AlfredHealth

Annual Report
2019—2020

theAlfred
Caulfield HOSPITAL
Sandringham HOSPITAL
MSHC MELBOURNE SEXUAL HEALTH CENTRE

Switchboard operator Fiona Young

Contents

Front cover
ICU Nurse **Amy Braunegg**

Back cover
Nurse **Paula Christian**

Pandemic images courtesy of **HoMie Creative**

Note: Images reflect PPE guidelines at the time photos were taken.

Our story

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 our partnerships we build our knowledge and share it with the world.

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

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 to 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 2019 to 30 June 2020. It also includes information and data which constitutes our Quality Account for the same reporting period.

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

There were three relevant Ministers for the period:

The Honourable Jenny Mikakos Minister for Health, Minister for Ambulance Services	1/7/2019 – 30/06/2020
The Honourable Martin Foley Minister for Mental Health	1/7/2019 – 30/06/2020
The Honourable Luke Donnellan Minister for Child Protection, Minister for Disability, Ageing and Carers	1/7/2019 – 30/06/2020

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**

Joshua Brinie from the Microbiology team

About Alfred Health

Alfred Research Alliance
New thinking. Real impact.

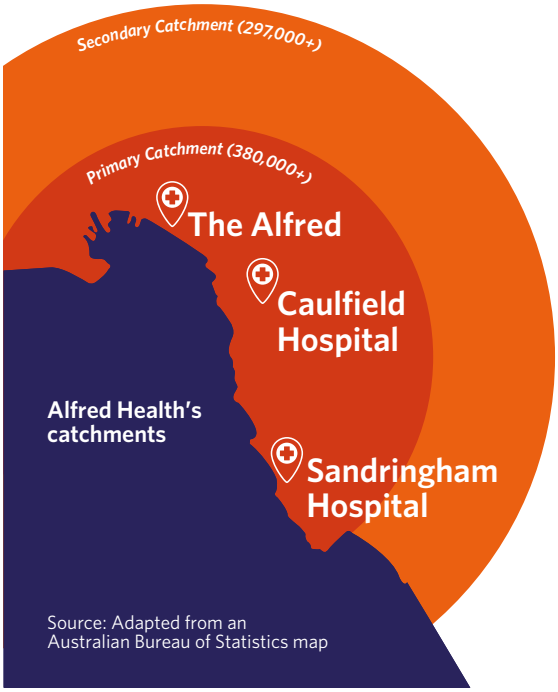
Alfred Health is one of Australia's leading healthcare services. We have a dual role: caring for more than 700,000 locals who live in inner-southern Melbourne, and providing health services for Victorians experiencing the most acute and complex conditions through our 15 statewide services.

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

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.



Our hospitals

The Alfred

The Alfred, a major tertiary and quaternary referral hospital, is best known as one of Australia's busiest emergency and trauma centres.

It is home to many statewide services, including the Heart and Lung Transplant Service, Victorian Melanoma Service and Major Trauma Service. We provide 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 Alfred is 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 its outpatient and community-based programs. It plays a statewide role in providing rehabilitation services, which includes the Acquired Brain Injury Rehabilitation Centre and the Transitional Living Service which works to further independence in patients before discharge.

Providing care for people in their homes continues to be a key part of the site's work. Its 'Better at Home' program offers a diverse range of services outside of an inpatient environment and is aimed at avoiding or shortening the need for hospital admission.

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.

Alongside the hospital's Emergency Department, the Sandringham Ambulatory Care Centre (SACC) plays a vital role treating non-urgent patients, allowing our ED staff to care for higher-acuity patients.

The Sandringham Community Bank® Day Procedure Centre continues to provide a modern, bright space for same-day surgery patients.

Community Services and Clinics

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.

Melbourne Sexual Health Centre

Melbourne Sexual Health Centre (MSHC) has dedicated clinics for all individuals at risk of sexually transmitted infection, on-site testing for sexually transmitted infections, and provides counselling, advice and health information.

Victoria's growing population and rising rates of STI have greatly increased demand, with 49,680 consultations provided via our general clinic.

While continuing to provide walk-in access for urgent cases, we also introduced a new system called 'Time to test' where non-urgent clients are allocated specific times to be seen in the next 24 hours. This service reduces the number of clients in the waiting room at any one time. For other high risk individuals without symptoms we provide an appointment for screening within 24 hours through a new phone triage system.

About Alfred Health (continued)

Victorian Sexual Health Service Strategy

Alfred Health received funding from the Victorian Department of Health and Human Services (DHHS) to support the Hub and Spoke model for STI services in Victoria.

As part of this, MSHC is part of a pilot program providing sexual health education, support and training at three GP practices. The practices will also provide testing and treatment for STIs, including HIV prevention medicines.

In July 2020, the HIV service (The Green Room) at MSHC became a specialist referral service for those people with Medicare.

Research

The focus on our research is to find innovative ways to improve STI control when the use of condoms is falling rapidly; and also encourage individuals with early symptoms to recognise these promptly and present for testing.

Meanwhile, one of our top research staff, Associate Professor Eric Chow, received an NHMRC Investigator ranking first in his category. In addition, at the 2019 International Society for Sexually Transmitted Diseases Research conference we had more abstracts and symposia than any other research group in the world including a plenary debate.

COVID-19

COVID-19 saw a fall in the number of consultations. To reduce risk, we introduced temperature monitoring, minimised time in consultation rooms by using phones for history taking and used masks when distancing could not be maintained. We also introduced Telehealth for counselling and Green Room client consultations.

St Kilda Road Clinic

The St Kilda Road Clinic works in partnership with consumers, families and the community to reduce the impact of mental illness, improve quality of life and promote recovery. It aims to deliver excellent quality care that is accessible to all and sensitive to a diverse community.

The service provides comprehensive mental health assessment, treatment and support to adult clients aged 25–64 years to people who live in the City of Port Phillip, Glen Eira and Stonnington. It offers psychiatric assessment and treatment, clinical case management, family and carer support and specialist allied health interventions.

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 30 June 2020.

Michael Gorton AM
Chair

18 September 2020

Statewide services

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

National service

Paediatric Lung Transplant Service

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

Blood disorders
(haemophilia)

Cancer care
(bone marrow transplantation, radiotherapy, oncology, haematology, cancer surgery)

Cardiology
(catheter lab, general cardiology and heart failure services)

Cardiothoracic
(cardiac surgery, heart transplant)

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, epilepsy, epilepsy surgery)

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)

Respiratory
(adult and paediatric lung transplant, adult cystic fibrosis, general respiratory, allergy, asthma and clinical immunology, lung function and sleep and ventilatory failure services)

Specialist medicine
(dermatology, endocrinology, diabetes, hyperbaric, infectious diseases, rheumatology)

Specialist surgery
(dental, faciomaxillary, plastic, vascular)

Urology

National Service

Paediatric Lung Transplant Service

Chairman and Chief Executive's Year in Review

Left: *Chair Michael Gorton AM*

Right: *Chief Executive Prof Andrew Way AM*

It is a privilege to present this year's annual report, which covers one of the most challenging 12 months in Alfred Health's history. Through the dedication and skill of our staff, we provided outstanding care to those most in need. In particular, we provided support for those affected by the White Island Volcano incident in New Zealand, the bushfires and of course, the COVID-19 pandemic that dominated 2020.

Response to COVID-19

Initiative, adaptability and commitment to community care were hallmarks of our response: it was truly a whole of health service effort touching clinical and non-clinical staff alike.

Extensive preparations changed the face of the health service as we ensured readiness to cope with whatever the pandemic presented.

Clinical staff in Emergency Departments, ICU and dedicated COVID wards cared for people infected by COVID-19 through overseas travel which typified the first wave, or community transmission which typified the second.

Over 70 per cent of our staff experienced significant change in their jobs. Staff took up roles in COVID screening clinics, testing thousands of people safely, efficiently and compassionately. Many worked in the community, assisting aged care facilities through the pandemic, and supporting the State Government's hotel quarantine program by providing clinical services and oversight from June. More than a thousand staff worked from home, keeping our campuses and staff safer.

Staff wellbeing

Keeping staff safe from COVID as they treated people with the highly infectious virus was the overriding priority. Central was the right personal protective equipment (PPE), which added an extra degree of difficulty for staff in their day-to-day work.

Systems and processes continued to evolve as we learnt more about the virus. Initiatives such as detailed contact tracing, PPE spotters, 'traceable' tearooms through QR codes; and a COVID screening app, contributed to keeping workplace transmissions low.

Our Wellbeing Collaborative harnessed resources to support staff, through practical initiatives such as accommodation and food, as well as the more personal such as delivery of donated gifts from generous community partners.

Specialised mental health support was offered through the Alfred MINDS program, providing staff with immediate access to Alfred Health clinical psychiatrists and psychologists.

Staff safety and wellbeing are always a focus. In 2020 they were pivotal.

Beyond inpatient care

COVID-19 encouraged us to think further, and faster, about care outside of hospital settings. By the end of the reporting period around 50 per cent of outpatients appointments were conducted over the phone or through video.

Home-based care became a priority, and building on the successful Better at Home program, we substantially increased 'beds' provided in the comfort and familiarity of their own home. We will continue to build on these initiatives in the next year, as we look to improve and transform patient experiences.

Patient Portal

Alfred Health continued to adopt new technology to improve patient care, launching our Patient Portal during the year. This was the first implementation of this kind for an adult health service in Australia. By the end of June 2020, close to 800 patients were registered.

The portal allows registered patients to easily access their Alfred Health information online and encourages involvement in their own care. Security has been a key consideration, with every effort made to keep patients' information secure so only the right people have access, including the clinicians providing a patient's care.

Critical care

Alfred Health continued to play a leading role in providing critical care to our community, though presentations dropped during the six months in 2020. Despite the pandemic we continued our heart and lung transplant program as well as complex cardiac care. While falls and trauma admissions dropped, people presenting with serious burns grew substantially.

In September 2019, our Intensive Care Unit expanded to 56 bed spaces, with the opening of a new 11-space fully functioning ICU pod on Level 3. This response to the growing need for critical care proved indispensable through the pandemic.

Building infrastructure for better care

While much of our infrastructure is aged, we were able to undertake some infrastructure projects during the year which will provide better environments for patients and staff.

In addition to the expansion of ICU, work was undertaken on the $6 million Innovation and Education Hub. Due to open at the end of 2020, this project transforms the former library into a contemporary learning environment with high-end information technology and innovation laboratories.

The South Block Clinical Trials project also provided a welcome boost to Alfred Health's cancer treatment and clinical trials capacity. Completed in 2020, the works saw an additional 19 patient points of care along with a significant improvement in the look and feel of the environment.

Research and education

Our commitment to research continued.

Partnerships with the Alfred Research Alliance and the Monash Partners Academic Health Centre highlight the importance of collaboration in solving some of the world's most important health challenges through research.

The Alfred Research Alliance instigated several COVID-19 research projects including vaccine and antiviral development, clinical trials and preclinical testing of promising candidates, the development of new diagnostic tests, and public health research.

Thanks to Board and staff

Thank you to our Board members and Executive team for their ongoing hard work and dedication. This year we farewelled Julian Gardiner AM from the Board after 9 years' service, and we welcome Ms Chloe Shorten. We were delighted that our CEO, Prof Andrew Way was recognised in the Australian Honours as a Member of the Order of Australia.

Thank you also to our donors and broader community. Your generosity, and shared aim to support Alfred Health so it can deliver world-leading healthcare is much appreciated.

And thank you to our staff – at times like these thank you does not seem enough. However, for your resilience, determination and commitment to care, especially in these difficult times, we and the Victorian community say a very sincere and heartfelt thank you.

Michael Gorton AM
Chair

Alfred Health
18 September 2020

Prof Andrew Way AM
Chief Executive

Alfred Health
18 September 2020

Reflections on COVID-19

Registered nurse Phoebe Kong

In the face of COVID-19, Alfred Health has continued to demonstrate outstanding healthcare leadership.

Quality clinical care

We have been at the frontline of providing treatment and care to those affected by COVID-19 with our dedicated clinical team – including those in Infection Prevention, Infectious Diseases, Intensive Care, Emergency and Acute and other speciality medicine areas, forming a key part of our response.

Their expertise and dedication have been crucial in what has been an evolving issue.

A Screening Clinic set up at The Alfred would put us at the forefront of testing Victorians for COVID-19, with up to 600 people presenting on a single day, and our nursing and pathology teams working hard to provide prompt testing and results.

Preparing for the pandemic

As the world began to learn about the pandemic, Alfred Health worked hard to ensure we had the capacity to provide quality care to patients presenting with COVID-19 and the broader community.

From early on, an operational plan was developed, which included input from the state pandemic plan and scenario-based preparation. With the environment uncertain and trajectory unpredictable, such planning was essential.

Strong leadership in challenging times

The formation of a dedicated COVID operational and leadership structure was also important, enabling a focused and co-ordinated approach to how Alfred Health managed the work that needed to be done to prepare for the pandemic.

Early experiences of an outbreak also shaped our ongoing responses and gave us an opportunity to learn – something which has been crucial in setting the pace.

Intensive Care Consultant
Dr Dashiell Gantner

Project Manager
Duncan Beiers

Infection Prevention
Clinical Nurse Consultant
Daniela Karanfilovska

Allied Health Assistant - Psychiatry
Joanne Tasevski

United as a team

In planning ahead, Alfred Health worked quickly but diligently creating additional Emergency Department, Intensive Care Unit and general ward capacity to meet potential demand.

Doing so required strong collaboration between our clinical, supply, education, information technology, capital works and engineering teams so the needs of patients and staff were met.

Understanding COVID-19

Ensuring staff had updated training and the latest guidelines to ensure they had the skill set required to treat patients was a priority.

Research was also a key part our response, with studies into the impact of COVID-19 on vulnerable people, such as those with compromised immune systems and older persons.

Going above and beyond

There have been increased demands on many of our staff – from our dedicated clinicians working in Intensive Care and our COVID-specific wards, to those in non-clinical and support roles who have also provided outstanding support.

Some of our staff have also had to demonstrate their versatility, with COVID-19 meaning some are working in new environments or roles, including the State Government's hotel quarantine program. Our services have also operated differently, with a focus on providing care outside an inpatient environment where possible, including Telehealth and home-based care.

Importantly, we have also prioritised staff wellbeing during the pandemic, with resources made available to ensure the mental and physical health of Alfred Health employees remain a priority.

Thanking our amazing staff

In what has been a difficult period, Alfred Health is most grateful for its dedicated staff.

This has been reflected in feedback received, with examples including positive comments about the Screening Clinic and thank you letters from schoolchildren.

Across the health service it has been a team effort. It has been a great example of our staff's ability to rise to to the challenge, and meet the needs of our patients and community.

COVID-19 Facts and Figures

29,330
COVID-19 tests conducted

28
confirmed COVID-19 positive admissions

2,646
suspected COVID-19 admissions, including

18,115
at our public Screening Clinic

3,238
at our Surveillance Clinic made up of staff, teachers, aged care workers and other health care workers.

7
requiring intensive care

432
requiring intensive care.

Figures up until 30 June 2020

Director of Infection Prevention and Healthcare Epidemiology
Prof Allen Cheng

Resource nurse ICU Cardiac
Jan Thyssen,

Director of Emergency
De VIlliers Smit

Enquiries Clerk
Lakhir Weinberg

Fast facts

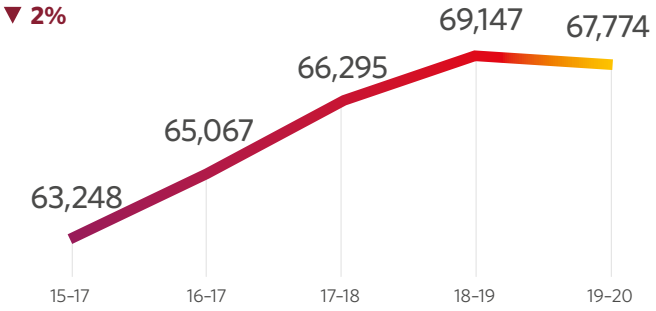
Note: Figures in 2019–20 reflect the impact of COVID-19 pandemic on some of our services and programs.

Emergency presentations

110,601

The Alfred

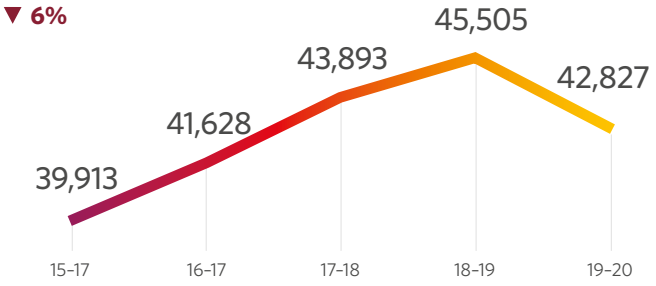
▼ 2%



Sandringham Hospital

Includes Sandringham Ambulatory Care Centre

▼ 6%



Episodes of inpatient care

112,190

Major trauma patients

1,499

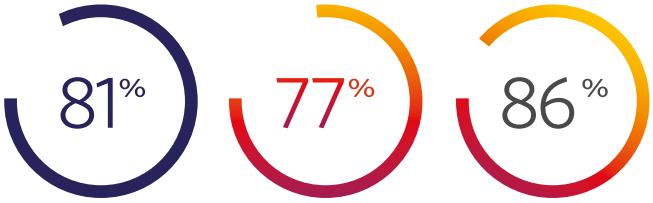
Specialist outpatient appointments

239,033

Clinical trials open

636

NEAT – National emergency access targets



Target | The Alfred | Sandringham

Employees

9,872

Volunteers

480

Staff flu vaccination rates

2018 DHHS target | Alfred Health 2019

Telehealth

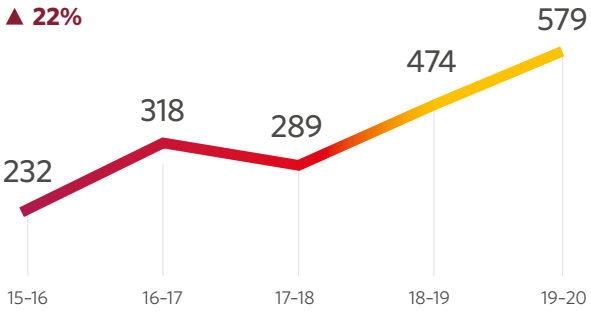
119 video consultations per month **June 2019 (pre-COVID)**

video consultations per month**June 2020 (during COVID)** 5,038

Better at home discharges

579

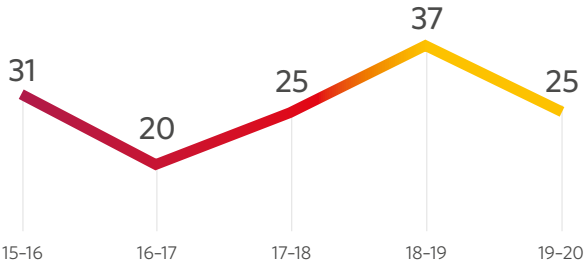
▲ 22%



Heart transplants

25

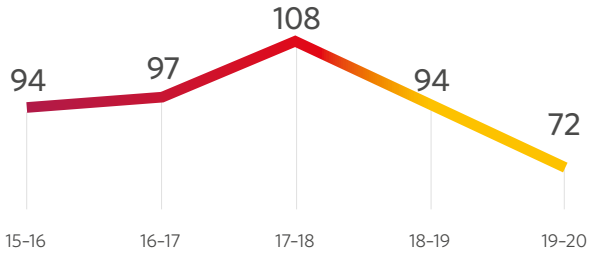
▼ 32%



Lung transplants

72

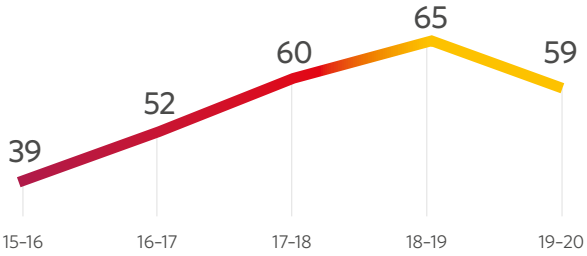
▼ 23%



Extracorporeal membrane oxygenation (ECMO) discharges

59

▼ 9%



9,499

Elective surgeries performed from waiting list

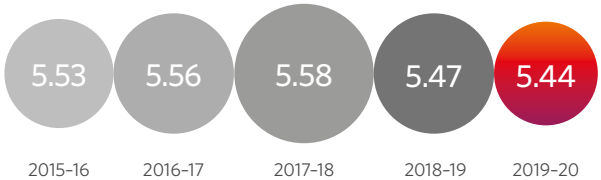
Patients treated within clinically recommended times

98%

Average length of stay – acute patients

The Alfred

▼ 2%



Sandringham Hospital

▼ 7%

Hospital in the Home patient Tony Hanna and nurse Jamyr Johnstone

Our Patients

Alfred Health includes patients and their families in our care to ensure a quality healthcare experience. The circumstances of the past year have shone a spotlight on the innovative ways we are caring for patients, with the way care is offered undergoing rapid change.

From home-based care to Telehealth and other 'virtual hospital' environments, Alfred Health is offering safe and high-quality treatment in a range of new and exciting spaces. We value the involvement of those who use our services and programs, who also help us improve our service planning and delivery.

Patients Come First Strategy 2016–20

Patients Come First is our roadmap to supporting the best possible patient experience. We engage current and past patients, carers and family members (consumers) in health service planning, as well as in its design and improvement.

Now in its fourth year, our work has focused on the key areas of comfort, environment, access, respect, team and compassion.

This is the final year of the strategy. Of the 70 original improvement actions identified, 60 per cent were completed, and 26 per cent made good progress. We will co-design the next version of the strategy with our patients, consumers, and community.

Consumer participation

We continue to have strong engagement with consumers across the health service, with 88 registered Consumer Advisors representing our diverse community. There has been an increase in consumer participation, through activities such as training of staff, design of clinical spaces and interviewing new Consultants in General Medicine.

We have 34 Consumer Advisors on committees such as Board Quality, the Community Advisory Committee and Medication Safety.

We also have specialist advisory groups covering Cystic Fibrosis, HIV Services and Acquired Brain Injury (ABI), who advise the Board and Chief Executive. The groups help to improve patient experiences and to promote consumer and community participation.

In December 2019, we appointed our first Consumer Consultant. They will help strengthen consumer participation by providing advice and support to staff, committees, working groups and our consumers and volunteers. This role is a partnership with the Health Issues Centre, Victorian peak consumer health advocacy NGO.

Better outcomes for all

While all patients are supported through our existing 'Patients Come First' strategy, some may be considered as being more vulnerable than others due to multiple and complex socio-demographic factors or health needs. The Vulnerable Persons Initiative was designed to support our staff respond to people who might have increase vulnerability.

