheet ($4,000k).

The following accounting pronouncements are also issued but not effective for the 2018–19 reporting period. At this stage, the preliminary assessment suggests they may have insignificant impacts on public sector reporting.

- AASB 2017-4 *Amendments to Australian Accounting Standards – Uncertainty over Income Tax Treatments*
- 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*
- AASB 2018-3 *Amendments to Australian Accounting Standards – Reduced Disclosure Requirements*

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

Note 8.7 – Events occurring after the balance sheet dates

No events after the balance sheet date which may have a material impact on these financial statements have occurred.

Note 8.8 – Controlled entities

Name of entity	Country of residence	Equity holding
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	Australia	100%

The Alfred Health's interest in revenues and expenses resulting from this is detailed below:

Controlled entities contribution to the consolidated results	2019 $'000	2018 $'000
Net result for the year		
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	(1,139)	337

Note 8.9 – Economic dependency

The 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 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 2020. On that basis, the financial statements have been prepared on a going concern basis.

Alfred Health's current asset ratio continues to be below an adequate short-term position (2019: 0.26 and 2018: 0.40) while cash generated from operations has reduced from a $57.8m surplus in 2018 to a $40.9m surplus in 2019, and cash reserves have moved from $54.8m in 2018 to $15.5m in 2019 (based on the parent entity results). A letter confirming adequate cash flow was also provided in the previous financial year.

Note 8.10 – Changes in accounting policy

Changes in accounting policy

Alfred Health has elected to apply the limited exemption in AASB 9 paragraph 7.2.15 relating to transition for classification and measurement and impairment, and accordingly has not restated comparative periods in the year of initial application. As a result:

(a) any adjustments to carrying amounts of financial assets or liabilities are recognised at the beginning of the current reporting period with difference recognised in opening retained earnings; and

(b) financial assets and provision for impairment have not been reclassified and/or restated in the comparative period.

This note explains the impact of the adoption of AASB 9 *Financial Instruments* on Alfred Health's financial statements.

Note 8.10 – Changes in accounting policy (continued)

Changes to classification and measurement

On initial application of AASB 9 on 1 July 2018, Alfred Health's management has assessed all financial assets based on Alfred Health's business models for managing the assets. The following are the changes in the classification of Alfred Health's financial assets:

(a) Listed shares previously classified as available-for-sale under AASB 139 are now classified as fair value through net result under AASB 9 because these equity investments are held for trading.

(b) Managed investment schemes previously classified as available-for-sale under AASB 139 are now classified as fair value through net result under AASB 9 because their cash flows do not represent solely payments of principal and interest, thus not meeting the AASB 9 criteria for classification at amortised cost.

As the result of the above-mentioned changes in classification, the related fair value gain of $26.3m was transferred from the available-for-sale revaluation surplus to retained earnings on 1 July 2018.

(c) Contractual receivables previously classified as other loans and receivables under AASB 139 are now reclassified as financial assets at amortised cost under AASB 9.

The accounting for financial liabilities remains the same as it was under AASB 139.

Summary of reclassification of assets and liabilities

		AASB 9 Measurement categories			
As at 30 June 2018	**AASB 139 measurement categories**	**Fair value through net result (designated)**	**Fair value through net result (mandatory)**	**Amortised cost**	**Fair value through other comprehensive income**
AASB 139 measurement categories					
Loans and receivables					
Receivables	45,471	-	-	45,471	-
Investments and other financial assets					
Available-for-sale investments	61,963	-	61,963	-	-
As at 1 July 2018	**107,434**	**-**	**61,963**	**45,471**	**-**

Changes to the impairment of financial assets

Under AASB 9, all loans and receivables as well as other debt instruments not carried at fair value through net result are subject to AASB 9's new expected credit loss (ECL) impairment model, which replaces AASB 139's incurred loss approach.