Vulnerable patient initiative

Alfred Health cares for patients from all backgrounds, including those identified as 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.

Key activities and work progressed in 2019–20 include:

- testing the Crucial Conversations Model so staff can advocate appropriately for patient needs and to escalate any concerns/issues in a timely manner
- validation of Vulnerability Screen Risk Assessment against a social work screen for vulnerability, with Ethics approval in July 2019
- development of a sensitive inquiry six-step process for frontline staff to use, aimed at supporting people at risk of vulnerability
- collaboration with the University of Technology Sydney to investigate the relationship between vulnerability and clinical incidents.

Family Violence Project

Our Family Violence Project continued to provide education to an additional 890 staff and 153 managers. We have now trained more than 2,600 staff since project inception. An online education module for all staff has also been developed.

Other achievements included:

- responding to COVID-19 and related social restrictions that increased risk of family violence by updating family violence resources and resuming targeted education
- providing an enhanced clinical service to patients with an extreme family violence tier one medical alert, with over 70 such alerts now in place
- leading health service participation in international awareness raising campaign '16 days of activism' against gender-based violence.

Access and inclusion

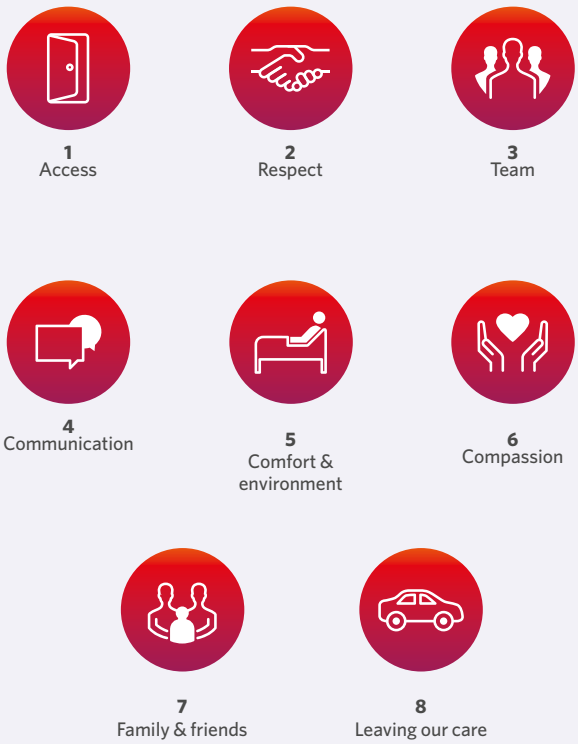
The Alfred Health Access and Inclusion Plan for People with Disability (2019–22) was launched in December 2019, coinciding with the International Day of People with Disability.

Responding to the needs of people with disability during the COVID-19 pandemic included providing accessible information, improving access to Telehealth and ensuring where necessary that inpatients with disability were supported by their carers, even with restricted visiting arrangements in place.

Meanwhile, a 50 per cent reduction in the number of inpatients experiencing barriers to discharge from hospital due to their disability compared to the previous year was achieved. This was due to improved processes with the NDIS, the appointment of an NDIS Hospital Liaison Officer and collaborations with the Summer Foundation.

Beyond the Plan itself, the Specialist Education and Knowledge Team project will build workforce capability and processes to enable people with disabilities to meet their healthcare needs. The project is supported by a $2.3 million Information, Linkages and Capacity Building (ILC) grant, with people with autism, intellectual disability or communication disability among those to benefit.

Experience pillars



Our Patients (continued)

Diversity and inclusion

This year we collaborated with SBS and Safer Care Victoria to adapt the SBS Cultural Competency Program for Alfred Health. Our aim was to develop skills and awareness among staff to help them better respond to the needs of our diverse community.

Improving access to Language Services across both inpatient and outpatient areas through telephone and video interpreting services was a priority. The Patients Requiring Language Services guideline was extensively rewritten to incorporate improvements to access of interpreters. A video interpreting service app is currently being planned.

Planning is also underway to redesign the main entrance of The Alfred to better reflect the whole of The Alfred community with our Reconciliation Action Plan artwork and story a key component.

Who Are Our Patients?

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

7 per cent of all patients speak a language other than English

Our patients speak **185** different languages

Our **top five** languages other than English are Greek, Russian, Mandarin, Cantonese and Turkish.

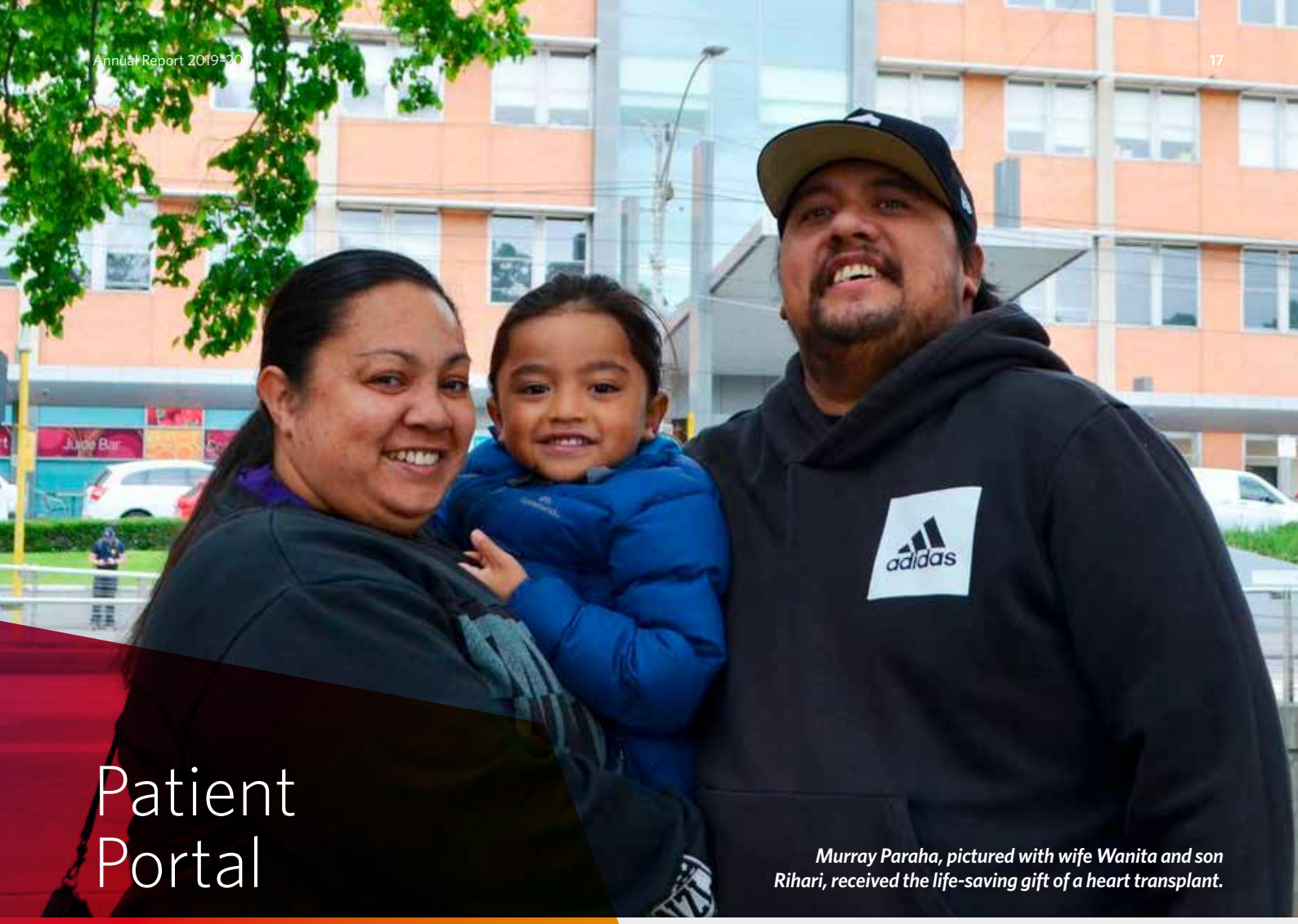
Aboriginal health

Developed in partnership with Reconciliation Australia and Boon Wurrung Foundation, The Alfred Health Reconciliation Action Plan (RAP) demonstrates our commitment to providing a culturally safe and appropriate healthcare service to our Aboriginal and Torres Strait Islander patients. It includes action items under the themes of Relationships, Respect, Opportunities, and Reporting. There has been steady progress, with 84 per cent of actions either completed or showing good progress toward completion. A new RAP is being developed, in consultation with our local Aboriginal community and Reconciliation Australia in late 2020.

An Aboriginal consultant was engaged to develop and deliver a structured cultural face-to-face training program to improve cultural awareness and competency to meet the needs of Aboriginal and Torres Strait Islander patients and workforce. Areas with higher levels of Aboriginal patient contacts were prioritised, with 407 staff attending. This included clinical and non-clinical staff, managers and executives. Feedback from staff participating in the training was positive with staff indicating it had enhanced their understanding of the challenges faced by Aboriginal people, including intergenerational trauma and the need to create a safe and welcoming environment.

As part of Reconciliation Week, an e-Learning Package was launched in May 2020. Developed by the Wandeat Bangoongagat working group for use in all Victorian health services, staff were encouraged to demonstrate their commitment to reconciliation by completing the training.

On a visit from Alice Springs, patient Irene was a little nervous when coming to The Alfred for dialysis. Fortunately, she saw some familiar faces in Rachel, Cassandra and Rica who had also spent time in the renal and haemodialysis unit in Alice Springs.



Murray Paraha, pictured with wife Wanita and son Rihari, received the life-saving gift of a heart transplant.

Patient Portal

In 2020, Alfred Health launched its Patient Portal. We have always been at the forefront in adopting new technology to improve patient care and this was the first implementation of this technology for adult health services in Australia.

Through this portal, registered patients can easily access their Alfred Health information online. The details come directly from their Alfred Health electronic medical record and is updated by Alfred Health clinicians.

Using a computer or mobile device, patients can access the portal to view their appointments, access test results and message healthcare teams.

Security has been a key consideration for the Patient Portal. Every effort has been made to keep patients' information secure so only the right people have access, including the clinicians providing a patient's care. The very latest in secure technology means information stored within Alfred Health's electronic medical record meets the highest security standards, including encryption and password protection.

Patient Portal encourage patients to become more involved in their care. It is delivered through our Cerner electronic medical record and is a key part of our eTQC program. By the end of June 2020, 768 patients had connected to Patient Portal.

Positive feedback on Patient Portal

"The portal gives me an immediate window on my blood results and comms between Alfred specialists and my GP. Both these are really good to have and saves me badgering people when they've better things to be doing, like treating patients!

I like how easy the Patient Portal is to navigate. Being from a rural area it is great knowing what appointments have been made, the fact that I can get in touch with my health care team if needed and being able to see letters and test results.

Overall being confident that I know what is happening regarding my health care."

Our Patients (continued)

Measuring the experience of our patients

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

Victorian Healthcare Experience Survey (VHES)

Conducted by the Victorian Government, the VHES collects data from users of Victorian public health services.

Percentage of patients that rated their care as very good or good – Alfred Health:

Adult inpatient: Target 95%

Jul – Sep 2018	Oct – Dec 2018	Jan – Mar 2019	Apr – Jun 2019
90%	89%	94%	89%
Jul – Sep 2019	**Oct – Dec 2019**	**Jan – Mar 2020**	**Apr – Jun 2020**
92%	94%	97%	94%

Emergency Department

Jul – Sep 2018	Oct – Dec 2018	Jan – Mar 2019	Apr – Jun 2019
91%	90%	91%	96%
Jul – Sep 2019	**Oct – Dec 2019**	**Jan – Mar 2020**	**Apr – Jun 2020**
90%	88%	90%	94%

Adult specialist clinics – annual survey

2017	2018	2019
96%	94%	88%

Community health – annual survey

2017	2018	2019
100%	98%	97%

VHES Cancer Survey

The VHES cancer survey, which focuses on the experiences of patients who are receiving cancer treatment, was conducted for the first time in 2018 with results published this financial year.

Percentage of patients that felt very satisfied or satisfied with The Alfred:

97% Health professionals involved in treatment	99% Health professionals involved in surgery
99% Health professionals involved in radiotherapy	96% Health professionals involved in chemotherapy

Patient Experience Survey (PES)

To understand the needs and experiences of care from our diverse community, this Alfred Health inpatient survey has been translated into Greek, Russian, Italian, Simplified Chinese and Turkish. Language Services Interpreters have continued to support the collection of experience data from CALD patients, with the number of interpreter assisted surveys increasing from 7 per cent to 10 per cent in the last two years.

From August 2019, patients were able to complete the patient Experience Survey on Alfred Health website.

In 2019–20, we collected the experiences of 2,051 patients, with the majority collected by trained volunteers, face-to-face in our wards, or over the phone with outpatients. The number of surveys was less than anticipated, with 2,614 people completing the PES in 2018–19. This was due to our volunteer program being suspended in February 2020 due to COVID-19.

Physiotherapist Lauren Chapman with patient Jasmine Young.

Inpatient experience

1,440 surveys collected

Percentage of patients that rate their overall quality of care as very good or good:

Alfred Health

The Alfred

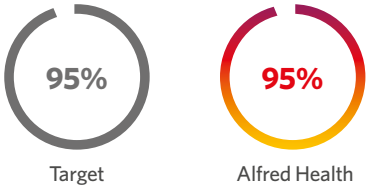
Caulfield

Sandringham

Outpatient experience

611 surveys collected

Percentage of patients that rate their overall quality of care as very good or good:



Compliments and complaints

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

In 2019–20:

1,659 Complaints received

decrease of 144, with 1,803 complaints in 2018-19.

1,162 Compliments received

decrease of 126, with 1,288 compliments in 2018-19.

Telehealth boost for George's recovery

As well as home visits, patient George received rehabilitation from a stroke with speech pathology appointments conducted via Telehealth.

A patient through Caulfield Hospital's Better at Home program, George and his wife Jenny were delighted with the support they have received through people such as speech pathologist Jemma Bear.

"We've loved it. It's the first time we've done it, but Telehealth has been perfect," George said.

Improving patient experiences

Telehealth

In response to the developing COVID-19 pandemic, there has been a rapid increase in our Telehealth services, as part of an effort to minimise unnecessary hospital visits.

Rates of Telehealth in specialist consulting clinics increased from 119 video consultations in June 2019 to 5,038 in June 2020.

For those at higher risk of COVID-19 related complications, such as older adults with pre-existing medical conditions, Telehealth can provide convenient access to care without the risk of hospital-associated infection exposure.

Telehealth technologies have also been used to support Alfred Health's physical distancing recommendations within the hospital, while still providing safe and timely patient care. Video calls have been successfully piloted on an inpatient ward, in the Emergency Department, and Intensive Care Unit, with expansion plans for all three Alfred Health sites underway.

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.

In response to the Act, Alfred Health has developed a guideline – *Recognising Carers and Care Relationships as Part of Delivering Patient Care.* Approved in July 2020, it 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.

Caring for carers during COVID-19

Alfred Health Carer Services has received high praise for how they are continuing to engage with carers during the pandemic.

In partnership with the DYA Australia art group, the Alfred Health Carer Services team has been offering art classes to carers via Zoom.

In what has been a challenging period, carer Suzanne Kelly said the art classes gave her an opportunity to take some time out for herself.

"The tutor was friendly and very helpful with useful art knowledge. I also liked hearing stories from other carers, and how they were faring in these difficult times," Suzanne said.

"Please know the positive difference being able to have this opportunity has made to my wellbeing. I really loved the connection and enjoying something fun for me."

Alfred Health Carer Services

Alfred Health Carer Services (AHCS) is funded by state and federal governments to support carers who support a family member or friend with a disability, mental or chronic illness and ageing-related conditions. We provide short-term support to carers of all ages. Our services include emotional support, respite, planning for the future, carer education, group events and links to other services. We also provide Commonwealth Home Support Program services to older people who have a carer.

AHCS covers the local government areas of: Port Phillip, Stonnington, Glen Eira, Bayside, Kingston, Greater Dandenong, Casey, Cardinia, Frankston and Mornington Peninsula. AHCS operates out of two offices, one at Caulfield Hospital, and one in Frankston.

Number of new requests managed by the service in the last financial year:	
Disability and Mental Health Carers	2,036
Young Carers	160
Aged Dementia	3,669
Phone Support	152
Total requests	**6,017**

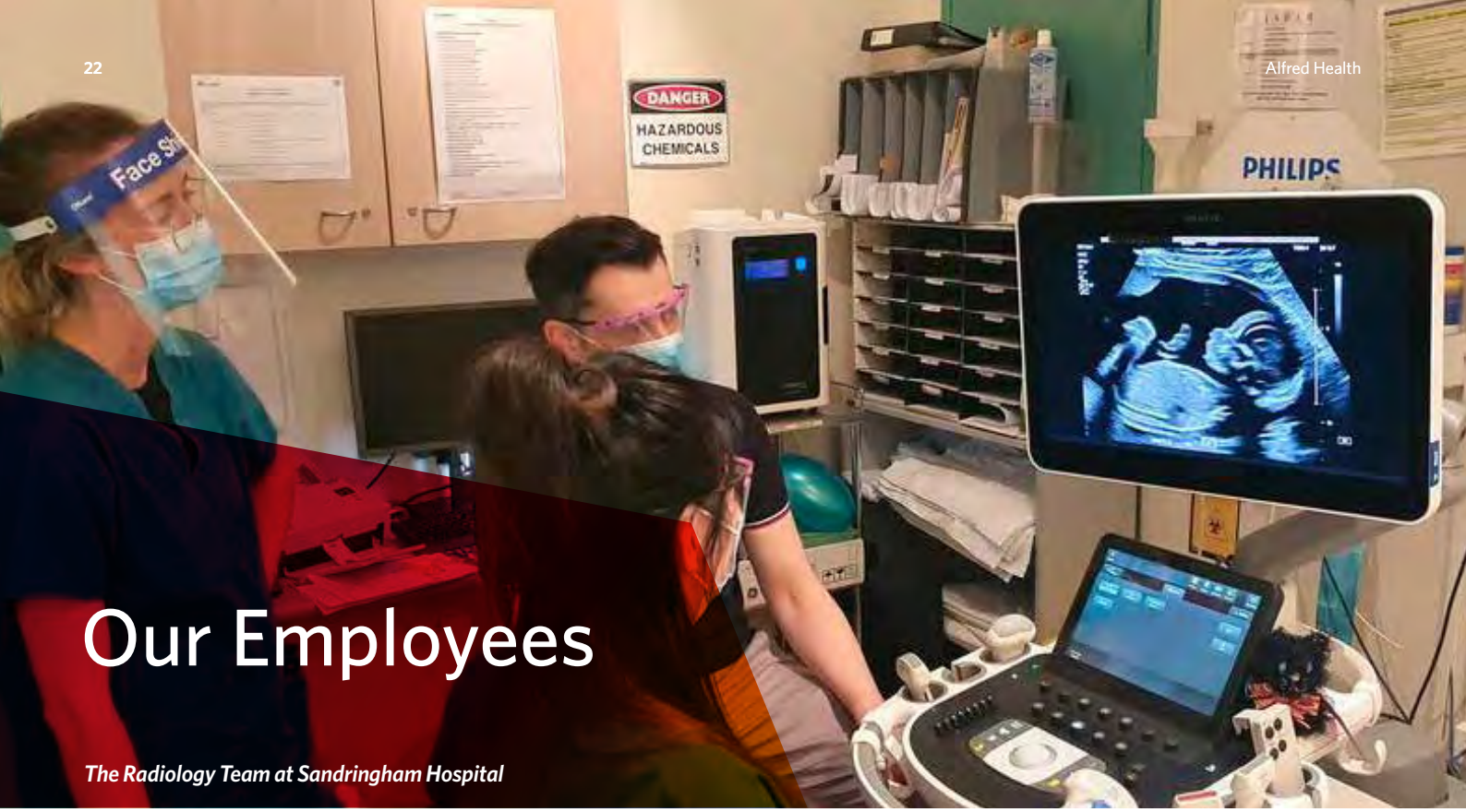
Patient car parking

Alfred Health works with our patients, carers, visitors and staff, local authorities and public transport providers to make sure they can access car parking facilities as safely, conveniently and economically as possible.

Although patient and visitor car parking at our hospital sites is limited, we improved access by increasing capacity, reducing waiting times and vehicle queuing by:

- use of car park stackers to co-locate all Alfred fleet vehicles into one location on-site
- valet parking staff vehicles during peak times to increase availability for patients, visitors and staff
- progressing the design and use of additional local offsite parking facilities
- engaging traffic consultants to identify how we can better utilise parking facilities on-site
- encouraging the use of public transport.

We comply with the DHHS hospital circular on car parking fees. We ensure all car parking charges and concessions are well publicised including at car park entrances, wherever payment is made, inside the hospital and online at **www.alfredhealth.org.au**. Alfred Health's Car Park Rates Policy is reviewed annually and seeks to reduce the financial burden of vulnerable patients who frequently attend our health service.



Our Employees

The Radiology Team at Sandringham Hospital

Alfred Health's team continued to provide outstanding care to our community, even in a most challenging year, as we helped fight COVID-19. Throughout it all, staff demonstrated commitment, compassion and versatility. The safety and wellbeing of our skilled and engaged workforce continued as a major priority.

Staff safety during COVID-19

From January 2020, Alfred Health actively developed infection prevention and control strategy guidelines and resources to support staff caring for patients while maintaining their own safety during the COVID-19 pandemic. These resources were regularly updated to ensure they were consistent with DHHS guidance.

Key infection control responses included:

- An expanded program for contact tracing and managing staff and patient exposures
- A system for staff follow-up and clearance to return to work, for those who require screening due to COVID-19 symptoms based on DHHS guidance
- Targeted education and training programs for staff from all disciplines, together with providing audit data and feedback to wards
- Advice provided on the development of national and state guidelines for COVID-19.

Delivering a flexible workforce

Our staff have demonstrated great adaptability during COVID-19. This has included retraining of some staff in skills required for our Emergency Department and Intensive Care Unit. We have also had staff redeployed into other roles so we can better meet the workforce demands created by COVID-19.

To minimise potential infection, staff were encouraged to work from home where possible, with up to 1000 staff working away from the office during the pandemic.

Recruiting and retaining

In 2019–20, Alfred Health had 9,858 staff (6,598 full-time equivalents), including 513 new employees who joined us this year.

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

The rise in employee numbers, particularly in 2020, can be largely attributed to additional staffing required to assist Alfred Health meet the increased demands of our COVID-19 pandemic response. These additional staff members, which cover both clinical and non-clinical areas, have been essential during this challenging period. They have ensured we can continue delivering quality care to our patients and the broader community, while also supporting our existing workforce.

Staff numbers grew by 15 per cent over the last five years, as services expanded and demand increased.

	Staff numbers
2015–16	8,570
2016–17	9,016
2017–18	9,283
2018–19	9,276
2019–20	9,858

2019 Location	Casual	Part Time	Full Time	Grand Total
Alfred Hospital	798	3529	2921	7248
Caulfield Hospital	173	749	558	1480
Sandringham Hospital	62	344	142	548
Grand Total	**1033**	**4622**	**3621**	**9276**

2020 Location	Casual	Part Time	Full Time	Grand Total
Alfred Hospital	1057	3751	3059	7867
Caulfield Hospital	160	738	547	1445
Sandringham Hospital	61	347	138	546
Grand Total	**1278**	**4836**	**3744**	**9858**

Increase of 513
from the previous year

▲ 6%

Workforce

	Current month FTE		YTD FTE	
	2019	2020	2019	2020
Nursing	2,616	2,705	2,599	2,654
Administration and clerical	1,078	1,181	1,060	1,122
Medical support	593	620	584	610
Hotel and allied services	212	212	211	211
Medical officers	225	234	219	229
Hospital medical officers	585	605	579	603
Sessional clinicians	165	184	164	173
Ancillary staff (Allied Health)	970	1017	979	996
Grand total	**6,444**	**6,758**	**6,395**	**6,598**

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.

Director of the Department of Infectious Diseases Anton Peleg

COVID-19 Screening Clinic Nurse Sarah Boland

COVID-19 Wellbeing Collaborative

To support staff through the COVID-19 pandemic, a Wellbeing Collaborative was formed. A group of more than 50 staff from a wide range of disciplines came together to co-design and implement experiences, tools, innovations and resources that supported staff wellbeing.

Alfred Health established a range of dedicated resources to ensure staff had access to the support they needed during the pandemic.

The range of support created was diverse, recognising that COVID-19 affected individual staff in different ways.

A dedicated Human Resources phone line acted as an initial contact point for staff. This service detailed the range of resources available, as well as answering questions about leave, testing, screening, furloughing, payments and childcare supports, as well as providing direction to counselling and staff support.

A wellbeing intranet page acted as a central hub for resources covering physical health, mental health, working from home, family support, exercise, links to financial support from Alfred Health's partners and a wellbeing self-check. Videos and podcasts and free offers for staff also featured.

The Alfred MINDS program offered confidential mental health assistance via Telehealth for staff experiencing psychological distress, with Alfred Health clinical psychiatrists and psychologists providing their support.

Staff who were furloughed were also supported, with wellness checks provided by our Employee Assistance Provider (Benestar), along with delivery of meals and phone calls of support.

Human Resources worked with The Alfred Foundation on collating and coordination of generous gifts and donations and distribution to staff and teams in need.

More broadly, staff were encouraged to share their experiences and reactions to the COVID-19 pandemic. This campaign was aimed at acknowledging and normalising what staff were experiencing. At a local level, initiatives such as a virtual peer support program for Junior Medical Staff, and the continuation of Schwartz Rounds, was also important.

Occupational health and safety

Keeping our staff healthy and supported requires environments that are physically and psychologically safe. Staff wellbeing and support continued to be key priorities. Staff are encouraged to highlight and report issues of safety and care that concern them.

Overview of health and safety

Measure	2017–18	2018–19	2019–20
Number of hazards reported per 100 FTE	13.8	6.96	5.31
Number of lost time standard claims per 100 FTE	0.56	0.4	0.77
Average cost per claim (including estimate)	$56,215	$63,072	$59,887
Fatality	0	0	0

Explanation

Hazards reported exclude clinical incidents and MET calls.

Injury compensation data

Measure	2017–18	2018–19	2019–20
WorkCover Claims	78	80	88
Injury Support Claims	27	23	27

Explanation

7 WorkCover claims were in relation to contracting COVID.

Main contributors of WorkCover claims

Measure	2017–18	2018–19	2019–20
Manual handling	27	39	44
Occupational violence and aggression (OVA)	13	10	8
Slips, trips and falls	11	12	10

Occupational violence and aggression (OVA)

More than 3150 staff have attended the internally designed AWARE training course, developed to help frontline staff identify, manage and de-escalate patient aggression. The AWARE (Assess, What now, Alert others, Respond, Evaluate) course continues to be highly regarded throughout the public health system with its principles being shared at numerous conferences. Through the COVID-19 pandemic, the course was redesigned to accommodate social distancing and hygiene requirements, and the management of specific patient behaviour and reactions during a pandemic, and also implemented an online course that has been well patronised.

Alfred Health continued to work closely with staff and our union partners on the Occupational Violence Steering Committee. Alfred Health's responses to managing OVA included the implementation of local ward superusers, a focus on providing training in ABI, and on the appropriate use of restraints to Alfred Health's ED symposium.

Occupational violence and aggression (OVA)	2017–18	2018–19	2019–20
WorkCover accepted claims with an occupational violence cause per 100 FTE	0.217	0.156	0.122
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0.269	0.153	0.29
Number of occupational violence incidents reported	489	473	516
Number of occupational violence incidents reported per 100 FTE	7.6	7.4	7.9
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	2.7%	2.1%	1.5%

Occupational violence statistics	2017–18	2018–19	2019–20
Number of OVA incidents reported	489	473	516
Number of WorkCover claims	13	10	8
OVA claims frequency rate (per million hours worked)	0.6	0.4	0.29
Injury support claims (Early intervention program)	2	0	1

Definitions are in the glossary on page 136.

WorkCover claims

Incident type	2017–18	2018–19	2019–20
Exposure to chemical/ substance	4	3	1
Hit or hit by, excluding violence	11	7	5
Mental stress	8	2	1
Occupational violence (physical and/or verbal)	4	8	8
Other	7	9	19
Slip, trip or fall	12	12	10
Manual handling	31	39	44
Grand total	77	80	88

Our Employees (continued)

Staff training and workforce initiatives

Alfred Health trains the healthcare professionals of the future by providing staff with a range of developmental opportunities. This enhances our staff's ability to do their job better and promotes a positive workplace.

Training and coaching opportunities included AWARE training, manual handling education, family violence education for both patient and staff issues, library training sessions, performance feedback workshops and warden training.

Workplace improvements continued, with the Schwartz Rounds providing a forum for clinical and non-clinical staff to discuss the emotional and social aspects of working in healthcare. The Vulnerable Persons project also explored the Crucial Conversations model to support team communication and escalate concerns about vulnerable patients in an appropriate and timely manner. This has received positive staff feedback.

Leadership development was highlighted by ongoing work in the Clinical Lead Program, and the THRIVE Program, which supports emerging leaders.

Schwartz Rounds, including those hosted at Caulfield Hospital, are an opportunity for staff to discuss the emotional and social aspects of working in healthcare.

Wellbeing initiatives

We continue to support the health and wellbeing of our staff, recognising the important link between staff health, patient outcomes and high quality of care.

Activity and health initiatives

Our Active Travel Zone (providing end-of-trip facilities for staff) at The Alfred has over 600 members, and over 400 staff are members of our on-site gym. New facilities for staff have been opened at Caulfield Hospital including a new secure bike parking facility, staff lounge and 'recharge' room (including showers and change room facilities). We also continue to support our staff to quit smoking, including providing funded nicotine replacement therapy and behavioural support.

Wellness Week

An inaugral 'Wellness Week' was held in August 2019, launching Alfred Health's 'wellness wheel': a visual representation of interconnected aspects influencing the wellbeing of individuals. The week included a launch event with comedian, staff health and wellness checks, meditation and mindfulness sessions, free bootcamp, and a performance from the Alfred Health choir.

Child care

Alfred Health continues to work closely with our child care provider, located on-site at the Alfred, to provide care for families of Alfred Health staff.

Education

Medical education

There were over 650 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 two, 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 2019, Alfred Health had a 97 per cent pass rate for the RACP Clinical Physician Exam (compared with the national average of 70 per cent).

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

Education programs co-ordinated by the Medical Education Unit at Alfred Health are also offered regularly, moving online during COVID-19. These include surgical education and a physician training program.

Additional initiatives to support doctors' wellbeing during the COVID-19 response have also been introduced, including regular wellbeing catch-ups with all junior doctor levels via Zoom and implementation of a virtual peer support initiative.

Alfred Health also has an Inter-professional Education Committee to develop a strategic approach to education across all professional disciplines, especially in response to COVID-19.

Nursing Education

The Nursing Education department supports the development of nurses across all levels of education including undergraduate, graduate, continuing nursing education and postgraduate studies. We work in partnership with our universities, including La Trobe, Monash, Deakin and Australian National University and clinical staff to support over 1,500 Bachelor of Nursing and Masters of Nursing students across all three sites.

The graduate support program provides ongoing education through weekly tutorials and study days for 175 first year registered nurses. We provide a comprehensive Continuing Professional Development program that uses many modalities to cover a range of topics from specialty practice to clinical skills, theory and practice competency.

With our University partners we run postgraduate programs in intensive care, emergency, cardiac, perioperative, acute care and mental and addiction health.

Allied Health Education

Allied Health Education provides leadership for the governance, development, implementation, evaluation and research of education programs that support undergraduate and post-graduate students, graduates and continuing professional development of Allied Health staff.

In 2018, Allied Health professions in the Allied Health Directorate provided 551 clinical placements with 12,000 clinical placement days. This equated to 92,000 clinical placement hours to 401 undergraduate students.

Eighteen Allied Health professional new graduates were employed. New graduate learning needs were identified by local disciplines, and programs responding to these needs were developed and implemented by individual disciplines.

Each discipline undertakes CPD within local professions typically through fortnightly opportunities offered within each department. Topics related to clinical practice updates, case presentations, and translational research findings are typically covered.

General and interdisciplinary education

During the last year, Alfred Health has successfully developed foundations for Inter-professional Education (IPE) to establish an integrated IPE education model. This has included bespoke programs such as the 'Yarn' about Indigenous Culture and the Family Violence program.

Alfred Health has created new models of care to manage COVID-19 and the unprecedented clinical demand. These models necessitated the introduction of training initiatives across various platforms from eLearning (LEX), in situ simulations, virtual learning, webinars and the use of multimedia. All this activity was overlaid with the ongoing challenge of 'How do we train our staff to continue to deliver effective, safe patient care; while following COVID precautions?'

A collaborative 'COVID-19 Education Services Team' was formed to support clinical education through this complex time. This team co-ordinated and drew on the skills of specialist Critical Care and General Medicine clinicians and educators, online learning experts, executive leadership and key administrators to enable the deployment of organisation-wide learning. The work program supported clinicians to develop, deliver and record activity in specialist education and training. Hundreds of Alfred Health staff have been trained as an extension of their existing specialty to provide care to COVID patients, particularly in Emergency and Intensive Care. Where possible and safely, inter-professional learning opportunities to train staff involved in high-risk interventions, such as cardiac arrest management and proning, were also facilitated.

Our Employees (continued)

Staff engagement

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

Note that the annual People Matter Survey, managed by VPSC, which canvasses the views of our staff, was not held in 2020 due to COVID-19.

Length of service

In November 2019, Alfred Health came together to honour and recognise over 580 staff members with significant years of service with Alfred Health.

The function brought together staff from all parts of the health service, with years of employment ranging from 10 years and more: four of our valued employees celebrating 45 years with the organisation. Chief Executive Andrew Way acknowledged the significant service of Drs Jacob Federman and Elias Laufer as well as Chief Radiographer Gillian Tickall, who shared stories of their working life and the impact Alfred Health has had on them. Food Stores Supervisor Gary Poulton has also marked 45 years.

Annual excellence awards

The Recognising Excellence Awards, held in November provided an opportunity for Alfred Health staff to highlight the achievements of their colleagues, both as individuals and teams.

2019 winners	Team	Individual
Focusing on patients	Hyperbaric Medical, Nursing and Technical Team Ward F2 Nursing (Highly Commended)	**Deborah Mylne**
Fostering education	**Joint winners –** Nurse Practitioners, Melbourne Sexual Health Clinic & Resternotomy for cardiac arrest after cardiac surgery ICU Team	**Karen Greenwood**
Diversity and inclusion	Alfred Mental and Addiction Health Diversity Committee	**Kellie Muir** **Jesse Scott (Highly Commended)**
Wellbeing and compassion	**Joint winners –** Alfred Radiology Clerical Team & Wellbeing Week Working Group	**David Harrower**
Working together	Health of Older People 'Get Dressed, Get Moving, Get Better' Team	**Cristina Roman**
Leading innovation	SEEG Team	**Sarah Jesudason** **Charlotte Stevens (Highly Commended)**

The Recognising Excellence Awards acknowledged our dedicated staff, including Cristina Roman and Charlotte Stevens

Staff numbers grew by 15 per cent over the last five years, as services expanded and demand increased.

ICU and Hyperbaric Unit Roster Associate Nurse Unit Manager Adele Templeton

Operational Highlights

Alfred Health offers a range of specialised services where we develop cutting-edge treatment for Australians with the most difficult to treat conditions.

From COVID-19 to our response to White Island, Alfred Health has played a leading role in managing and preparing for challenging health events. We remain committed to providing innovative and better healthcare experiences beyond this. We continue to work with our patients and consumers so we can better connect with our community, including with our submission to the Mental Health Royal Commission.

Alfred Brain

Alfred Brain brings together the surgical and medical neuroscience units of Neurosurgery, Neurology, Stroke, Epilepsy, Multiple Sclerosis Neuroimmunology (MSNI) and the Monash Alfred Psychiatric Research Centre (MAPrc).

Highlights in 2019–20 included groundbreaking work in the functional neurosurgery space. Eight advanced epilepsy surgery cases with stereo electro-encephalography (SEEG) were performed at The Alfred, led by Dr Andrew Neal and A/Prof Martin Hunn.

SEEG is a highly specialised technique used to guide surgical resection in patients with uncontrolled epilepsy. It provides a uniquely powerful way to record brain network activity and novel insights into how the brain "thinks".

To establish SEEG, a multi-disciplinary team of neurosurgeons, neurologists, neurophysiology scientists, neuropsychologists, nurses and neuroradiologists was formed. This has allowed The Alfred to be recognised as a Level 4 Epilepsy Centre according to the National Association of Epilepsy Centre's criteria, and offers transformational treatment for patients with severe otherwise untreatable epilepsy from across Australia.

Alfred Brain researchers have been highly successful in securing competitive research grants for cutting-edge translational neuroscience research, confirming the team's reputation as an international leader in the field.

These include NHMRC Investigator Grants, which are awarded to the most outstanding biomedical researcher leaders in the country, with Professor Helmut Butzkueven, A/Prof Anneke van der Walt, Prof. Terry O'Brien, Jayashri Kulkarni, Richelle Mychasiuk and A/Prof Dr David Wright among the recipients. In addition, Medical Research Future Fund Grants were received by Prof Terence O'Brien, Dr Mastura Monif and Prof Patrick Kwan.

Other key work conducted by the Alfred Brain team included:

- A new weekly multi-disciplinary Neurology Clinic has commenced at Sandringham. The clinic, led by academic neurologists Robb Wesselingh and Josh Laing, will provide specialty consultations and management in general neurology and subspecialty care for Epilepsy and MSNI. It will also include nurse consultants, dieticians and Fellows as part of a multi-disciplinary team.
- The formation of a dedicated Alfred Brain ward on 6 East. Established in June 2020, it co-locates Medical and Surgical Neuroscience Units, including neurosurgery, neurology and epilepsy for the first time at Alfred Health.
- More than 40 clinical trials of new Neuroscience treatments, including for epilepsy, Parkinson's disease, Alzheimer's Disease, Frontotemporal Dementia, Progressive Supranuclear Palsy, concussion, migraine, neuropathic pain, sleep disordered breathing and stroke.

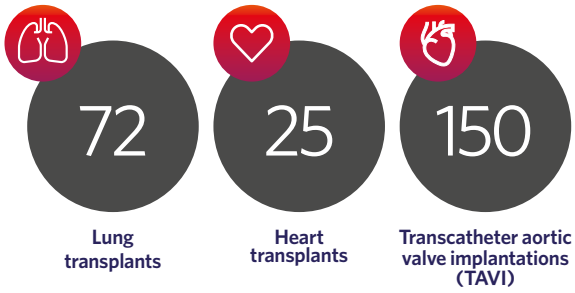
Alfred Cancer

Alfred Cancer offers one of the most extensive cancer services in Victoria.

The past year has seen our Radiation Oncology team at Gippsland Radiation Oncology (GRO) based at Latrobe Regional Hospital participate in a radiotherapy breast cancer study, in what was GRO's first international clinical trial.

Medical Oncology saw strong growth in clinical trial participation, both in recruitment as well as breadth of trials, including early phase trials. We also cemented links with the Monash Partners Precision Oncology Program to provide patients access to innovative molecular technology that informs treatment via novel targeted therapies, immunotherapy and clinical trials.

In Haematology, the team conducted ground-breaking research in acute myeloid leukemia – a blood cancer – through the clinical development of two novel drugs for patients and in understanding the underlying biological processes. We invented nano particle-based techniques to specifically target cancer cells. There were several clinicians and scientists recognised by research fellowships and professorial promotions. We were successful in securing competitive grants from NHMRC, MRFF, Cancer Council Victoria and the Victorian Cancer Agency.



Alfred Heart and Lung

Alfred Health's Heart and Lung Program is at the cutting edge of treatments for severe heart and lung diseases. It now offers one of the largest public transcatheter aortic valve implantation (TAVI) programs in Australia, with 150 procedures completed in 2019–20 (an increase on 116 cases in 2018–19).

In the face of the challenges presented by COVID-19, the team's outstanding work continued, with 25 heart transplants and 72 lung transplants performed in 2019-20.

Our commitment to ongoing innovation included a new Cardiology/Cardiothoracic Shared Care Model implemented in February 2020 for patients requiring consultation from these two specialty units. This quality improvement project has already seen improved clinical collaboration and better patient experiences. It is hoped that more efficient data capture processes will help us progress care more efficiently and reduce surgical waiting times and overall length of stay in hospital.

Among other highlights this year was our ongoing collaboration with services beyond our local population. Services such as Bairnsdale, LaTrobe and Bass Coast (Wonthaggi) hospitals are among those we work with to provide care to those in regional Victoria.

We continued to be on the leading edge of technology. Despite the COVID-19 pandemic, our heart transplant, lung transplant and mechanical support programs have continued to save the lives of many Australians. In a Victorian first, an advanced form of cardiac support known as an Impella device was successfully implanted in the Alfred Catheter Laboratory.

Research was also a priority. The Alfred was the lead site for an international trial demonstrating the equivalence of TAVI compared to surgical Aortic Valve replacement in low risk surgical patients.

Respiratory services have played an important role in the COVID response. They have increased ambulatory care, and care at home, with a growth in Telehealth capacity supporting patients who live in rural and regional areas, as well as interstate.

The Alfred Brain team continued its groundbreaking work in the functional neurosurgery space.

Paediatric lung transplant patient Thuong Mai has thanked The Alfred team for giving her a second chance.

Teenager's remarkable tale of recovery

In a remarkable example of team collaboration at The Alfred, paediatric lung transplant patient Thuong Mai returned home after successfully receiving a double lung transplant, a kidney from her mother and record-levels of blood products among many other medical interventions.

Teams and specialities involved in Thuong's care included anaesthetics, perfusion, respiratory, ICU, renal, dialysis, Blood Bank, occupational therapists, physiotherapists, dietitians, cardiothoracic surgeons and language services.

Associate Prof Basu Gopal, medical lead for kidney transplant at The Alfred, said there was immense pride in seeing Thuong Mai walking out of hospital.

"The reward I get is to see a patient live their life. It's a great feeling."

Thuong says she is grateful to her lung donor and family, along with everyone at The Alfred, for giving her a second chance.

"The medical staff, the nurses who helped me, have done a wonderful job and I appreciate their devotion to helping me."

Alfred Specialty Medicine

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

Infectious Diseases and Infection Prevention have played a pivotal role in clinical management and support during the COVID-19 pandemic.

There was rapid upscaling of their team and function to support clearance of patients, liaising between Alfred Health and the Department of Health and Human Services, policy and guidance guidelines and contact tracing. Case management was also important, including managing staff who have been furloughed and ensuring efficient return to work processes. Infection Prevention also played a key role, supporting hand hygiene and safety auditing.

The Renal Medicine team continued its performance as the highest quality peritoneal dialysis service provision, leading the state in the lowest rate of dialysis-associated infections and beating international standards of excellence by 40 per cent.

They have substantially increased their volume across complex ambulatory care, with growth in Telehealth capacity providing expert renal care to rural, regional and interstate patients. The team has also initiated a transformational operational project to align service provision with future needs.

Emergency and acute

In 2019–20, The Alfred had 67,774 emergency department presentations, while Sandringham had 42,827 presentations.

In September 2019, the ICU expanded to 56 cubicle spaces, with the opening of a new 11-space fully functioning ICU pod on Level 3. The pod has increased our ability to care for all critically ill patients. It means we can continue to respond to the growing need for critical care while providing high dependency beds that support our surgical and trauma patients in particular.

Other highlights included:

- ICU continued to partner with regional health services to expand Telehealth care and support critical unwell patients, avoiding the need to transfer patients to Metro Tertiary ICUs.
- ICU will officially lead the state ECMO (extracorporeal membrane oxygenation) service.
- General Medicine model of care changes resulted in a 15 per cent reduction in length of stay despite an 8 per cent increase in separations and the reduction of our Alfred Hospital-based workforce from five to four teams.
- General Medicine's new 'My Patient Needs' project utilises a needs-based patient assessment to 'help patients achieve their best life' with strong focus on integrating care with community services.
- Alfred Emergency Services was awarded a 3.5 year DHHS contract to deliver basic and advanced training to nurses working in Rural Urgent Care Centres across Victoria. The program involves online learning, face-to-face workshops and clinical placements all delivered within Regional Victoria.

Meanwhile, the Sandringham Emergency Department and Alfred Health Emergency Academic Program conducted '145 Stay Alive', a public health community engagement initiative on car seat safety.

Other Sandringham highlights included the introduction of a two-tier Emergency Education Service leading to an increase in education support hours and higher quality teaching.

Surgical Services

The Surgical Services Program delivers the majority of surgical services across Alfred Health. The program includes five general surgical units, specialty surgical units, anaesthesia and perioperative medicine, operating suite service, surgical inpatient wards, a medical day unit, day of surgery admissions, day surgery and endoscopy service. The program also oversees the elective surgery waiting list.