For other loans and receivables, Alfred Health applies the AASB 9 simplified approach to measure expected credit losses based on the change in the ECLs over the life of the asset. Application of the lifetime ECL allowance method results in an increase in the impairment loss allowance of $510k. Refer to note 7.1(c) for details about the calculation of the allowance. The loss allowance increased further by $317k for these financial assets during the financial year.

For debt instruments at amortised costs, Alfred Health considers them to be low risk and therefore determines the loss allowance based on ECLs associated with the probability of default in the next 12 months. Applying the ECL model does not result in recognition of additional loss allowance (previous loss allowance was nil). No further increase in allowance in the current financial year.

Transition impact of first time adoption of AASB 9 on balance sheet

Balance sheet	Amount at 30/6/2018	Reclassification	Remeasurement (ECL)	Restated amount at 1/7/2018
Receivables	49,369	-	-	49,369
Available for sale	61,963	(61,963)	-	-
Financial assets at fair value through net result	-	61,963	-	61,963
Impairment loss allowance	(3,898)	-	(510)	(4,408)
Other financial assets	54,880	-	-	54,880
Total financial assets	**162,314**	**-**	**(510)**	**161,804**
Total liabilities	**338,442**	**-**	**-**	**338,442**
Accumulated surplus/(deficit)	(289,679)	26,333	(510)	(263,856)
Financial assets available for sale revaluation surplus	26,333	(26,333)	-	-
Other items in equity	1,100,576	-	-	1,100,576
Total equity	**837,230**	**-**	**(510)**	**836,720**

Note 8.11 – Glossary of terms and style conventions

Actuarial gains or losses on superannuation defined benefit plans

Actuarial gains or losses are changes in the present value of the superannuation defined benefit liability resulting from

(a) experience adjustments (the effects of differences between the previous actuarial assumptions and what has actually occurred); and
(b) the effects of changes in actuarial assumptions.

Amortisation

Amortisation is the expense which results from the consumption, extraction or use over time of a non-produced physical or intangible asset.

Comprehensive result

The net result of all items of income and expense recognised for the period. It is the aggregate of operating result and other comprehensive income.

Commitments

Commitments include those operating, capital and other outsourcing commitments arising from non-cancellable contractual or statutory sources.

Current grants

Amounts payable or receivable for current purposes for which economic benefits of equal value are receivable or payable in return.

Depreciation

Depreciation is an expense that arises from the consumption through wear or time of a produced physical or intangible asset. This expense reduces the 'net result for the year'.

Effective interest method

The effective interest method is used to calculate the amortised cost of a financial asset or liability and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial instrument, or, where appropriate, a shorter period.

Employee benefits expenses

Employee benefits expenses include all costs related to employment including wages and salaries, fringe benefits tax, leave entitlements, redundancy payments, defined benefits superannuation plans, and defined contribution superannuation plans.

Financial asset

A financial asset is any asset that is:

(a) cash;
(b) an equity instrument of another entity;
(c) a contractual or statutory right:
  - to receive cash or another financial asset from another entity; or
  - to exchange financial assets or financial liabilities with another entity under conditions that are potentially favourable to the entity; or
(d) a contract that will or may be settled in the entity's own equity instruments and is:
  - a non-derivative for which the entity is or may be obliged to receive a variable number of the entity's own equity instruments; or
  - a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments.

Financial instrument

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Financial assets or liabilities that are not contractual (such as statutory receivables or payables that arise as a result of statutory requirements imposed by governments) are not financial instruments.

Financial liability

A financial liability is any liability that is:

(a) A contractual obligation:
  (i) to deliver cash or another financial asset to another entity; or
  (ii) to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to the entity; or
(b) A contract that will or may be settled in the entity's own equity instruments and is:
  (i) a non-derivative for which the entity is or may be obliged to deliver a variable number of the entity's own equity instruments; or
  (ii) a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments. For this purpose the entity's own equity instruments do not include instruments that are themselves contracts for the future receipt or delivery of the entity's own equity instruments.

Financial statements

A complete set of financial statements comprises:

(a) Balance sheet as at the end of the period;
(b) Comprehensive operating statement for the period;
(c) A statement of changes in equity for the period;
(d) Cash flow statement for the period;
(e) Notes, comprising a summary of significant accounting policies and other explanatory information;
(f) Comparative information in respect of the preceding period as specified in paragraph 38 of AASB 101 *Presentation of Financial Statements*; and
(g) A statement of financial position at the beginning of the preceding period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements in accordance with paragraphs 41 of AASB 101.

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 8.11 – Glossary of terms and style conventions (continued)

Non-financial assets

Non-financial assets are all assets that are not 'financial assets'. It includes inventories, land, buildings, infrastructure, road networks, land under roads, plant and equipment, investment properties, cultural and heritage assets, intangible and biological assets.

Non-profit institution

A legal or social entity that is created for the purpose of producing or distributing goods and services but is not permitted to be a source of income, profit or other financial gain for the units that establish, control or finance it.

Payables

Includes short and long-term trade debt and accounts payable, grants, taxes and interest payable.

Produced assets

Produced assets include buildings, plant and equipment, inventories, cultivated assets and certain intangible assets. Intangible produced assets may include computer software, motion picture films, and research and development costs (which does not include the startup costs associated with capital projects).

Public financial corporation sector

Public financial corporations (PFCs) are bodies primarily engaged in the provision of financial intermediation services or auxiliary financial services. They are able to incur financial liabilities on their own account (e.g. taking deposits, issuing securities or providing insurance services).

Estimates are not published for the public financial corporation sector.

Public non-financial corporation sector

The public non-financial corporation (PNFC) sector comprises bodies mainly engaged in the production of goods and services (of a non-financial nature) for sale in the market place at prices that aim to recover most of the costs involved (e.g. water and port authorities). In general, PNFCs are legally distinguishable from the governments that own them.

Receivables

Includes amounts owing from government through appropriation receivable, short and long-term trade credit and accounts receivable, accrued investment income, grants, taxes and interest receivable.

Sales of goods and services

Refers to income from the direct provision of goods and services and includes fees and charges for services rendered, sales of goods and services, fees from regulatory services and work done as an agent for private enterprises. It also includes rental income under operating leases and on produced assets such as buildings and entertainment, but excludes rent income from the use of non-produced assets such as land. User charges includes sale of goods and services income.

Supplies and services

Supplies and services generally represent cost of goods sold and the day-to-day running costs, including maintenance costs, incurred in the normal operations of the Department.

Transactions

Revised transactions are those economic flows that are considered to arise as a result of policy decisions, usually an interaction between two entities by mutual agreement. They also include flows in an entity such as depreciation where the owner is simultaneously acting as the owner of the depreciating asset and as the consumer of the service provided by the asset.

Taxation is regarded as mutually agreed interactions between the government and taxpayers. Transactions can be in kind (e.g. assets provided/given free of charge or for nominal consideration) or where the final consideration is cash.

Style conventions

Figures in the tables and in the text have been rounded. Discrepancies in tables between totals and sums of components reflect rounding. Percentage variations in all tables are based on the underlying unrounded amounts.

The notation used in the tables is as follows:

zero, or rounded to zero

(000) negative numbers

2019 – current year period

2018 – 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
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 2018–19
	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

The Alfred
55 Commercial Road, Melbourne VIC 3004
Telephone: (03) 9076 2000
Facsimile: (03) 9076 2222

Caulfield Hospital
260 Kooyong Road, Caulfield VIC 3162
Telephone: (03) 9076 6000
Facsimile: (03) 9076 6434

Sandringham Hospital
193 Bluff Road, Sandringham VIC 3191
Telephone: (03) 9076 1000
Facsimile: (03) 9598 1539

Melbourne Sexual Health Centre
580 Swanston Street, Carlton VIC 3053
Telephone: (03) 9341 6200
Facsimile: (03) 9341 6279

www.alfred.org.au
ABN 27 318 956 319

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