Among this year's highlights was the opening of 5 West, a new 40-bed trauma and orthopaedic ward. The new ward will treat about 2,500 seriously injured patients each year. Purposely built for trauma patients, the ward provides more room and more privacy. Infection control measures are of the highest standard and there are opportunities to rehabilitate patients during their stay, including an Allied Health Therapies space. A new procedure room also means minor surgical needs can be attended to.

After 50 years of dedicated service, we farewelled Bill Johnson. An outstanding leader and caring mentor, Bill's roles included Head of Unit, and Chairman of the Division of Surgery, a position he shared with Cas McInnes. He was also a lecturer in the Monash University Department of Surgery at Alfred Hospital.

Other key events included the appointment of Wendy Brown as Program Director of Surgical Services; and Alfred Health Director of Anaesthesia and Perioperative Medicine Prof Paul Myles presenting the Sir Edward Hughes Keynote Lecture at the 2019 Surgical Research Forum.

Operational Highlights (continued)

Mental and addiction health

Alfred Health Child and Youth Mental Health Service (CYMHS) and headspace

Alfred Health runs a comprehensive mental health service for children and youth living in the southern metropolitan region. This is delivered through a state-funded service located in Moorabbin, as well as a federally funded primary care headspace centre in Elsternwick and Bentleigh and a specialist early psychosis program across the entire region.

This service adapted rapidly to the COVID-19 pandemic, taking a total of 1,478 Telehealth calls (1,079 at headspace and 399 at CYMHS) during April and March of 2020, which was 35.5 per cent of the total calls across all of Alfred Health's services for that period.

headspace Early Psychosis (hEP) implemented a Family Peer Support Work program that provides support to families of young people receiving care. The support is provided by peer workers with lived experience of caring for a child or young adult with a serious mental illness.

The CYMHS service has implemented MHIDI-Y – a new dual disability service for young people (12–24 years) with an intellectual disability and serious mental health or behavioural difficulties.

The Youth Forensic Specialist Service (YFSS) provides support to young people aged 10–21 who are exhibiting high-risk problem behaviours. This can include young people who may pose a risk of harm towards others with emerging or formed mental health difficulties.

Adult Community Program

To support our consumers with psychosis build meaningful social connections, our Adult Community Mental Health Program developed an 8-week social skill intervention called Rel8. In this program, therapists offer practical knowledge and skills to promote positive social interactions and help participants build friendships. The group practises new skills both in-session and in real-world settings. In an evaluation, participants highlighted improvement in their confidence, communication skills and social connections with others.

IPU

Local rotary clubs have combined to provide comfort bags for IPU inpatients (pictured). The idea for the bags came from a meeting between a representative from Rotary and the St Stephens opportunity shop and a Psychiatric Unit staff member. The staff provided a wish list of items to include including a hairbrush, socks, body cream, lip balm, water bottle and a deodorant. From there, volunteers, local businesses and a Rotary Club Grant helped make the project a reality, with basic clothing also added to the comfort bags. The IPU team is grateful to everyone for their support of this ongoing commitment.

A Family Room featuring comfortable furniture, toys, books and other resources has been beneficial. FaPMI coordinator Alice Morgan worked closely with the IPU staff to design and decorate the room. Although the official opening of the room has not occurred due to COVID-19 restrictions, it has already been used by families. Additionally, a book for children with parents who are admitted on the IPU was also developed, providing families with an insight into the environment where their loved ones are being treated.

Rehabilitation, aged and community care

Working closely with our many hospital and community partners, the Rehabilitation, Aged and Community Care (RACC) program continued to innovate in the delivery of high quality care. We provided this care in our hospital beds, community centres and in people's homes.

Among the key highlights was our Best@Home initiative. Building upon a strong legacy of home-based care, we continued to promote a mentality of 'home first'. COVID-19 encouraged us to think further about how we could provide quality treatment outside of an inpatient environment, with innovations such as Telehealth proving popular alternatives.

Our commitment to community integration was highlighted through our involvement in the HealthLinks initiative, which focuses on integrated healthcare for people with chronic and complex health conditions. With our Hospital Admission Risk Program (HARP) playing a key role, we have seen success with a reduction in hospital admissions.

Our Mobile Assessment and Treatment Service (MATS) continued their hard work – including supporting those in residential care – bringing specialist geriatric nursing and medical care to our older patients within a home environment in place of staying in hospital.

The ongoing dedication of our long-term programs was also noteworthy, including the Caulfield Pain Management team, who celebrated 40 years of delivering care.

Our specialist Rehabilitation teams supported people in our local area and across the state to achieve their independence after life-changing events such as stroke, spinal cord injury, acquired brain injury and trauma. Our burns specialist team supported survivors of the White Island volcano eruption to regain their function and return home to continue their recovery.

Our Health of Older People team continued their important work. Our teams in our overnight wards, many specialist clinics, Transition Care Program and Community Health services all progressed local initiatives to address frailty and provide greater options for ageing well in the community.

Margaret's quality care at home

As part of her recovery from a knee replacement, Margaret (pictured with daughter Glenda) has had rehabilitation through the Better at Home program. She has received quality treatment with daily home visits from a physiotherapist and a nurse, as well as regular support from a doctor.

Receiving care at home, a physiotherapist provided her with support to do daily exercise, including practising going up the flight of stairs to her apartment. However, there is a range of incidental exercise she does at home which she might not necessarily do in a hospital.

"At home you learn to do things yourself – like getting up and going to the toilet, and getting a meal."

She is also happy to be in an environment she is more comfortable in. "I can sleep better at home."

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.

Over the past year we have expanded our services to offer more home-based care options for cancer, MS and gastroenterology patients. We have also provided greater allied health access.

Utilisation of Telehealth has increased, providing safe and efficient review of patients in their home setting. We have also implemented Bluetooth specimen collection printers to enable pathology collection standardised with inpatient areas and optimising safety functionality of EMR.

Specialist clinics (outpatients)

Alfred Health offers a diverse range of Specialist Consulting Clinics, providing treatment and care to patients who are not currently admitted to hospital.

Patients are referred to one of our Specialist Clinic services by a GP, or for follow-up treatment after receiving inpatient care.

Specialist Consulting Clinics provide scheduled medical, nursing and allied health services at all three campuses of Alfred Health. Approximately 1000 patients are treated daily across Alfred Health Specialist Consulting Clinics within surgical, medical and other specialties.

As part of our COVID-19 response plan, there were significant changes to our Specialist Clinic services in 2020.

This meant services were prioritised to provide urgent care. Telehealth was also utilised wherever it was safe to do so, enabling care to be delivered without the requirement for travel to the health service.

We continued to offer on-site Specialist Clinics, however, the location changed for some of our clinics, to help provide capacity for other services. For example, some clinics at The Alfred Centre moved to Alfred Lane House.

We are grateful to our hard working staff who demonstrated great agility and adaptability in having to work in a changing and unique environment, and thank our patients for their understanding during this period.

Delivering Quality Care

Molecular Microbiology Supervising Scientist Lisa Liolios

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 each patient meets the National Safety and Quality Health Service Standards.

Among the key achievements in the past year was passing accreditation. Our Infection Team also played a leading role in our response to COVID-19, and the safety of patients, staff and broader community.

Beyond this we are committed to ongoing improvement at an internal level, always looking to build on what we have achieved, and deliver better care to our community.

Tick of approval for Alfred Health

Alfred Health is accredited against the National Safety and Quality Health Service standards (2nd edition).

In October 2019, assessors from the Australian Commission for Safety in Healthcare confirmed that Alfred Health met all standards and actions, with no recommendations – meaning the health service received full accreditation status.

The assessors commented on the openness and transparency of staff, as well as their willingness to discuss patient care and to work continuously to improve outcomes.

In their report, the accreditors said: "Consumer engagement and partnering in planning and designing care is highly evident … There are sound governance processes in place from the Board, Executive, all programs and at site level throughout Alfred Health."

The organisation's accreditation performance reassures our community that we have reliable systems and processes in place to support the delivery of high quality care and health outcomes.

ACCREDITATION 2019 NSQHS STANDARDS

Infection Prevention

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

COVID-19 response

Alfred Health actively developed infection prevention and control strategies, guidelines and resources to support staff in caring for patients while maintaining their own safety. These resources are consistent with DHHS guidance.

For further details see the Our Employees chapter.

SAB rate

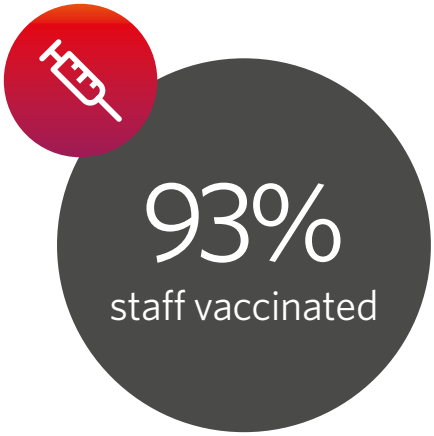
Staphylococcus aureus bloodstream (SAB) infections are serious infections with significant associated morbidity and mortality. The benchmark rate set in July 2017, remains at 1/10,000 occupied bed days (OBDs). Across Alfred Health the benchmark rate was achieved for one reported quarter (Oct – Dec 19) for this nine-month period.

Central line-associated bloodstream infections

Central line associated bloodstream infections (CLABSIs) in our ICU continue to be monitored against the statewide target of zero. Multiple interventions were implemented in ICU and included:

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

The Alfred ICU cares for some of the most complex and acute patients in Australia. While we see low rates of CLABSI in our ICU we have observed one CLABSI per month with the exception of July, October and December 2019 where zero CLABSIs were reported.



Hand hygiene

Nurse Rose Phan understands the importance of hand hygiene.

With a State Government target set at 83 per cent compliance, Alfred Health has exceeded this target for all audit periods from 2019–20:

Jul 2019 – Oct 2019

Nov 2019 – Mar 2020

Apr 2020 – Jun 2020

In 2020, a particular emphasis was placed on hand hygiene in relation to PPE application and removal, together with ongoing auditor training.

Staff influenza vaccination

The 2019 influenza campaign, which ended in August 2019, saw 90.8 per cent of staff vaccinated at Alfred, 87.7 per cent at Caulfield and 87.5 percent at Sandringham, exceeding the DHHS target of 84 per cent at all campuses. Annual DHHS targets have therefore been exceeded since 2013. Influenza vaccination continues to be strongly encouraged for all healthcare workers across the organisation as well as our high-risk patients. As of 30 June – and part-way through the 2020 campaign – 93 per cent of staff were vaccinated.

Delivering Quality Care (continued)

Surgical site infection

We monitor infections related to key surgeries, in accordance with DHHS requirements. In 2019–20, surveillance was undertaken on orthopaedic surgery, hip and knee replacements. At The Alfred infection rates fell below benchmark rates, Sandringham Hospital only had one quarter outside the benchmark rates.

At Alfred Health, we also continue to monitor infections following cardiothoracic surgery. Intensive initiatives have been implemented over recent years to decrease our rate of infection following coronary artery bypass graft surgery including:

- reviewed hand hygiene and antimicrobial prophylaxis
- additional auditing to examine the theatre environment, cleaning and operating room processes and practices.

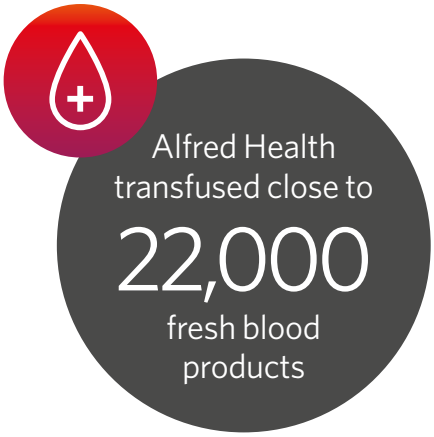
Decreased infection rates have been observed and continued efforts are being made to reduce infection risk.

Surveillance for infections following colorectal surgery is undertaken as a DHHS-mandated activity (six-month period). Findings have all been within benchmark targets.

Antimicrobial stewardship (AMS)

The AMS program has been enhanced by implementation of Alfred Health's Electronic Medical Record in 2018, which allows for a clear vision of all antimicrobials used across the health service. This facilitates a targeted review of all patients on the selection of broad spectrum antibiotics to ensure that they are being used appropriately. The sepsis campaign has continued.

We 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.



Carbapenemase-producing Enterobacteriaceae (CPE)

As with many other health services, Alfred Health is meeting challenges associated with emerging cases of multi-resistant bacteria in Australia, including CPE. We continued to work closely with the DHHS and followed statewide CPE management guidelines to initiate control measures across our high risk wards.

Measures that continue to be implemented are:

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

Staff education and auditing of clinical practices continue across the organisation. Recent work internationally focused on the potential for contaminated sinks to act as reservoirs for multi-resistant organisms; we successfully implemented a decontamination routine in intensive care to reduce the potential for transmission.

In September 2019, we engaged an external surveyor to assess our practices in relation to CPE management. An intensive review was undertaken over a three-day period across the health service. This review acknowledged the comprehensive prevention program at Alfred Health and did not identify any deficits in CPE prevention activities. To enhance the program, universal use of bleach-based cleaning will be applied across the organisation and improved communication strategies will be employed – these are currently being developed.

Blood management

Alfred Health transfused close to 22,000 fresh blood products (Red Blood cells/Fresh Frozen Plasma, Platelets, Cryoprecipitate) between 2019–20. Almost 13,000 units (60 per cent) were red blood cells.

Wastage of fresh blood products remains below target but efforts to minimise wastage of red cells is ongoing.

Monthly audits of red cell transfusion appropriateness are undertaken at The Alfred and Sandringham sites using the Blood Matters audit tool. The majority of red cell transfusions given meet guidelines.

Patient consent to transfusion is reviewed monthly and consistently meets target of 95 per cent each month across all three hospital sites.

Medication safety

During the COVID-19 pandemic, the potential for increased numbers of patients requiring intensive care and critical medications was identified. Projected quantities were calculated and ordered, to ensure our patients received their medications in a timely manner under Stage 3 restrictions.

As supply was especially critical for medications used with ventilation equipment – such as intravenous opioid analgesics, sedatives and neuromuscular blocking agents – pharmacy staff worked closely with clinicians in critical care areas.

When shortages occurred due to disruption of regular supply, alternative medication brands were sourced, including some from overseas which had labelling or other information in languages other than English.

To ensure these new medication brands are safe, the Medication Safety pharmacist works with procurement staff and the Formulary Manager to review each new medication.

Harm minimisation

Alfred Health has a co-ordinated approach to harm minimisation linked to the risks of falls, delirium, malnutrition and pressure injuries.

To facilitate patient, family and carer engagement, harm minimisation activities included:

- exploring opportunities to pull data from the electronic medical record to audit our interdisciplinary patient safety plans of care; and
- expansion of the recently updated nursing patient safety audit to better understand our interdisciplinary patient safety plans of care.

The PUPPS/ BMI audit was not held due to COVID. It is scheduled to be completed in ICU later in 2020, if possible.

Falls and delirium

The End PJ Paralysis Project, which aims to reduce functional decline of patients while in hospital, held activities including running an op shop and walking groups. A forum was held with consumers, experts in the field and staff to establish key initiatives to help patients stay active and engaged.

Improving collaboration was also a highlight, with the co-ordination of statewide acute and sub-acute falls data benchmarking.

The Safer Care Victoria Delirium Collaborative project was run on one of our acute general medicine wards. It was successful in identifying a number of improvements in delirium care and creating a safer ward culture; with solutions to be trialled in other clinical areas.

	May 2016 – Apr 2017	May 2017 – Apr 2018	May 2018 – Apr 2019	May 2019 – Apr 2020
Actual falls	1,958	2,086	2,216	2056
Actual serious injury (ISR1 and 2)	31	22	25	19

Malnutrition

During the year, automatic weight tasking in the EMR was introduced to prompt nursing staff to weigh patients on admission and weekly. A 'Meal order host' program reduced default meals, with a focus on communicating with patients in isolation so that they are able to receive their menu selections. A new Quick Reference Guide was also developed to assist completion of the malnutrition screening tool, MUST, even when a patient cannot be weighed because they are in isolation.

Pressure injury prevention

Wound Clinical Nurse Consultants work closely with interdisciplinary teams and wards to educate, support and review patients who are identified at risk of pressure injuries. A model was also developed for wound leads in some wards across Alfred Health.

The Staff Wound Intranet site was updated with new staff education resources including updates to wound education posters, including skin tear assessment and a management poster. The 'Wound Matters' staff newsletter also assisted with local wound education.

Advance Care Planning

The Advance Care Planning (ACP) 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.

Working closely with community and ambulatory care services, ACP continued to advocate strongly for patients in the chronic disease population, with referrals increasing. This has included contacting appropriate patients directly via phone to offer appointments.

The ACP service is also involved in quality improvement projects, including working with Southern Melbourne Integrated Care Service to improve involvement with oncology patients.

Due to COVID-19, the ACP program has been offering phone and Telehealth appointments. This has been received very positively by consumers and will become part of normal practice in the future. ACP Clinicians have also continued to offer multi-disciplinary education via Microsoft Teams which has been well attended.

Sharon Billings is part of the dedicated Advance Care Planning Team

Performance

Registered nurse Chloe Jo and Clinical Nurse Specialist Georgina Lea

Part A: Statement of Priorities 2019–20

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

DHHS Goals (AH Strategic Goal)	DHHS Strategies	Alfred Health Deliverables	Progress Update
Better Health			
A system geared to prevention as much as treatment. **Everyone understands their own health and risks.** **Illness is detected and managed early.** **Healthy neighbourhoods and communities encourage healthy lifestyles.** **AH Strategic Goals 1 and 2**	Reduce statewide risks. Build healthy neighbourhoods. Help people to stay healthy. Target health gaps.	Strengthening regional partnerships to improve access to specialist services for regional Victorians.	**COMPLETED** New partnership established with Bass Coast Health to support services in Cancer and Cardiac Care. Alfred Health is now the primary referral centre for cardiac care from Gippsland Region with a new cardiac pathway at Bass Coast. ICU Telehealth service has transitioned from project to sustainable funded service model with Mildura, Bass Coast Health, Bairnsdale Regional Health Service, Central Gippsland (Sale) and Wimmera Health Care Group (Horsham).
		Implement Alfred Health's Primary Care and Population Health Strategy, with a focus on • reducing harm from alcohol; • suicide prevention and wellbeing; • vaccinations; • preventing harm from blood-borne viruses; and • reducing weight and healthy weight maintenance.	**COMPLETED** Good progress of Alfred Health's Primary Care and Population Health Strategy: • Ongoing achievement of Gold Status against International Standards for Smokefree Healthcare Services. • Prevalence study of alcohol among inpatients. • Staff wellbeing and workplace health checks, measured alcohol use and obesity. • Commenced audit of safe needle and syringe disposal facilitates for staff, patients and visitors across Alfred Health. • Completed pilot study for the 20-minute rapid testing for Hepatitis. • Establishment of a Suicide Prevention Expert Advisory Group with representatives across Alfred Health. • Launch of inaugural staff 'Wellness Week'.

DHHS Goals (AH Strategic Goal)	DHHS Strategies	Alfred Health Deliverables	Progress Update
Better Access			
Care is always there when people need it. **More access to care in the home and community.** **People are connected to the full range of care and support they need.** **There is equal access to care.** **AH Strategic Goals 6 and 7**	Plan and invest. Unlock innovation. Provide easier access. Ensure fair access.	Improve End of Life Care across Alfred Health through: • Implement, evaluate and continue to adapt a partnership model for Voluntary Assisted Dying; • Improve access to palliative care especially during transitions of care and integrate more effectively with Alfred Health inpatient and community services.	**COMPLETED** Voluntary Assisted Dying Policy and Guideline developed and implemented with ongoing evaluation and adjustment of guideline incorporating consumer feedback and implementation experience. Continued improvement in co-ordination of care and improved access to palliative care.
		Contribute to a modern and technologically enabled service environment through completion of: new Trauma Ward; • Innovation and Education Hub; • first stage of the South Block redevelopment; • decant stage of the Urgent Infrastructure Project (MWB), and • continued development of plans for redevelopment of the Alfred Hospital.	**GOOD PROGRESS** 5 West (trauma ward) completed. Innovation and Education Hub on track for completion August 2020. South Block Stage 1 redevelopment (Cancer & Clinical Trial capacity) completed. Decant stages of Alfred Urgent Infrastructure Upgrade (MWB) completed. Alfred Health is contributing to the development of the Alfred Redevelopment Business Case
		Implement Cost Improvement plan to review scope and configuration of services, deliver significant cost savings in cross-functional services and optimise efficient use of resources.	**COMPLETED** Cost Improvement Plan delivered significant cost savings in cross-functional services and supported achievement of balanced budget.
Better Care			
Target zero avoidable harm. **Healthcare that focuses on outcomes.** **Patients and carers are active partners in care.** **Care fits together around people's needs.** **(AH Strategic Goals 5 and 6)**	Put quality first. Join up care. Partner with patients. Strengthen the workforce. Embed evidence. Ensure equal care.	Consolidation of eTQC phase 1 and implementation of eTQC phase 2.	**COMPLETED** South Block Stage 1 redevelopment completed, resulting in increased physical capacity to support clinical trials. Clinical TrialHub program has commenced with appointment of Director Clinical TrialHub. Planning commenced for TrialHub Flagship Programs to commence in 2020–21. eTQC outcomes: Consolidation of Phase 1 benefits and ongoing monitoring. Several Phase 2 initiatives have been completed which include Camera Capture, Outpatients PowerChart ECG, Inpatients closed loop ECG, ED LaunchPoint and Patient Portal. The remaining items have been delayed due to resources being diverted to COVID-19 related activities, with work continuing into the new financial year.
		Continue to build capability in clinical trials through completion of stage 1 redevelopment of South Block and establish administrative infrastructure and space for TrialHub for following Flagship Programs: Melanoma trials, Prostate Cancer trials, Rare Cancers/ Diseases trials, and Parent-Outreach Hospital.	

Performance (continued)

Part A: Statement of Priorities 2019–20 (continued)

DHHS Goals (AH Strategic Goal)	DHHS Strategies	Alfred Health Deliverables	Progress Update
Specific 2019–20 Priorities			
Supporting the Mental Health System **(AH Strategic Goal 1)**	Improve service access to mental health treatment to address the physical and mental health needs of consumers.	Establish a physical health hub with a multi-disciplinary team to improve the physical health outcomes of people with mental illness.	**COMPLETED** Multi-disciplinary team established with Nurse Practitioner-led Focus on assessment and monitoring of health outcomes of people with mental illness; built into EMR with audit schedule. Mental Health Specialist clinics established for Infectious Diseases/ immunisation and health lifestyle programs. Pilot of dietician program extended into Mental Health inpatients, demonstrated outcomes and now under further development and embedding.
Addressing Occupational Violence **(AH Strategic Goal 4)**	Foster an organisation-wide occupational health and safety risk management approach, including identifying security risks and implementing controls, with a focus on prevention and improved reporting and consultation. Implement the department's security training principles to address identified security risks.	Implement organisation-wide strategy incorporating the DHHS Framework for Preventing and Managing OVA and the ANMF 10-point plan. Expand Alfred Health's AWARE coaching program to support staff post training. Evaluate implementation of the Broset Observation tool (BOC Tool) in Emergency Department.	**GOOD PROGRESS** AWARE Superuser pilot training completed (employing key stakeholders from target ward areas). AWARE eLearning refresher module developed and implemented. 'Broset' (Behaviours of Concern) tool pilot program in The Alfred ED delayed due to COVID, to recommence June 2020.
Addressing Bullying and Harassment **(AH Strategic Goal 4)**	Actively promote positive workplace behaviours, encourage reporting and action on all reports. Implement the department's Framework for promoting a positive workplace culture: preventing bullying, harassment and discrimination and Workplace culture and bullying, harassment and discrimination training: guiding principles for Victorian health services.	Continue to embed positive workplace behaviours across all sites through integrated program of training, communications, orientation, performance reviews, staff surveys, investigations and reporting. • Implement a culture safety program 2019–20. • Build capability of Senior Leadership team to act as role models and coaches for a safe culture. • Consultation with staff to identify barriers to reporting poor behaviour.	**SOME PROGRESS** High-level respect and civility strategy roadmap developed by Dec 2019. Primary aim of strategy is psychological safety for staff in the workplace through: a) earlier intervention; and b) increased capability to respond at all levels. Senior Leadership Capability Program delayed due to COVID-19, to recommence July 2020. Continued to promote Alfred Health's stance on workplace behaviour at staff orientation and online modules.
Supporting Vulnerable Patients **(AH Strategic Goal 3)**	Partner with patients to develop strategies that build capability within the organisation to address the health needs of communities and consumers at risk of poor access to healthcare.	Examine a vulnerability profile present in clinical incident data (RiskMan) in conjunction with University of Technology Sydney. Develop and implement a communications strategy to raise awareness across the organisation on vulnerability. Test effectiveness of 'Four vulnerability screen questions' in the EMR.	**GOOD PROGRESS** Data analysis and finalisation of vulnerability profile report will be completed by Dec 2020. Communication for vulnerability communication strategy commenced, four vulnerability screening questions have been tested. Successful in grant funding for the SPEAK project for disability – will commence in July 2020.

DHHS Goals (AH Strategic Goal)	DHHS Strategies	Alfred Health Deliverables	Progress Update
Specific 2019–20 Priorities			
Supporting Aboriginal Cultural Safety **(AH Strategic Goal 3)**	Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices across all parts of the organisation to recognise and respect Aboriginal culture and deliver services that meet the needs, expectations and rights of Aboriginal patients, their families and Aboriginal staff.	Continue to implement Alfred Health Innovate RAP. Develop and implement an education strategy to increase Aboriginal and Torres Strait Islander cultural awareness organisationally.	**GOOD PROGRESS** Cultural training program initiated with over 400 staff attending face-to-face training pre-COVID-19 restrictions. Revised Advisory Group membership has incorporated more local community members. Utilising Aboriginal patient story for use in education and feedback to clinical areas. Established (pre-COVID-19) clinical working group to identify strategies to address the disparity in health outcomes relative to access/inclusion and communication. Capital project underway to incorporate acknowledgement of traditional owners at Main Entrance and develop Aboriginal Garden.
Addressing Family Violence **(AH Strategic Goal 3)**	Strengthen responses to family violence in line with the Multi-agency Risk Assessment and Risk Management Framework (MARAM) and assist the government in understanding workforce capabilities by championing participation in the census of workforces that intersect with family violence.	Embed organisation-wide model for responding to family violence into usual practice. Embed the SHRFV training program for staff education. Implement a sustainable framework for maintaining cultural change and staff training program. Champion participation in the census of workforces that intersect with family violence.	**COMPLETED** Online module and training register in operation – over 2,500 staff trained in FV identification and response, including over 250 managers. FV communications established through intranet and websites, and digital screens. Workforce Capability Census completed and Clinical Champions network continuing.
Implementing Disability Action Plans **(AH Strategic Goal 3)**	Continue to build upon last year's action by ensuring implementation and embedding of a disability action plan which seeks to reduce barriers, promote inclusion and change attitudes and practices to improve the quality of care and employment opportunities for people with disability.	Implement Alfred Health Access and Inclusion Plan, specifically: • optimise use of the disability screening questions in the EMR; • access to suitable physical environments; and • ensure clinical staff are trained and supported in delivery of clinical care for patients with complex disabilities.	**COMPLETED** Access and Inclusion plan intranet site completed and promoted. Consultation commenced with Telehealth and Alfred Patient Portal to ensure accessibility of these services to people with disability. Self-assessment for NDIS service provider quality and safeguarding audit completed.
Supporting Environmental Sustainability **(AH Strategic Goal 7)**	Contribute to improving the environmental sustainability of the health system by identifying and implementing projects and/or processes to reduce carbon emissions.	Implement Alfred Health's Environmental Sustainability Strategy, improve waste management and environmental citizenship: • raise awareness, transparency and accountability for our environmental impact; and • design and implementation of capital and engineering projects to reduce carbon emissions. • Complete "Single Use Metal Instrument (SUMI) recycling" pilot. • Complete and evaluate "War on Waste" pilot project at Sandringham hospital campus.	**COMPLETED** War On Waste project commenced at Sandringham Hospital campus with evidence of waste reduction. To be rolled out across organisation. Environmental citizenship widely promoted and increased across Programs. Sustainability intranet site established for information and promotion. Stand-alone Sustainability Public Report launched and available on website. Fluoro light upgrade at Melbourne Sexual Health Clinic completed.

Performance (continued)

Part B: Performance Priorities

High quality and safe care

Key performance indicator	Target	2019–20 actuals
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Accredited	Achieved
Infection prevention and control		
Compliance with the Hand Hygiene Australia program	83%	86.4%
Percentage of healthcare workers immunised for influenza	84%	88.6%
Patient experience		**2019–20 actuals**
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – quarter 1	95%	92%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – quarter 2	95%	94%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – quarter 3	95%	97%
Victorian Healthcare Experience Survey – transition of care – quarter 1	75%	75%
Victorian Healthcare Experience Survey – transition of care – quarter 2	75%	79%
Victorian Healthcare Experience Survey – transition of care – quarter 3	75%	78%
Victorian Healthcare Experience Survey – patients' perception of cleanliness – quarter 1	70%	65%
Victorian Healthcare Experience Survey – patients' perception of cleanliness – quarter 2	70%	68%
Victorian Healthcare Experience Survey – patients' perception of cleanliness – quarter 3	70%	62%
Healthcare associated infections (HAIs)		
Rate of patients with surgical site infection	No outliers	21
Number of patients with ICU central-line associated bloodstream infection	Nil	Not achieved
Rate of patients with SAB per 10,000 occupied bed days	<1	0.84
Adverse events		
Sentinel events – root cause analysis (RCA) reporting	All RCA reports submitted within 30 business days	Not achieved
Unplanned readmission hip replacement	Annual rate M 2.5%	The Alfred 4.6% Sandringham 4.1%

Key performance indicator	Target	2019–20 actuals
Mental Health		
Percentage of adult acute mental health inpatients who are readmitted within 28 days of discharge	14%	14%
Rate of seclusion events relating to an adult acute mental health admission	< 15/1,000	6
Rate of seclusion events relating to an aged acute mental health admission	< 15/1,000	0
Percentage of child acute mental health inpatients who have a post-discharge follow-up within seven days	80%	85%
Percentage of adult acute mental health inpatients who have a post-discharge follow-up within seven days	80%	89%
Percentage of aged acute mental health inpatients who have a post-discharge follow-up within seven days	80%	92%
Continuing Care		
Functional independence gain from an episode of rehabilitation admission to discharge relative to length of stay	> 0.645	0.562

Strong governance, leadership and culture

Key performance indicator	Target	2019–20 actuals
Organisational culture [2]		
People Matter Survey – percentage of staff with an overall positive response to safety and culture questions	80%	90%
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%	95%
People Matter Survey – percentage of staff with a positive response to the question, "Patient care errors are handled appropriately in my area"	80%	93%
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%	90%
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 error of others"	80%	88%
People Matter Survey – percentage of staff with a positive response to the question, "Management is driving us to be a safety-centred organisation"	80%	89%
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%	82%
People Matter Survey – percentage of staff with a positive response to the question, "Trainees in my discipline are adequately supervised"	80%	86%
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%	94%

[2] *Figures presented based on Q1 Monitor Report prepared by Victorian Agency for Health Information. Due to COVID-19, the 2020 People Matter Survey had not been conducted at time of publication.*

Performance (continued)

Part B: Performance Priorities (continued)

Timely access to care

Key performance indicator	Target	2019–20 actuals	
Emergency care		**The Alfred**	**Sandringham**
Percentage of patients transferred from ambulance to emergency department within 40 minutes	90%	84%	93%
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%	77%	86%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	0	0

Timely access to care

Key performance indicator	Target	2019–20 actuals
Elective surgery [3]		
Percentage of urgency category 1 elective surgery patients admitted within 30 days	100%	99.3%
Percentage of urgency category 1,2 and 3 elective surgery patients admitted within clinically recommended time	94%	98%
Percentage of patients on the waiting list who have waited longer than clinically recommended time for their respective triage category	5% or 15% proportional improvement from prior year	9.7%
Number of patients on the elective surgery waiting list	2,000	2,793
Number of hospital initiated postponements per 100 scheduled elective surgery admissions	< 7 /100	3
Number of patients admitted from the elective surgery waiting list [4]	11,250	9,499
Specialist clinics		
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	81.5%
Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%	91.0%

Effective financial management

Key performance indicator	Target	2019–20 actuals
Finance		
Operating result ($m)	0	$0.50 million
Average number of days to paying trade creditors	60 days	42 days
Average number of days to receiving patient fee debtors	60 days	66 days
Public and Private WIES[5] activity performance to target	100%	95.5%
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	0.69
Forecast number of days a health service can maintain its operations with unrestricted cash (based on end of year forecast)	14 days	2.0 days
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	Not achieved
Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June	Variance < $250,000	$0.6 million

[3] *Figures may be effected by COVID-19 pandemic*

[4] *The target shown is the number of patients on the elective surgery waiting list as at 30 June 2020*

[5] *WIES is a Weighted Inlier Equivalent Separation*

Part C: Activity and funding

	2019–20 activity achievement
Acute Admitted	
WIES Public	84,711
WIES Private	14,907
WIES DVA	558
WIES TAC	6,414
Acute Non-Admitted	
Home Enteral Nutrition	991
Home Renal Dialysis	94
Radiotherapy WAUs Public	74,719
Radiotherapy WAUs DVA	897
Specialist Clinics (inc DVA)	239,033
Subacute & Non-Acute Admitted	
Subacute WIES – Rehabilitation Public	1,171
Subacute WIES – Rehabilitation Private	370
Subacute WIES – Rehab DVA	11
Subacute WIES – GEM Public	2,873
Subacute WIES – GEM Private	912
Subacute WIES – GEM DVA	49
Transition Care – Bed days	23,975
Transition Care – Home days	4,678
Subacute Non-Admitted	
Health Independence Program – Public	83,576
Aged care	
HACC	16,189
Mental Health and Drug Services	
Mental Health Ambulatory	89,876
Mental Health Inpatient – Available bed days	23,586
Mental Health Subacute (inc CCU and PARC)	8,633
Drug Services	131
Primary Health	
Community Health/Primary Care Programs	11,833
Other	
NFC – Paediatric Lung Transplantation	5

Performance (continued)

Financial Summary

A Net Operating Result of $0.5m was recorded in 2019–20. The result is in line with the Net Operating Result target in the Statement of Priorities.

The Operating Result for 2019-20 was a $3.4 million surplus which includes a net gain of $2.9m associated with COVID-19 related State supplied assets provided free of charge. In line with DHHS guidance this has been removed from the Net Operating Result and Statement of Priority reporting.

Total revenue and expenditure increased in 2019-20 largely due to planned activity growth throughout the health service and the impacts of COVID-19 .

Net Assets decreased by $54.8 million in 2019-20. This was largely due to the increase in employee provisions and liabilities as a result of the impacts of the new revenue accounting standards on the recognition of capital grants revenue.

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

	2016 $'000	2017 $'000	2018 $'000	2019 $'000	2020 $'000
Operating result*	**251**	**203**	**240**	**193**	**504**
Total revenue	1,104,793	1,189,097	1,228,190	1,314,925	1,420,708
Total expenses	(1,124,590)	(1,213,489)	(1,264,477)	(1,352,319)	(1,452,121)
Net result from transactions	**(19,797)**	**(24,392)**	**(36,287)**	**(37,394)**	**(31,413)**
Total other economic flows	(4,545)	(4,125)	2,570	(6,938)	(9,674)
Net result	**(24,342)**	**(28,517)**	**(33,717)**	**(44,332)**	**(41,087)**
Total assets	1,085,146	1,096,904	1,160,112	1,446,645	1,486,095
Total liabilities	294,174	306,182	338,323	356,039	450,252
Net assets / Total equity	**790,972**	**790,722**	**821,789**	**1,090,606**	**1,035,843**

Reconciliation of net results from transactions and operating result

	2020 $'000
Net operating result [1]	**504**
COVID-19 State supply arrangements – assets/supply received free of charge or for nil consideration under the State supply.	4,971
State supply items consumed up to 30 June 2020	(2,088)
Operating result [2]	**3,387**
Capital and specific items	
Capital purpose income	62,286
Capital expenses	(990)
Depreciation and amortisation	(96,096)
Net result from transactions	**(31,413)**

(1) The Net Operating Result is the result Alfred Health reports against in its Statement of Priorities, also referred to as the Net Result before capital and specific items.
(2) The Operating Result includes the COVID-related State supplied assets provided free of charge which are excluded from Alfred Health's Statement of Priorities performance monitoring.
*Years described in this table refers to financial years ended 30 June of the relevant year.

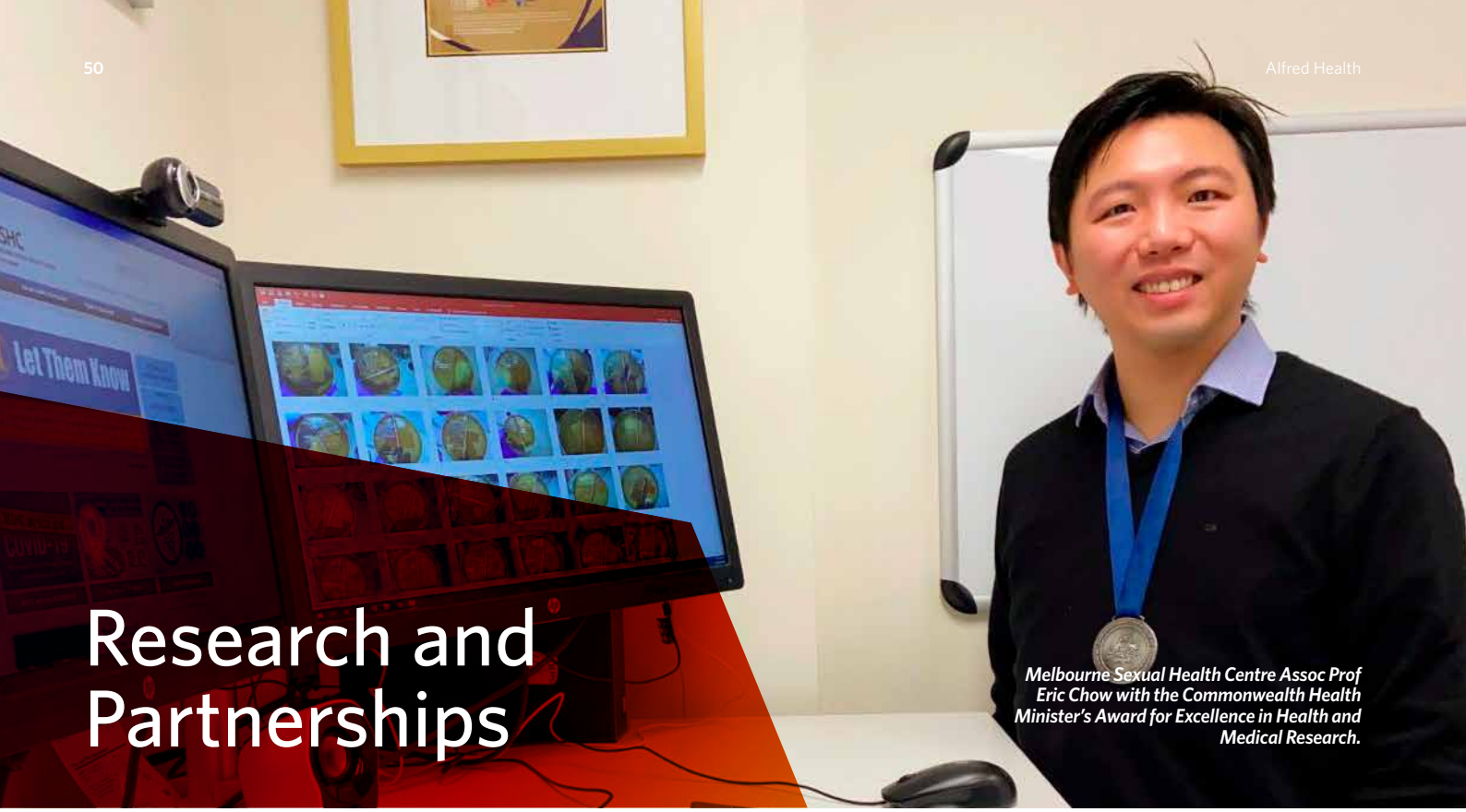
Information and communication technology (ICT) expenditure

The total ICT expenditure incurred during 2019–20 is $47.2 million (excluding GST):

Business as usual (BAU) ICT expenditure ($m)	Non-business as usual (non-BAU) ICT expenditure ($m)	Operational expenditure ($m)	Capital expenditure ($m)	Year
35.5	11.7	10.5	1.2	30 June 2020

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

Emergency Department nurse Maddison Gardener



Research and Partnerships

Melbourne Sexual Health Centre Assoc Prof Eric Chow with the Commonwealth Health Minister's Award for Excellence in Health and Medical Research.

Alfred Health continues to be one of the most research-intense health services in Australia. All our research is translational – meaning patients directly benefit from the work of scientists and clinicians.

Major Research Highlights

Motion machine could improve Parkinson's symptoms

The Alfred and Monash University are testing an innovative new machine that could improve the symptoms of people with Parkinson's Disease by using gravity and movement.

The Reviver machine intentionally challenges participants' sense of balance in a safe and controlled environment. The reaction to being tilted off balance creates a powerful and innate response that can activate muscle groups that have become disengaged.

The trial aims to determine whether an exercise program on the Reviver machine (technically known as a vestibular-stimulation, isometric exercise machine) can lead to improved balance, mobility and sensory-motor co-ordination for people with an advanced stage of Parkinson's Disease and Atypical Parkinsonism.

Lead researcher, Dr Ben Sinclair, says early anecdotal feedback suggests the machine may improve mobility and reduce symptoms in users. "This study provides a rare opportunity to explore and uncover a new possible treatment pathway for people affected by Parkinson's."

Lead researcher Dr Ben Sinclair oversees trial patient Leanore's session on the Reviver machine.

Leading the way in mind-controlled limbs

Our surgical team and patients from the 'Advanced Surgical Amputee Program' (ASAP)

More upper limb amputees in Australia are regaining their independence thanks to The Alfred's revolutionary thought-controlled prosthetic arm program.

Led by The Alfred's Director of Plastic Surgery, Frank Bruscino-Raiola, the Osseointegration and Targeted Muscle Reinnervation (TMR) program at The Alfred is the only one of its kind in Australia.

The program involves two major procedures. The first surgery is an osseointegration, where a titanium implant is fused into the remaining bone of the amputated limb. This provides a stable base on which to attach the prosthetic arm. The TMR procedure involves re-wiring nerves so they can connect with electrodes in the specially designed prosthesis, which enables the brain to communicate with the prosthetic arm.

After a recovery period, patients engage in an extensive virtual reality program that helps train their brain to control their prosthetic arms – just like a real arm.

Among the people whose lives have been changed by the program is Daniel Campbell, who lost his arm in a farming accident. "After I lost my arm, I couldn't even do simple things. But now I have my arm I'm keen to get back to it and have a go. It's given me a lot of my independence back. The Alfred team are brilliant."

Satellite hub for clinical trial in Australian-first

The Alfred Oncology Unit have partnered with Royal Hobart Hospital to ensure a Tasmanian mother with cervical cancer could continue to participate in a clinical trial during the COVID-19 pandemic.

Natalia Rodriguez had been travelling from Launceston to The Alfred every three weeks to participate in a trial of two immunotherapy drugs. Results had been promising, with tumours which had spread throughout her body shrinking.

When Tasmania shut its borders due to the pandemic, a satellite hub for the trial, using an innovative practice called 'Teletrials' was set up at Royal Hobart Hospital. This was the first in Australia, and possibly the world, that the Teletrials model has been used for a phase 1 clinical trial.

Trial treatments can only be given at approved sites, and this trial was not available in Tasmania. However, working with the pharmaceutical company involved, state governments and regulatory bodies, Medical Oncologist Dr Mark Voskoboynik and his team at The Alfred made it possible for Natalia's treatment on the clinical trial to continue in Tasmania.

Natalia has immense gratitude for the team who ensured she could continue her treatment.

"It's been a huge process to get this happening. I'm so grateful."

Research and Partnerships (continued)

Alfred Research Alliance

The Alfred Research Alliance brings together eight independent and diverse organisations to create a community of excellence for medical research, education and health services, centred around The Alfred.

Last year, Alfred Health, Monash University, Baker Heart and Diabetes Institute, Burnet Institute, Deakin University and La Trobe University were joined by two new members, Nucleus Network and 360biolabs, bringing with them phase 1 clinical trials expertise and virology and immunology services respectively.

In 2019, the Alliance:

- Secured more than **$133 million** in external research funding
- Published a total of **2479 pieces**, including journal articles, reviews, book chapters and books
- Congratulated **270 students** on completing their masters and doctoral degrees.

The Alliance members continue to work together to achieve research funding, progress and outcomes, to educate a new generation, and to join in celebration and recognition.

A visit by Australia's Chief Scientist, Dr Alan Finkel, to The Alfred precinct was a key feature of the year. The event provided an opportunity to showcase the Alliance's unique translational research loop dedicated to solving critical health challenges, with Dr Finkel meeting with researchers and clinicians to learn about their research and patient focus.

Other highlights included celebrating NAIDOC week with a precinct-wide event featuring the insights of Boon Wurrung elder N'arweet Carolyn Briggs AM; and an International Women's Day event with Walkley Award-winning journalist Catherine Fox speaking about how to achieve real culture change.

The Alfred Research Alliance continues to play a leadership role.

COVID-19 and the Alfred Research Alliance

Since March, the extraordinary challenges of the COVID-19 pandemic have seen Alliance members pivot to respond in a variety of ways. While clinical and support staff at Alfred Health have been testing and treating those directly affected by the virus, scientists across the precinct have joined in the pursuit of treatments and prevention.

More than 30 COVID-19 projects are underway on site at the time of going to press, including vaccine and antiviral development, clinical trials and preclinical testing of promising candidates, the development of new diagnostic tests and public health research. A number of Alliance staff have also been seconded to the Department of Health and Human Services to lend their expertise to policy makers as they shaped their response.

Regardless of circumstance, working on-site or remotely, Alliance members continue to demonstrate their extraordinary adaptability and commitment as they respond to the world's most pressing health challenges and deliver improved health outcomes for all.

Research Funding

Alfred Health researchers were lead investigators of several new NHMRC (National Health and Medical Research Council) grants commencing in 2020.

Investigator Grants

- **Prof Mark Cooper AO:** Reducing the burden of diabetic complications. $3,451,595
- **Prof Carol Hodgson:** Early interventions to improve the quality of survival after critical illness. $1,243,891
- **Prof Jayashri Kulkarni AM:** Innovating women's mental health. $2,401,595
- **Dr Nenad Macesic:** Integrating genomic and artificial intelligence approaches to combat antimicrobial resistance. $639,750
- **Prof Terry O'Brien:** Developing new treatments and identifying biomarkers to enable transformational, precision medicine-based care for patients with drug resistant epilepsy. $2,848,640
- **Prof Karlheinz Peter:** Developing innovative targeting strategies for diagnosis and treatment of cardiovascular and inflammatory diseases. $2,536,617
- **Dr Sandeep Prabhu:** Catheter ablation for atrial fibrillation in patients with heart failure and myocardial fibrosis. $530,469
- **Dr Emma Ridley:** Generation of high quality, clinically relevant knowledge to inform global nutrition practice during critical illness. $561,800
- **Prof Andrew Taylor:** Cardiac MRI in the evaluation of cardiovascular disease – enhancing mechanistic understanding and diagnostic certainty to drive new paradigms of care. $1,864,015

Clinical Trials and Cohort Studies Grants

- **Assoc Prof Joseph Doyle:** Same-visit hepatitis C testing and treatment to accelerate cure among people who inject drugs: a cluster randomised controlled trial. $1,459,971
- **Prof Paul Myles:** Tranexamic acid to reduce infection after gastrointestinal surgery – the TRIGS trial. $5,196,595

Medical Research Future Fund – Keeping Australians Out of Hospital

- **Prof Anne Holland:** Transforming pulmonary rehabilitation to reduce hospital admissions in COPD. $1,220,668

Monash Partners Academic Health Science Centre

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

In 2019–20 it funded and progressed 10 flagship transformative translational research initiatives. It attracted State Government investment to support streamlining of research and data governance and pilot Learning Health System funding. It also established and attracted funding for the inaugural national network in women's health across Centres nationally.

Furthermore, it formed a strategic partnership with the Monash Institute of Medical Engineering to help turn clinical problems into real world solutions expanding into funded digital health and health service impact streams.

Consumer and community involvement continued to form a key part of its work, including during the COVID-19 pandemic with research support.

Data initiatives included establishing the GRIP PhD program with 14 healthcare embedded and funded PhD students addressing priority digital health problems.

Research awards and recognition

Anaesthesiology and Perioperative Medicine Director, **Professor Paul Myles** has become the eighth Australian elected to the National Academy of Medicine (NAM) in the United States, joining the prestigious academy as an international member. His election acknowledges his long-time engagement in patient-centred research.

The NAM published the landmark report on patient safety in healthcare, 'To Err is Human', which fundamentally reshaped health systems around the world by acknowledging the existence and impact of errors in medicine.

Sexual health epidemiologist **Assoc Prof Eric Chow** received the 2019 NHMRC Peter Doherty Investigator Grant Award (Emerging Leadership).

Assoc Prof Chow is Head of the Health Data Management and Biostatistics Unit at the Melbourne Sexual Health Centre, Alfred Health and the Central Clinical School, Monash University.

His research aims to improve treatment, prevention and control of sexually transmitted infections, with a focus on gonorrhoea and human papillomavirus. He is currently conducting clinical trials to examine whether antiseptic mouthwash could be used as a novel treatment and preventive strategy for gonorrhoea.

Physiotherapist **Louise Fuller** was recognised with the prestigious Sir William Kilpatrick Churchill Fellowship to investigate a variety of post-lung transplant rehabilitation models internationally to help her develop guidelines for Australia.

Louise has played a leading role in Alfred Health's lung transplant rehabilitation program, with her key achievements including expanding the transplant gym to meet the needs of more than 100 lung transplant recipients who The Alfred sees annually.

Physiotherapist Louise Fuller received the Sir William Kilpatrick Churchill Fellowship

Professor Tracey Bucknall is internationally recognised as a decision scientist in health care, with research focusing on improving patient safety and reducing medical error. In 2019, she was inducted into the International Nurse Researcher Hall of Fame of Sigma International for significant and sustained national and international recognition for her work, and for conducting research that has impacted the profession and the people it serves.

Projects and infrastructure

Project Manager Steve Skapetis

Alfred Health continued to undertake major infrastructure works during the year to support the heath service deliver quality care in a safe environment for our staff and patients.

In the face of the COVID-19 pandemic, much work was done to ensure our services had the capacity and quality infrastructure required to manage a potential increase in patients.

COVID preparation

The establishment of a Screening Clinic was part of The Alfred's COVID preparation works.

The major engineering challenge for the year was to create clinical areas where the health service could treat the potential increase in patients with COVID-19. At The Alfred this meant converting existing office spaces, retail areas and vacant spaces in the Old Monash Building into additional emergency cubicles. Other existing retail spaces were converted into staff amenity and change rooms.

In the Emergency Department, cubicle spaces as well as CT and general X-ray spaces were adapted into negative pressure accommodation, to allow for treatment of COVID-19 patients.

Intensive Care capacity was also boosted. Main Ward Block Ward 2 East and 2 West were converted into ICU equivalent facilities with negative pressure capabilities. The main ICU was adapted into dedicated negative pressure zones to improve separation and staff safety. Vacant space in the Old Monash Building was also converted into staff amenity and change rooms for ICU staff.

New trauma ward at The Alfred

Registered Nurses Gabby and Gemma in the new 5 West

In October 2019, work on The Alfred's new trauma ward, 5 West, was completed – on time, and on budget.

5 West is our first, purpose-built facility dedicated to early recovery of trauma patients. The ward provides a contemporary setting for the treatment of trauma patients, and the early stages of their rehabilitation. It features 40 new beds as well as a dedicated therapy zone and procedure room.

It will help us meet the growing demand for emergency and trauma care, and provide an improved experience for our trauma and orthopaedic patients.

Fire and infrastructure improvements

A $69.5 million investment – to upgrade fire safety, infrastructure and amenity associated with five wards within the Main Ward Block – was started in 2019–20.

Comprehensive enabling works were completed that provided 40 decant beds in Centre Block and the Main Ward Block and a comprehensive refurbishment of the former ward 2F. Detailed design for the main works has been completed, however, the project has been put on hold pending the use of wards 2 East and 2 West in MWB as ICU expansion spaces for COVID-19.

Many of the decant bed spaces have been put into use to support ward reconfigurations for COVID-19.

The Betty and John Laidlaw AO Innovation and Education Hub

The $6 million Innovation Hub, which will transform the former library and education facilities into a contemporary learning and innovation hub, progressed well.

When opened, the Hub will provide high-end information technology featuring meeting rooms, innovation laboratories, breakout spaces and a café. It will also be home to nursing education and organisational development. The project is due for completion in September 2020.

South Block Clinical Trials project

The South Block Clinical Trials project has provided a welcome boost to Alfred Health's cancer treatment and clinical trials capacity.

Completed in 2020, the project has seen significant benefits for patient care. The works saw an additional 19 patient points of care created over two levels of The Alfred Hospital South Block. Amenity has also been improved, with patients now receiving treatment in a more comfortable environment.

Likewise, staff members have benefited. Associated ancillary support facilities, such as staff stations and storage, were created by consolidating and relocating indirect care functions to a new office accommodation.

The project was completed with minimal disruption to patients and staff, with careful planning to ensure continued operation of the facility while works were completed.

High value equipment and infrastructure funding.

Medical equipment	
ENT Microscope - Theatre	347,953
Echocardiograph machines (2) – Cardiac Theatres	600,000
General X-Ray Room (3) – Emergency, Radiology and Alfred Centre	1,470,000
3D Fluoroscopic C Arm – Neurosurgery	480,000
Molecular Diagnostic Instrument – Pathology	530,000
Engineering infrastructure	
Hyperbaric upgrade	1,315,000
SCARDA	850,000
Emergency lighting	850,000
Total funding	**6,442,953**

Building Project 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

- 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 Hospital

- Pathology and kitchen redevelopment
- Behaviours of Concern Area – Emergency Department
- Fire detection and FIP Upgrade

Projects with building permits under construction

The Alfred

- The Innovation and Education Hub

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

Psychiatry Nurse Nicky Scholvin and Peer Worker Christopher Stefano

Health promotion

Prevention through health services

Alfred Health continued to receive funding to support Victorian public health services in preventive health, with a focus on healthy eating and being tobacco-free. In 2019–20, support was provided to 35 other Victorian health services in prevention activities to improve the health of the Victorian community, with 58 Victorian health services supported since 2016.

Primary Care and Population Health Strategy

Work with key stakeholders to implement our Primary Care and Population Health Strategy 2018–2023 was ongoing. Its focus included:

- 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.

Advisory groups were established, bringing together expertise from across Alfred Health to progress these priority areas.

Alcohol

Alfred Health and the Burnet Institute conducted a survey to determine prevalence and distribution of alcohol-related harm across the inpatient population as well as the feasibility and acceptability of screening inpatients. These results will be used to develop a model of care for patients experiencing alcohol-related harms.

Smokefree

A 12-month evaluation of innovative smokefree signage commissioned by Alfred Health showed a 35 per cent reduction in smoking around The Alfred. This complements our ongoing clinical work supporting patients and staff who smoke.

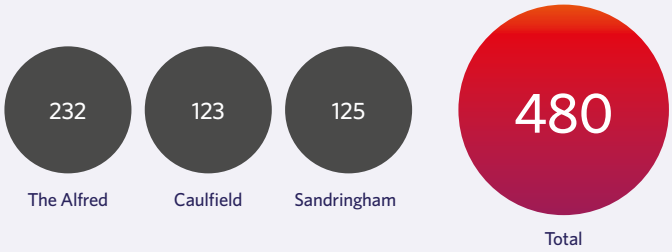
Healthy eating

Following successful implementation of point-of-sale communication across all our cafés, point-of-sale labelling was expanded to vending machines on site. Research showed a sustained positive shift in purchasing, with a 32 per cent increase in 'green' snack sales and 10 per cent decrease in 'red' snack sales.

58
Victorian health services supported since 2016

Alfred Health Volunteers

Number of volunteers within Alfred Health:



Volunteers continue to be an integral part of Alfred Health.

In September 2019, 101 new volunteers were orientated to The Alfred and Caulfield hospitals after having completed the volunteer training for Alfred Health. This intake marked the 30th intake of volunteers inducted into the Alfred Health Volunteer program since 2001. Many of these volunteers have been placed in various units within our health service, including wayfinding, psychiatric unit, aged care, Acquired Brain Injury unit, trolley services and as host volunteers in the wards.

Due to COVID-19, all volunteer activities were suspended as of March 2020. A regular Staying Connected newsletter has been produced to support volunteers during this time.

At Sandringham Hospital, patients continued to be entertained despite volunteering restrictions because of the pandemic. One of their therapy dogs, 'Lizzy aka Dr Barks', developed a DVD featuring pet tricks while also practising good hygiene. Volunteer knitters are continuing to make an outstanding contribution by knitting toys for younger patients.

Volunteer Doreen was part of The Alfred's fundraising efforts in 2019.

Fundraising

The Alfred Foundation

The Alfred Foundation plays an important role in improving the lives of our patients, their families, and our community.

Although there have been challenges during 2019–20, including the COVID-19 pandemic and Australia's horrific bushfires, community generosity and commitment to The Alfred has continued.

This is reflected in the extraordinary $20.5 million donated to The Alfred in 2019–20, an increase of $7.5 million on the previous year, in part thanks to a significant gift specifically to advance HIV/AIDS research and treatment.

The expanded and upgraded Trauma Ward and the expanded Intensive Care Unit were examples of projects funded significantly through community donations.

In March 2020, the Foundation launched its COVID Appeal. More than $800,000 was raised to support projects that will lead the way in diagnosis, treatment, and research of the virus.

This past year the community has funded many initiatives, large and small, which align with four key funding pillars identified by the Foundation:

1. **Transforming Care:** Trauma Ward development, The Isla Wellington Stroke & Treatment Centre, youth peer support in open dialogue project, programs to enhance the experience of cancer patients and patient accommodation facilities for rural and regional cancer patients.
2. **Leading Technology:** Intensive Care Unit expansion, automated medication dispensing units, MALDI-TOF laser, continuous programmable infusion pumps for renal patients, Neurosurgery equipment, specialist equipment for the Adult Burns Ward and 4D cardiac ultrasound.
3. **Advancing Technology:** Development of cancer biobank, Pulmonary Fibrosis research, adolescent violence in the home scoping project, suicide prevention project, Cystic Fibrosis new drug development research, radiation oncology research into brain tumours and echocardiographic detection of subclinical left ventricular systolic dysfunction (LVSD) in people with HIV.
4. **Developing Extraordinary Caregivers:** The John & Betty Laidlaw Education & Innovation Hub, Morgan Mansell Early Career Australian Melanoma Researcher of the Year prize, Jenkins Lymphoma fellowship and two scholarships for the career development of nurses.

Community and Environment (continued)

The Alfred Foundation Board

In 2019–20 The Alfred Foundation Board comprised of:

- Sir Rod Eddington AO (Chairman)
- Mr Patrick Baker (Director, The Alfred Foundation)
- Mr Ravi Bhatia
- Ms Greta Bradman
- Mr Anthony Charles
- Mr Allan Hood
- Ms Meg Landrigan
- Mr Eddie McGuire AM
- Mr Chris Nolan (Father's Day Committee Chair)
- Mr Nick O'Donohue (Life Support Committee Chair)
- Ms Julie Ogilvy
- Mr Tony Phillips
- Mr George Richards
- Mr Rob Sayer
- Mr Paul Sheahan AM
- Mrs Carolyn Stubbs OAM (Women@TheAlfred Chair)
- Professor Andrew Way AM (Chief Executive, Alfred Health)
- Mr Alan Williams
- Sir Donald Trescowthick AC KBE (Joint Patron)

Caulfield Hospital fundraising

Generous fundraising and philanthropic support continues to be important for Caulfield Hospital.

Funds raised from two annual appeals were used to purchase equipment for our Dementia and ABI (Acquired Brain Injury) units.

Grants were received from the following philanthropic organisations:

- Estate of William Galloway
- Estate of Henry Herbert Yoffa

Funds were also raised through the Cardiac Support Group. A very generous donation was made by Craig and Melissa Campbell to purchase a Philips Sure Signs Monitor for Rehab C.

The Helmsmen Kiosk volunteers made their annual donation, which was used to purchase medical equipment for the Aged Care and Rehab Wards. The medical equipment purchased is to prevent patients from sustaining pressure injuries as well as the management of such injuries.

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

Sandringham Hospital fundraising

Sandringham Hospital received generous support during the year. Major fundraising events included the 24hr Sandy Hospital Charity Ride, the Oaks Day Luncheon at Royal Brighton Yacht Club and Lunch by the Bay fundraising luncheon.

The hospital continued its strong community connection. With the support of Bayside Companion Dog Training School, the therapy dog program has continued to bring enjoyment to patients and staff. A major supporter of the hospital, Graham Ludecke from the Black Rock Sports Auxiliary, received a Medal of the Order of Australia (OAM) in the Queen's Birthday Honours. The hospital's Emergency Department also conducted a 'Be car seat safe' community campaign.

The 24hr Sandy Hospital Charity Ride was among the key fundraising events during the year.

Significant support, which ensured we could purchase a range of medical equipment, was received from:

- 24hr Sandy Hospital Charity Ride
- Bayside Companion Dog Training School
- Black Rock Sports Auxiliary
- Collier Charitable Fund
- Estate of Judith Ann Lidgerwood
- Estate of Valda May Salton
- Humpty Dumpty Foundation
- Lunch by the Bay
- Lions Club of Beaumaris
- Moorabbin Airport and the Goodman Foundation
- Rotary Club of Beaumaris
- Royal Brighton Yacht Club
- Sandringham Hospital Kiosk Volunteers
- Sandringham Hospital Social Club
- The Alfred & Jean Dickson Foundation
- Anonymous supporters

Environmental sustainability

Our *Environmental Sustainability Strategy 2017–21* aims to engage, educate and empower staff to create an environmentally sustainable workplace.

Members of our Environmental Sustainability Committee represent key portfolios of the organisation to embed sustainability practices across all areas of the health service to reduce our environmental impact.

The DHHS-administered Environmental Data Management System (EDMS) collates environmental performance data for public health services. The EDMS generates reports related to our greenhouse gas emissions, waste generation and energy and water consumption.

Environmental sustainability highlights for the year included the installation of LED lighting at Melbourne Sexual Heath Centre, reducing carbon emissions by 25 per cent and showing a 20 per cent reduction in electricity bills, as well as improving the indoor environment for staff.

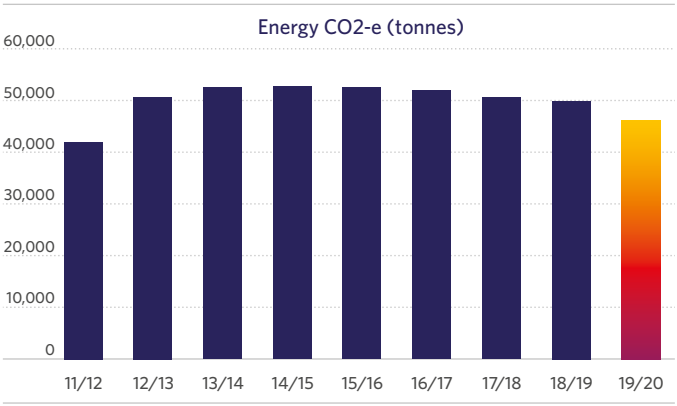
The Alfred Health War on Waste strategy trial was implemented at Sandringham Hospital. The strategy included co-locating waste bins to allow segregation of waste at the point of disposal and educating staff about responsible waste disposal practices. As a result, recycling rates have doubled since trial implementation and waste disposal costs have reduced by over 10 per cent. A broader rollout across other Alfred Health sites has been recommended.

Other highlights included the development of an online learning module to educate staff in responsible waste management and continuing our partnership with the DHHS in a range of waste education initiatives.

Jason and Nick are part of the team which have joined Sandringham Hospital's War on Waste.

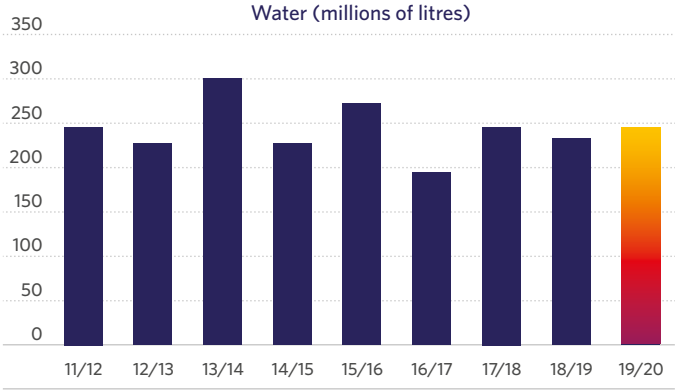
Carbon emissions

Carbon emissions continued their downward trend in 2019–20.



Water consumption

Water consumption increased in 2019–20.



The sustainability features of a new chiller system in Centre Block of The Alfred, including reduced electricity and water use. Pictured is Tom O'Brien from Engineering Services.

Governance

Radiation therapist Sarah Graves

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. During the year the Board had nine directors.

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 businesslike manner, which maximises efficiency, effectiveness and cost-effectiveness and ensures the service's financial viability
7. ensure that mechanisms are available to inform consumers and protect their rights and to facilitate consultation with the community
8. operate a public health service as authorised by or under the Act
9. carry out any other activities that may be conveniently carried out in connection with the operation of a public health service or calculated to make more efficient any of the service's assets or activities.

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

Board of Directors as at 30 June 2019

Mr Michael Gorton *AM*
BCom, LLB FRACS (Hon), FANZCA (Hon), FAICD

Board Chair

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

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 is the Chair of Wellways Australia and a Board Member of Ambulance Victoria, Holmesglen Institute and the Australasian College of Emergency Medicine.

He is a former Board Member of Melbourne Health, Melbourne Primary Health Network (PHN) and the former Chair of the Australian Health Practitioner Regulation Agency (AHPRA) and the Victorian Equal Opportunity and Human Rights Commission.

Dr Victoria Atkinson
MBBS, FRACS, AFRACMA, Master of Health Management

Board Member

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 focused 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 Master 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 USA.

Ms Melanie Eagle
BA BSW LLB Post Graduate Diploma of International Development GAICD

Board Member

Ms Eagle has qualifications in Law, Social Work, International Development, Arts and is a Graduate of the Australian Institute of Company Directors.

She is the Chief Executive Officer at Hepatitis Victoria/LiverWELL – the peak organisation providing advocacy, awareness raising, education and support in relation to viral hepatitis and liver disease.

Her professional work has spanned the public sector (city strategic planning, social policy, women's policy, law reform and equal opportunity); the private sector (as solicitor); and the union movement. She was Mayor and a Councillor of the St Kilda Council. She has served on a wide range of Boards including Star Health (formerly Inner South Community Health Centre); Hanover Welfare; Prahran Mission; the Epilepsy Foundation and the Chronic Illness Alliance of Victoria.

Melanie is the inaugural Chair of both Respect Victoria and the Disability Worker Registration Board, and is a Director of Hepatitis Australia and a Patron of the Epilepsy Foundation.

Governance (continued)

Board of Directors as at 30 June 2019

Mrs Sally Campbell
BA. LLB, GAICD

Board Member

Mrs Campbell brings extensive executive commercial and public sector experience to Alfred Health Board that has been earned in a wide range of organisations in Australia, New Zealand, and the United Kingdom.

Ms 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 leadership and organisational change in large, complex and politically sensitive organisations. Also, she enthusiastically works to ensure all employees, governance leads, and stakeholders respect 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 & 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.

Dr Benjamin Goodfellow
FRANZCP MBBS MPM CAPC

Board Member

Dr Goodfellow is a child and adolescent psychiatrist in public and private practice with a fellowship in infant mental health from the Royal Children's Hospital.

Among his public health roles, he is the consultant for the infant psychiatry program and paediatric consultation-liaison service at Geelong University Hospital, a standing member of the High-risk Infant Panel at DHHS – Child Protection Geelong.

Dr Goodfellow has a background in health systems development and public policy with a focus on clinical standards and productivity, particularly at the interface of health services with government and NGOs.

He is a senior lecturer at Deakin University, former editor of the Australian Association of Infant Mental Health newsletter 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 Anne Howells
BCom, CA, MB (Corporate Governance), GAICD

Board Chair

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 & 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).

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

Board Member

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

Between 1985 and 1995 she was employed at the Royal Children's Hospital Melbourne as the HIV/AIDS and Haemophilia Clinical Nurse Consultant and Counsellor. This statewide service was provided to families, individuals and staff. During this time Ms McNaught was a member of various committees, some of which included the National AIDS Counsellor Association, Paediatric AIDS Task Force, the AIDS Education Strategy Committee, the RCH Infection Control Committee and the AIDS Health Department task force education program.

From 1993 until 1995 she was a member of the Board of Management of the Mordialloc–Cheltenham Community Hospital. Since 2001, Ms McNaught has been a barrister at the Victorian Bar and currently is a member of the Victorian Bar Health and Wellbeing Committee.

Ms Miriam Suss *OAM*
BA MSW, GAICD

Board Member

Ms Suss is a social worker by profession who has served as the Director of Social Work and Community Development Services at Jewish Care.

She was also 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's career has covered the provision and management of social work services, community development in a range of settings and fundraising and development for the not-for-profit sector.

Ms Suss is currently the Acting Chair of Language Loop, the Victorian Interpreter and Translation Service, a Victorian Government business enterprise. She also serves as the Honorary Secretary for the Melbourne University Social Work Alumni Association.

Mr Lynton Norris
BBus (Acc) BBus (IntTrade) FCPA GAICD

Board Member

Mr Norris is a consultant and experienced company director. He is a recognised leader in funding and payment models, compliance and performance reporting, policy development and complex data analysis and analytics.

Mr Norris has over 20 years' experience in both government and the private sector and held senior executive roles in the Commonwealth, State and Territory Government health and human service portfolios at the Deputy Director-General, Chief Executive Officer and Director level. He has led and served on various government expert and advisory panels, pertaining to national funding agreements, disaster recovery, data integrity and analysis.

Mr Norris is currently a Non-Executive Director of Aristotle Cloud Services Australia and was a member of Health Purchasing Victoria's Finance and Risk Management Committee for nine years.

He holds degrees in International Trade and Accounting, is a Fellow Certified Practising Accountant (FCPA), and a graduate member of the Australian Institute of Company Directors (GAICD).

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 Victorian Government's Public Entity Executive Remuneration 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 meets 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 culture and wellbeing of staff
- any systemic problems identified with the culture and wellbeing 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, the Victorian Government's Public Entity Executive Remuneration Policy, and prevailing legislation.

Committee membership 2019–20

Audit Committee

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

Finance Committee

Ms Anne Howells (Chair)
Mr Michael Gorton AM
Dr Victoria Atkinson
Mr Lynton Norris
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
Ms Kim Hungerford (from 4 February 2020)
Mr Terry McNamara (from 4 February 2020)

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
Dr Sudeep Saraf
Dr Elizabeth Deveny
Ms Cath Harrod
Mr Kent Burgess
Associate Prof Joseph Doyle

People and Culture Committee

Ms Kaye McNaught (Chair)
Ms Miriam Suss
Mr Lynton Norris

Quality Committee

Dr Victoria Atkinson (Chair)
Mr Michael Gorton AM
Ms Melanie Eagle
Dr Cathy Balding
Ms Carolyn Ward
Ms Kay Currie
Ms Kelly Decker
Ms Carly Bertram
Associate Prof Robert Stirling

Remuneration Committee

Mr Michael Gorton AM (Chair)
Dr Victoria Atkinson
Ms Anne Howells
Mr Lynton Norris

Governance (continued)

Risk management

Alfred Health has an integrated clinical and enterprise risk register which currently consists of 36 open risks at the end of 2020 financial year. High and extreme risks are addressed by specific committees with responsibilities such as falls prevention, pressure injuries, medication safety and behaviours of concern. This ensures focus and co-ordination of effort on the important issues for Alfred Health and our patients and uses the data to support improvement in safety. The Risk Management Framework aligns with the international Risk Management Standard (AS/NZ ISO 31000:2018-02) and each year the risk profile of the health service is reviewed.

The incident reporting system, using the dataset of the Victorian Health Incident Management System (VHIMS), is an integral component of Alfred Health's risk management framework. Alfred Health provides regular VHIMS data to Safer Care Victoria for analysis in order to inform patient safety efforts at a state level. Regular training and 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 are routinely analysed for trends and reported to the various committees and groups responsible, including to the Executive Committee and the Quality 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. All serious adverse events undergo in-depth case review and are discussed by the Clinical Outcomes Review Committee which involves senior staff from all disciplines across the organisation. 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.

He 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. Prior to her current role, she was the Clinical Service Director for 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 masters degrees in health management and clinical nursing.

Executive Director, Medical Services and Chief Medical Officer

Dr Lee Hamley MBBS MBA FRACMA

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

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

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

Dr Hamley's external appointments include being a member of the Council of the Victorian Institute of Forensic Medicine.

Executive Director, Nursing Services and Chief Nursing Officer

Ms Janet Weir-Phyland RN BScN MBA

Ms Weir-Phyland provides professional leadership to Alfred Health nursing workforce and is responsible for Allied Health Services and Non Clinical Support Service. She provides executive 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 co-ordination 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 is also responsible for annual planning processes including the Statement of Priorities.

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 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, systems and devices so the right clinical care can be provided at the right time and in the best location for the patient.

IDD covers Biomedical Engineering and all aspects of IT infrastructure, devices and support, projects, applications development, cyber-security and privacy. It also includes the ongoing development of our clinical information systems and digital health platforms.

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.

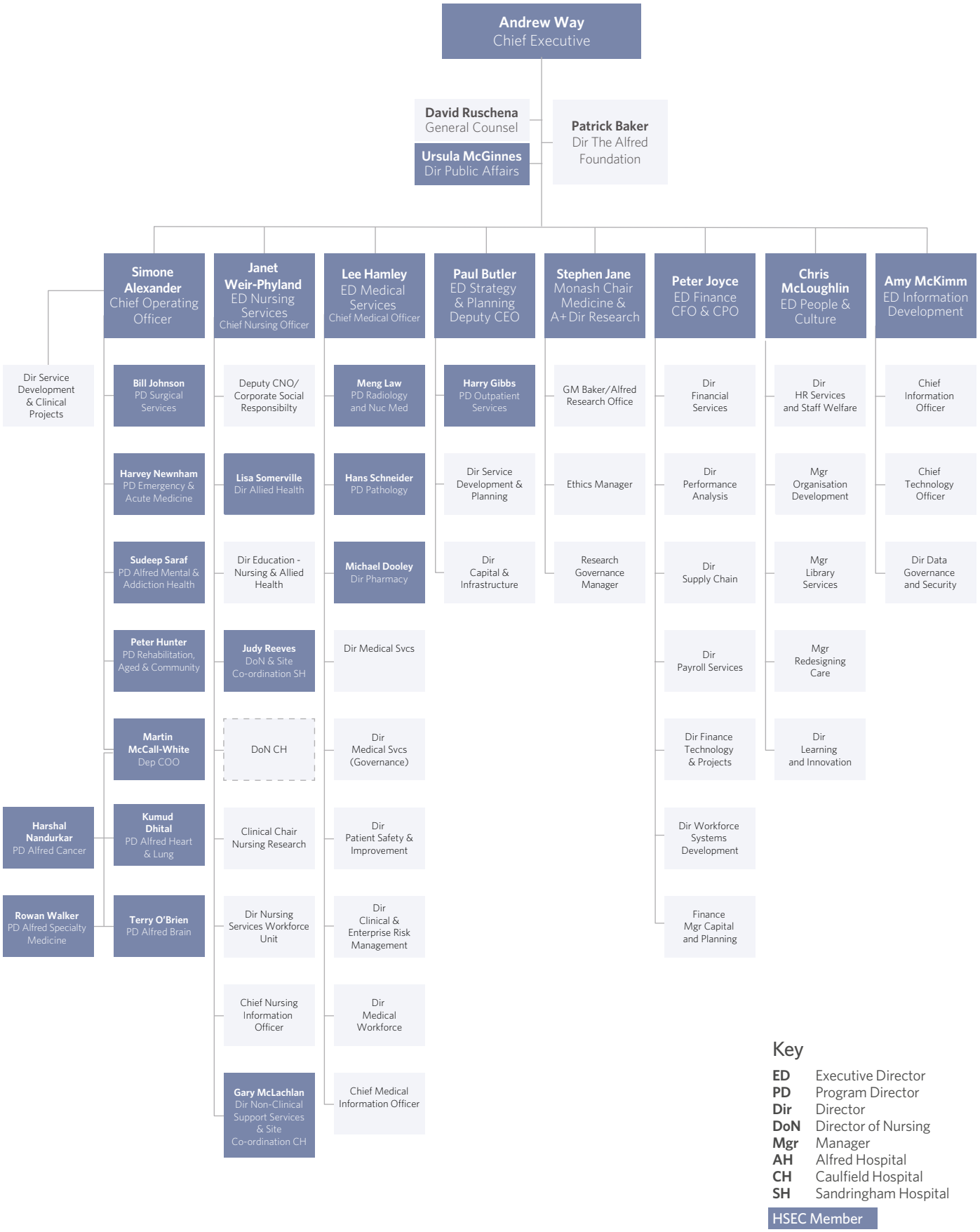
General Counsel

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

Responsible for providing legal advice across Alfred Health.

Governance (continued)

Organisational structure



Legislation change

There were no legislative changes that affected the delivery of medical services in 2019–20.

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:

- one from a Member of Parliament
- 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 2019–2020

	2019–20
Applications Received	2659
Applications granted (Full)	2321
Applications granted (part)	12
Access denied	6
No documents	1
Other	21
Not finalised	298
Not finalised 2018/2019	333
Access granted in full	333
Access granted in part	0
Access denied	0
Other	0

Public Interest Disclosures Act 2012 (Vic)

Alfred Health complies with its obligations under the *Public Interest 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**

Governance (continued)

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

Details of consultancies (under $10,000)

In 2019-20, there were no consultancies where the total fees payable to the consultants were less than $10,000.

Details of consultancies (valued at $10,000 or greater)

In 2019-20, there were 6 consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2019-20 in relation to these consultancies is $249,437 (excl GST). Details of individual consultancies can be viewed at www.alfredhealth.org.au

Consultant	Purpose of consultancy	Total approved project fees (Excl GST)	Expenditure 2019–20 (excl GST)	Future approved expenditure
Lightfoot Solutions Australia Pty Ltd	Review of prosthetics and anaesthetics billing	27,000	18,900	-
Graylin Pty Ltd	Mock assessment of NSQHS Standards	24,500	24,500	-
Paxton Consulting Pty Ltd	Clinical costing standards review	90,273	90,273	-
Ernst & Young	Victorian Melanoma Centre – strategic options analysis	67,900	67,900	-
PeopleScape (Vic) Pty Ltd	Alfred SCORE consultancy analysis and reporting	31,500	31,500	-
Bendigo Health Care Group	Geriatric Evaluation and Management (GEM) Service stakeholder consultation	16,364	16,364	-
Total		**257,537**	**249,437**	**-**

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
18 September 2020

Financial management compliance

I, Michael Gorton, on behalf of the Responsible Body, certify that Alfred Health has no Material Compliance Deficiency with respect to the applicable Standing Directions under the *Financial Management Act 1994* and Instructions.

Michael Gorton AM

Chair

Melbourne
18 September 2020

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
18 September 2020

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
18 September 2020

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 the Department's compliance with statutory disclosure requirements.

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FRD 22H	Purpose, functions, powers and duties	3, 60
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FRD 22H	Activities, programs and achievements for the reporting period	8–9, 30–35
FRD 22H	Significant changes in key initiatives and expectations for the future	8–9, 30–35
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Attestations		
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	Occupational Violence reporting	25
	Reporting obligations under the *Safe Patient Care Act 2015*	66
	Reporting of compliance regarding Car Parking Fees	21

Financial Statements Year Ended 30 June 2020

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 2020 and the financial position of Alfred Health and the Consolidated Entity at 30 June 2020.

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 18 September 2020.

Mr Michael Gorton AM
Board Chair

Melbourne
18 September 2020

Prof Andrew Way AM
Accountable Officer

Melbourne
18 September 2020

Mr Peter Joyce
Chief Finance & Accounting Officer

Melbourne
18 September 2020

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

VAGO
Victorian Auditor-General's Office

To the Board of Alfred Health

Opinion	I have audited the consolidated financial report of Alfred Health (the health service) and its controlled entities (together the consolidated entity), which comprises the: • consolidated entity and health service balance sheets as at 30 June 2020 • 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 2020 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
21 September 2020

Travis Derricott
as delegate for the Auditor-General of Victoria

Comprehensive operating statement

for the financial year ended 30 June 2020

	Note	Parent entity 2020 $'000	Parent entity 2019 $'000	Consolidated 2020 $'000	Consolidated 2019 $'000
Revenue and income from transactions					
Operating activities	2.1(a)	1,418,039	1,311,215	1,422,968	1,310,012
Non-operating activities	2.1(a)	2,668	3,710	3,172	5,018
Total revenue and income from transactions		**1,420,707**	**1,314,925**	**1,426,140**	**1,315,030**
Expenses from transactions					
Employee expenses	3.1	(946,020)	(872,229)	(946,020)	(872,229)
Supplies and consumables	3.1	(292,116)	(290,199)	(292,116)	(290,199)
Finance costs	3.1	(1,639)	(1,188)	(1,639)	(1,188)
Other operating expenses	3.1	(116,249)	(110,989)	(116,314)	(112,392)
Depreciation and amortisation	3.1	(96,096)	(77,714)	(96,096)	(77,714)
Total expenses from transactions		**(1,452,120)**	**(1,352,319)**	**(1,452,185)**	**(1,353,722)**
Net result from transactions – net operating balance		**(31,413)**	**(37,394)**	**(26,045)**	**(38,692)**
Other economic flows included in net result					
Net gain/(loss) on non-financial assets	3.2	5	(126)	5	(126)
Net gain/(loss) on financial instruments at fair value	3.2	(9,038)	(5,130)	(10,199)	(4,971)
Other gain/(loss) from other economic flows	3.2	(641)	(1,682)	(641)	(1,682)
Total other economic flows included in net result		**(9,674)**	**(6,938)**	**(10,835)**	**(6,779)**
Net result for the year		**(41,087)**	**(44,332)**	**(36,880)**	**(45,471)**
Other comprehensive income					
Items that will not be reclassified to net result					
Changes in property, plant and equipment revaluation surplus	4.2(b)	-	313,658	-	313,658
Total other comprehensive income		**-**	**313,658**	**-**	**313,658**
Comprehensive result for the year		**(41,087)**	**269,326**	**(36,880)**	**268,187**

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

The consolidated entity has applied AASB 15 *Revenue*, AASB 1058 *Income for not-for profit entities* and AASB 16 *Leases*, effective from 1 July 2019 and no adjustments were made to the comparative balances as the application of these was applied prospectively.

Balance sheet

as at 30 June 2020

	Note	Parent entity 2020 $'000	Parent entity 2019 $'000	Consolidated 2020 $'000	Consolidated 2019 $'000
Current assets					
Cash and cash equivalents	6.2	52,100	15,468	59,088	15,707
Receivables	5.1	51,150	51,650	51,246	52,020
Inventories		14,085	10,150	14,085	10,150
Other assets		7,013	3,353	7,013	3,368
Total current assets		**124,348**	**80,621**	**131,432**	**81,245**
Non-current assets					
Receivables	5.1	27,583	23,376	27,583	23,376
Investments and other financial assets	4.1	42,359	45,840	53,908	59,634
Property, plant & equipment	4.2(a)	1,280,285	1,279,018	1,280,285	1,279,018
Intangible assets	4.3	11,520	17,790	11,520	17,790
Total non-current assets		**1,361,747**	**1,366,024**	**1,373,296**	**1,379,818**
Total assets		**1,486,095**	**1,446,645**	**1,504,728**	**1,461,063**
Current liabilities					
Payables	5.2	141,081	106,600	141,206	106,717
Borrowings	6.1	23,871	2,701	23,871	2,701
Provisions	3.4	216,479	195,677	216,479	195,677
Other liabilities		72	69	72	69
Total current liabilities		**381,503**	**305,047**	**381,628**	**305,164**
Non-current liabilities					
Borrowings	6.1	27,533	12,518	27,533	12,518
Provisions	3.4	41,216	38,474	41,216	38,474
Total non-current liabilities		**68,749**	**50,992**	**68,749**	**50,992**
Total liabilities		**450,252**	**356,039**	**450,377**	**356,156**
Net assets		**1,035,843**	**1,090,606**	**1,054,351**	**1,104,907**
Equity					
Property, plant & equipment revaluation surplus	4.2(f)	949,526	949,526	949,526	949,526
General purpose surplus		83,750	63,804	83,750	63,804
Restricted specific purpose surplus		50,277	50,096	68,786	64,397
Contributed capital		329,004	324,134	329,004	324,134
Accumulated deficits		(376,714)	(296,954)	(376,715)	(296,954)
Total equity		**1,035,843**	**1,090,606**	**1,054,351**	**1,104,907**

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

The consolidated entity has applied AASB 15 *Revenue*, AASB 1058 *Income for not-for profit entities* and AASB 16 *Leases*, effective from 1 July 2019 and no adjustments were made to the comparative balances as the application of these was applied prospectively.

Statement of changes in equity

for the financial year ended 30 June 2020

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 $'000	Total $'000
Balance at 1 July 2018		**635,868**	**26,333**	**77,741**	**62,833**	**324,134**	**(289,679)**	**837,230**
Opening balance adjustment on adoption of AASB9		-	(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/(to) 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**
Effect of adoption of AASB 15, 16 and 1058	8.10	-	-	-	-	-	(18,546)	(18,546)
Restated balance at 1 July 2019		**949,526**	**-**	**63,804**	**64,397**	**324,134**	**(315,500)**	**1,086,361**
Net result for the year		-	-	-	-	-	(36,880)	(36,880)
Capital Contribution [(i)]		-	-	-	-	4,870	-	4,870
Transfer from/(to) accumulated surplus				19,946	4,389		(24,335)	-
Balance at 30 June 2020		**949,526**	**-**	**83,750**	**68,786**	**329,004**	**(376,715)**	**1,054,351**

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

The consolidated entity has applied AASB 15 *Revenue*, AASB 1058 *Income for not-for profit entities* and AASB 16 *Leases*, effective from 1 July 2019 and no adjustments were made to the comparative balances as the application of these was applied prospectively.

(i) Due to the Government's decision to fund all COVID-19 State capital initiatives under a Treasurer's Advance, 50% of the payment received ($9.7m) was recorded as an equity transfer. The Commonwealth portion of the initiatives was recorded as a capital grant.

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 $'000	Total $'000
Balance at 1 July 2018		**635,868**	**25,382**	**77,741**	**48,636**	**324,134**	**(289,971)**	**821,790**
Opening balance adjustment on adoption of AASB9		-	(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/(to) 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**
Effect of adoption of AASB 15, 16 and 1058	8.10	-	-	-	-	-	(18,546)	(18,546)
Restated balance at 1 July 2019		**949,526**	**-**	**63,804**	**50,096**	**324,134**	**(315,500)**	1,072,060
Net result for the year		-	-	-	-	-	(41,087)	(41,087)
Capital Contribution [(i)]		-	-	-	-	4,870	-	4,870
Transfer from/(to) accumulated surplus		-	-	19,946	181	-	(20,127)	-
Balance at 30 June 2020		**949,526**	**-**	**83,750**	**50,277**	**329,004**	**(376,714)**	**1,035, 843**

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

The consolidated entity has applied AASB 15 *Revenue*, AASB 1058 *Income for not-for profit entities* and AASB 16 *Leases*, effective from 1 July 2019 and no adjustments were made to the comparative balances as the application of these was applied prospectively.

(i) Due to the Government's decision to fund all COVID-19 State capital initiatives under a Treasurer's Advance, 50% of the payment received ($9.7m) was recorded as an equity transfer. The Commonwealth portion of the initiatives was recorded as a capital grant.

Cash flow statement

for the financial year ended 30 June 2020

	Note	Parent entity 2020 $'000	Parent entity 2019 $'000	Consolidated 2020 $'000	Consolidated 2019 $'000
Cash flows from operating activities					
Operating grants from government		1,171,415	1,052,456	1,171,415	1,052,456
Capital grants from government – State		52,883	25,114	52,883	25,114
Capital grants from government – Commonwealth		786	786	786	786
Patient fees received		40,245	46,224	40,245	46,224
Private practice fees received		61,065	65,725	61,065	65,725
Donations and bequests received		12,713	13,465	19,115	11,771
GST received from/(paid to) ATO		37,957	31,324	37,957	31,324
Interest received		722	764	722	764
Car park income received		10,261	10,702	10,261	10,702
Other capital receipts		3,735	4,208	3,735	4,208
Other receipts		75,540	71,650	75,900	71,863
Total receipts		**1,467,322**	**1,322,418**	**1,474,084**	**1,320,937**
Employee expenses paid		(905,421)	(842,834)	(905,421)	(842,834)
Non salary labour costs		(11,818)	(11,143)	(11,818)	(11,143)
Payments for supplies and consumables		(440,323)	(398,598)	(441,836)	(399,519)
Payments for repairs and maintenance		(30,512)	(29,390)	(30,512)	(29,390)
Finance costs		(1,473)	(1,054)	(1,473)	(1,054)
Total payments		**(1,389,547)**	**(1,283,019)**	**(1,391,060)**	**(1,283,940)**
Net cash flow from operating activities	8.1	**77,775**	**39,399**	**83,024**	**36,997**
Cash flows from investing activities					
Purchase of non-financial assets		(58,191)	(81,065)	(58,191)	(81,066)
Proceeds from disposal of investments		2,248	3,406	3,748	5,993
Capital donations and bequests received		2,510	1,500	2,510	1,500
Net cash flows (used in) investing activities		**(53,433)**	**(76,159)**	**(51,933)**	**(73,573)**
Cash flows from financing activities					
Cash advance from Department of Health and Human Services		16,020	-	16,020	-
Repayment of borrowings		(2,701)	(2,597)	(2,701)	(2,597)
Receipt of capital contribution		4,870	-	4,870	-
Cash outflow for leases		(5,899)	-	(5,899)	-
Net cash flows from/(used in) financing activities		**12,290**	**(2,597)**	**12,290**	**(2,597)**
Net increase/(decrease) in cash and cash equivalents held		**36,632**	**(39,357)**	**43,381**	**(39,173)**
Cash and cash equivalents at beginning of financial year		15,468	54,825	15,707	54,880
Cash and cash equivalents at end of financial year	6.2	**52,100**	**15,468**	**59,088**	**15,707**

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

Notes to the financial statements

30 June 2020

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Note 1 – Summary of significant accounting policies

Basis of preparation

These annual financial statements represent the audited general purpose financial statements for Alfred Health and the Consolidated Entity for the year ended 30 June 2020. The purpose of the report is to provide users with information about Alfred Health's stewardship of resources entrusted to it.

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.

A state of emergency was declared in Victoria on 16 March 2020 due to the global coronavirus pandemic, known as COVID-19. A state of disaster was subsequently declared on 2 August 2020. To contain the spread of the virus and to prioritise the health and safety of our communities various restrictions have been announced and implemented by the State Government, which in turn has impacted the manner in which businesses operate, including Alfred Health.

In response, Alfred Health placed restrictions on non-essential visitors, implemented reduced visitor hours, deferred elective surgery and reduced activity, performed COVID-19 testing and implemented work from home arrangements where appropriate. For further details refer to note 2.1 Funding delivery of our services and note 4.2 Property, plant and equipment.

(a) Statement of compliance

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

The financial statements also comply with relevant Financial Reporting Directions (FRDs) issued by the Department of Treasury 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 AASBs.

The annual financial statements were authorised for issue by the Board of Alfred Health on 18 September 2020.

(b) Reporting entity

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

55 Commercial Road
Melbourne
Victoria 3004

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

(c) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2020, and the comparative information presented in these financial statements for the year ended 30 June 2019.

The financial statements are prepared on a going concern basis (refer to note 8.8 economic dependency).

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

Notes to the financial statements (continued)

Note 1 – Summary of significant accounting policies (continued)

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 AASBs 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 4.2 property, plant and equipment); and
- Employee benefit provisions are 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).

Goods and services tax (GST)

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

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

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

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

(d) Principles of consolidation

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

The consolidated financial statements of Alfred Health include all reporting entities controlled by Alfred Health as at 30 June 2020.

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 8.9 Controlled entities.

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.

(e) 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.

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.

Other transfers that are in the nature of contributions or distributions or that have been designated as contributed capital are also treated as contributed capital.

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.

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.

(f) 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 Revenue and income from transactions, 3.1 Expenses from transactions, 6.2 Cash and cash equivalents, 7.1 Financial Instruments and 8.1 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities.

Notes to the financial statements (continued)

Note 2 – Funding delivery of our services

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 revenue and income based on parliamentary appropriations, and is predominately funded by accrual based grant funding for the provision of outputs. Alfred Health also receives revenue and income from the supply of services.

Structure

2.1 Revenue and income from transactions

Note 2.1 - Revenue and income from transactions (a) – Revenue and income from transactions

	Consolidated 2020 $'000	Consolidated 2019 $'000
Government grants (State) – Operating [(i)]	1,005,245	927,277
Government grants (Commonwealth) - Operating	152,035	143,894
Government grants (State) - Capital	41,277	25,114
Government grants (Commonwealth) - Capital	116	786
Other capital purpose income	25,415	13,557
Patient fees	44,693	46,210
Private practice fees	59,829	60,003
Commercial activities	12,609	12,774
Assets received free of charge or for nominal consideration (refer to note 2.1b).	5,484	1,500
Other revenue from operating activities (including non-capital donations) (refer to note 2.1c)	76,265	78,897
Total revenue and income from operating activities	**1,422,968**	**1,310,012**
Other interest and investment income (refer to note 2.1c)	3,172	5,018
Total income from non-operating activities	**3,172**	**5,018**
Total revenue and income from transactions	**1,426,140**	**1,315,030**

(i) Government Grant (State) – Operating includes funding of $71.0m which was spent due to the impacts of COVID-19.

Impact of COVID-19 on revenue and income

As indicated in note (1), Alfred Health's response to the pandemic included the deferral of elective surgeries and reduced activity. This resulted in Alfred Health incurring lost revenue as well as direct and indirect COVID-19 costs. The Department of Health and Human Services provided funding which was spent due to COVID-19 impacts on Alfred Health. Alfred Health also received essential personal protective equipment free of charge under the state supply arrangement.

Accounting Policies

Revenue recognition

Revenue and Income is recognised in accordance with:

a) contributions by owners, in accordance with AASB 1004;

b) income for not-for-profit entities, in accordance with AASB 1058;

c) revenue or a contract liability arising from a contract with a customer, in accordance with AASB 15;

d) a lease liability in accordance with AASB 16;

e) a financial instrument, in accordance with AASB 9; or

f) a provision, in accordance with AASB 137 *Provisions, Contingent Liabilities and Contingent Assets*.

Government grants

Income from grants to construct an asset are recognised when (or as) Alfred Health satisfies its obligations under the transfer. This aligns with Alfred Health's obligation to construct the asset. The progressive percentage costs incurred is used to recognise income because this most closely reflects the progress to completion as costs are incurred as the works are done.

Income from grants that are enforceable and with sufficiently specific performance obligations are accounted for under AASB 15 as revenue from contracts with customers, with revenue recognised as these performance obligations are met.

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

Related amounts may take the form of:

a) contributions by owners, in accordance with AASB 1004;

b) revenue or a contract liability arising from a contract with a customer, in accordance with AASB 15;

c) a lease liability in accordance with AASB 16;

d) a financial instrument, in accordance with AASB 9; or

e) a provision, in accordance with AASB 137 *Provisions, Contingent Liabilities and Contingent Assets*.

As a result of the transitional impacts of adopting AASB 15 and AASB 1058, a portion of the grant revenue has been deferred. If the grant income is accounted for in accordance with AASB 15, the deferred grant revenue has been recognised in contract liabilities whereas grant revenue in relation to the construction of capital assets which the health service controls has been recognised in accordance with AASB 1058 and recognised as deferred grant revenue (refer note 5.2).

If the grant revenue was accounted for under the previous accounting standard AASB 1004 in 2019-20, the total grant revenue received would have been recognised in full.

Performance obligations

The types of government grants recognised under AASB 15 *Revenue from Contracts with Customers* includes:

- Activity Based Funding (ABF) paid as WIES casemix
- other one-off grants if funding conditions contain enforceable and sufficiently specific performance obligations.

The performance obligations for ABF are the number and mix of patients admitted to hospital (casemix) in accordance with levels of activity agreed to with the Department of Health and Human Services (DHHS) in the annual Statement of Priorities (SoP). Revenue is recognised when a patient is discharged and in accordance with the WIES activity for each separation. The performance obligations have been selected as they align with funding conditions set out in the Policy and funding guidelines issued by DHHS.

For other grants with performance obligations Alfred Health exercises judgement over whether the performance obligations have been met, on a grant by grant basis.

Performance obligations and revenue recognition policies

Revenue is measured based on the consideration specified in the contract with the customer. Alfred Health recognises revenue when it transfers control of a good or service to the customer i.e. revenue is recognised when, or as, the performance obligations are satisfied.

- Customers obtain control of the supplies and consumables at a point in time when the goods are delivered to and have been accepted at their premises.
- Income from the sale of goods are recognised when the goods are delivered and have been accepted by the customer at their premises.
- Revenue from the rendering of services is recognised at a point in time when the performance obligation is satisfied when the service is completed; and over time when the customer simultaneously receives and consumes the services as it is provided.

Consideration received in advance of recognising the associated revenue from the customer is recorded as a contract liability (note 5.2.c). Where the performance obligations is satisfied but not yet billed, a contract asset is recorded (note 5.1.b).

Notes to the financial statements (continued)

Previous accounting policies for 30 June 2019

Grant income arises from transactions in which a party provides goods or assets (or extinguishes a liability) to Alfred Health without receiving approximately equal value in return. While grants may result in the provision of some goods or services to the transferring party, they do not provide a claim to receive benefits directly of approximately equal value (and are termed 'non-reciprocal' transfers). Receipt and sacrifice of approximately equal value may occur, but only by coincidence.

Some grants are reciprocal in nature (i.e. equal value is given back by the recipient of the grant to the provider). Alfred Health recognises income when it has satisfied its performance obligations under the terms of the grant.

For non-reciprocal grants, Alfred Health recognises revenue when the grant is received.

Grants can be received as general purpose grants, which refers to grants which are not subject to conditions regarding their use. Alternatively, they may be received as specific purpose grants, which are paid for a particular purpose and/or have conditions attached regarding their use.

The following are transactions that the Alfred Health has determined to be classified as revenue from contracts with customers in accordance with AASB 15. Due to the modified retrospective transition method chosen in applying AASB 15, comparative information has not been restated to reflect the new requirements.

Patient and fees

The performance obligations related to patient fees are the completion of medical services. These performance obligations have been selected as they align with the terms and conditions of the providing services. Revenue is recognised as these performance obligations are met.

Private practice fees

The performance obligations related to private practice fees are the completion of medical services. These performance obligations have been selected as they align with the terms and conditions agreed with the private provider.

Revenue is recognised as these performance obligations are met. Private practice fees include recoupments from the private practice for the use of hospital facilities.

Commercial activities

Revenue from commercial activities includes items such as car park income, research income, clinical trials, ethics review fees and training and seminar income. Performance obligations related to commercial activities are provision of non health-related services at either a point in time or over time. These performance obligations have been selected as they align with the terms and conditions per the contract with the provider of the commercial activities. Where there is judgement around whether a performance obligation is met, Alfred Health exercises judgement.

Note 2.1(b) – Fair value of assets and services received free of charge or for nominal consideration

	Consolidated 2020 $'000	Consolidated 2019 $'000
Cash donations and gifts	500	1,500
Plant and equipment	13	-
Assets received free of charge under State supply arrangements (i)	4,971	-
Total fair value of assets and services received free of charge or for nominal consideration	**5,484**	**1,500**

(i) In order to meet the State of Victoria's health network supply needs during the COVID-19 pandemic, arrangements were put in place to centralise the purchasing of essential personal protective equipment and essential capital. The general principles of the State Supply Arrangement were that Health Purchasing Victoria sourced, secured and agreed terms for the purchase of the products, funded by the Department of Health and Human Services, while Monash Health and the Department took delivery, and distributed an allocation of the products to Alfred Health as resources provided free of charge.

Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the recipient obtains control over the resources, irrespective of whether restrictions or conditions are imposed over the use of the contributions.

The exception to this would be when the resource is received from another government department (or agency) as a consequence of a restructuring of administrative arrangements, in which case such a transfer will be recognised at its carrying value in the transferring department or agency as a capital contribution transfer.

Voluntary services

Contributions in the form of services are only recognised when a fair value can be reliably determined, and the services would have been purchased if not donated. Alfred Health does not depend on volunteers to deliver its services.

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

2.1 (c) Other revenue from operating activities

	Consolidated 2020 $'000	Consolidated 2019 $'000
Cash donations and gifts (non-capital)	8,875	9770
Rental income – investment properties	354	345
Salary and other recoveries	43,695	37,267
Research and sundry revenue	23,341	31,515
Total other revenue from non-operating activities	**76,265**	**78,897**
Investment income	2,450	3,936
Other interest income	722	1,082
Total income from non-operating activities	**3,172**	**5,018**

Other income is recognised as revenue when received. Other income includes recoveries for salaries and wages and external services provided, and donations and bequests. If donations are for a specific purpose, they may be appropriated to a surplus, such as the specific restricted purpose surplus.

Interest income

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.

Rental income

Rental income from leasing of property are operating leases and are recognised on a straight-line basis over the lease term.

Operating leases relate to the property owned by Alfred Health with various lease terms. All operating lease contracts contain market review clauses. The lessee does not have an option to purchase the property at the expiry of the lease period. The risks associated with rights that Alfred Health retains in underlying assets are not considered to be significant.

Notes to the financial statements (continued)

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

Note 3.1 – Expenses from transactions

	Consolidated 2020 $'000	Consolidated 2019 $'000
Employee expenses		
Salaries and wages	741,384	678,521
On-costs	183,854	175,088
Agency expenses	8,436	7,806
Fee for service medical officer expenses	3,382	3,337
WorkCover premium	8,964	7,477
Total employee expenses	**946,020**	**872,229**
Supplies and consumables		
Drug supplies	142,282	136,400
Medical and surgical supplies (including prostheses)	63,965	62,529
Diagnostic and radiology supplies	14,254	13,260
Other supplies and consumables	71,615	78,010
Total supplies and consumables	**292,116**	**290,199**
Finance costs		
Finance costs	1,639	1,188
Total finance costs	**1,639**	**1,188**
Other operating expenses		
Fuel, light, power and water	9,191	9,774
Repairs and maintenance	20,638	17,057
Maintenance contracts	18,642	17,860
Medical indemnity insurance	11,118	10,336
Expenses related to short term leases	212	136
Other administrative expenses	56,124	56,019
Expenditure for capital purposes	389	1,210
Total other operating expenses	**116,314**	**112,392**
Other non-operating expenses		
Depreciation and amortisation (refer note 4.4)	96,096	77,714
Total other non-operating expenses	**96,096**	**77,714**
Total expenses from transactions	**1,452,185**	**1,353,722**

Notes to the financial statements (continued)

Note 3.1 – Expenses from transactions (continued)

As indicated in Note 1, Alfred Health's daily activities were impacted by the pandemic. This resulted in direct and indirect costs being incurred, such as the establishment of a screening clinic, pathology costs, increased wages, consumables and small asset purchases, security and cleaning costs.

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 16 *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.

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.

Operating lease payments

Operating lease payments up until 30 June 2019 (including contingent rentals) were recognised on a straight-line basis over the lease term, except where another systematic basis was more representative of the time pattern of the benefits derived from the use of the leased asset.

From 1 July 2019, the following lease payments are recognised on a straight-line basis:

- Short-term leases – leases with a term less than 12 months; and
- Low value leases – leases with the underlying asset's fair value (when new, regardless of the age of the asset being leased) is no more than $10,000.

Variable lease payments are not included in the measurement of the lease liability (i.e. variable lease payments that do not depend on an index or a rate, initially measured using the index or rate as at the commencement date). These payments are recognised in the period in which the event or condition that triggers those payments occur.

Note 3.2 – Other economic flows included in net result

	Consolidated 2020 $'000	Consolidated 2019 $'000
Net gain/(loss) on non-financial assets		
Net gain/(loss) on disposal of property plant and equipment	5	(126)
Total gain/(loss) on non-financial assets	**5**	**(126)**
Net gain/(loss) on financial instruments at fair value		
Allowance for impairment losses of contractual receivables	(5,850)	(5,117)
Net gain/(loss) on revaluation of financial instruments	(4,349)	146
Total net gain/(loss) on financial instruments at fair value	**(10,199)**	**(4,971)**
Other (loss) from other economic flows		
Net (loss) arising from revaluation of long service liability	(641)	(1,682)
Total other (loss) from other economic flows	**(641)**	**(1,682)**
Total (loss) from economic flows included in net result	**(10,835)**	**(6,779)**

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 rate.

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 4.2 property, plant and equipment);
- Net gain/(loss) on disposal of non-financial assets; and
- Any gain/(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) includes:

- 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/deficits or net result due to disposal or derecognition or reclassification.

Notes to the financial statements (continued)

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

	Expense		Revenue	
	Consolidated 2020 $'000	Consolidated 2019 $'000	Consolidated 2020 $'000	Consolidated 2019 $'000
Commercial activities				
Private practice and other patient activities	5,098	5,660	5,246	6,628
Car park	3,542	3,385	10,238	10,673
Property expense/revenue	158	184	245	228
Other activities				
Fundraising and community support	3,006	2,790	14,810	13,271
Research and scholarship	28,569	26,284	23,570	25,356
Other	15,315	15,144	18,327	18,746
Total expenses and revenue	**55,688**	**53,447**	**72,436**	**74,902**

Note 3.4 – Employee benefits in the balance sheet

	Consolidated 2020 $'000	Consolidated 2019 $'000
Current provisions		
Employee benefits [i]		
Accrued days off		
- Unconditional and expected to be settled wholly within 12 months [ii]	2,285	2,073
Annual leave		
- Unconditional and expected to be settled wholly within 12 months [ii]	70,061	63,274
- Unconditional and expected to be settled after 12 months [iii]	8,211	7,293
Long service leave		
- Unconditional and expected to be settled wholly within 12 months [ii]	9,786	10,868
- Unconditional and expected to be settled after 12 months [iii]	106,077	93,912
	196,420	177,420
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months [ii]	8,037	7,532
- Unconditional and expected to be settled after 12 months [iii]	12,022	10,725
	20,059	18,257
Total current provisions	**216,479**	**195,677**
Non-current provisions		
Conditional long service leave [iii]	37,271	34,766
Provisions related to employee benefit on-costs [iii]	3,945	3,708
Total non-current provisions	**41,216**	**38,474**
Total provisions	**257,695**	**234,151**
(a) Employee benefits and related on-costs		
Current employee benefits and related on-costs		
Unconditional long service leave entitlements	128,128	115,956
Annual leave entitlements	85,823	77,427
Accrued days off	2,528	2,294
Non-current employee benefits and related on-costs		
Conditional long service leave entitlements [ii]	41,216	38,474
Total employee benefits and related on-costs	**257,695**	**234,151**

(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.

Notes to the financial statements (continued)

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

(b) Movement in on-costs provision

	Consolidated 2020 $'000	Consolidated 2019 $'000
Balance at start of year	**21,964**	**19,815**
Additional provisions recognised	1,968	1,972
Unwinding of discount and effect of changes in the discount rate	73	177
Balance at end of year	**24,005**	**21,964**

Employee benefit recognition

Provision is made for benefits accruing to employees in respect of accrued days off, 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 as 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 2020 $'000	Consolidated 2019 $'000	Consolidated 2020 $'000	Consolidated 2019 $'000
Defined benefit plans [i]:				
Health Super	656	704	99	108
Defined contribution plans:				
First State	33,751	33,139	2,477	2,474
Vic Super	170	184	14	12
Hesta	25,456	23,387	2,012	1,901
Other	12,837	10,477	3,619	2,945
Total superannuation	**72,870**	**67,891**	**8,221**	**7,440**

(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.

Notes to the financial statements (continued)

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

4.1 Investments and other financial assets

4.2 Property, plant and equipment

4.3 Intangible assets

4.4 Depreciation and amortisation

Note 4.1 – Investments and other financial assets

	Consolidated Specific purpose fund	
	2020 $'000	**2019 $'000**
Non-current assets		
Financial assets at fair value through the net result		
Managed funds	51,196	56,888
Financial assets at amortised costs		
Managed funds	2,712	2,746
Total investments and other financial assets	**53,908**	**59,634**
Represented by:		
Investments held in trust [(i)]	53,908	59,634
Total investments and other financial assets	**53,908**	**59,634**

(i) The COVID-19 pandemic has created volatility in the financial market. Performance of the financial markets may continue to fluctuate and impact the fair value of financial assets and investments in future reporting periods.

Alfred Health measures its managed funds at fair value through net result in 2020. Unless such assets are part of a disposal group held for sale, all managed funds are classified as non-current. Accounting policies for investments and other financial assets are disclosed in note 7.1 financial instruments.

Note 4.2 – Property, plant and equipment

a) Gross carrying amount and accumulated depreciation

	Consolidated 2020 $'000	Consolidated 2019 $'000
Land		
Crown land at fair value	248,904	273,216
Land – right of use (i)	24,312	-
Total land at fair value	**273,216**	**273,216**
Buildings		
Buildings under construction at cost	12,832	11,241
Buildings at fair value	934,569	901,055
Less accumulated depreciation	(61,722)	-
Sub total buildings at fair value	885,679	912,296
Buildings – right of use	25,993	-
Less accumulated depreciation	(5,383)	-
Sub total buildings – right of use	20,610	-
Leasehold improvements at cost	5,674	5,031
Less accumulated amortisation	(1,689)	(1,549)
Sub total leasehold improvements	3,985	3,482
Total buildings	**910,274**	**915,778**
Plant & equipment, furniture & fittings & motor vehicles		
Medical equipment at fair value	196,805	181,988
Less accumulated depreciation	(133,947)	(122,344)
Total medical equipment	62,858	59,644
Computers & communication equipment at fair value	57,371	57,934
Less accumulated depreciation	(55,139)	(52,933)
Total computers & communication equipment	2,232	5,001
Furniture & fittings at fair value	7,403	7,307
Less accumulated depreciation	(6,775)	(6,601)
Total furniture & fittings	628	706
Other plant and equipment at fair value	62,214	55,099
Less accumulated depreciation	(44,687)	(41,488)
Total other plant and equipment	17,527	13,611
Right of use – plant & equipment, furniture & fittings and motor vehicles	2,772	-
Less accumulated depreciation	(1,078)	-
Total right of use – plant & equipment, furniture & fittings and motor vehicles	1,694	-
Motor vehicles	60	60
Less accumulated depreciation	(60)	(60)
Total motor vehicles	-	-
Plant & equipment – work in progress at cost	11,856	11,062
Total plant & equipment, furniture & fittings and motor vehicles	**96,795**	**90,024**
Total property, plant and equipment	**1,280,285**	**1,279,018**

(i) The carrying amount of land subject to a peppercorn lease arrangement (i.e. concessionary finance lease) immediately before the date of initial application of AASB 16 shall be the deemed cost of the Right-Of-Use asset and lease liability for the purpose of transition.

Notes to the financial statements (continued)

Note 4.2 – Property, plant and equipment (continued)

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

Consolidated	Land $'000	Right of use - Land $'000	Buildings $'000	Right of use - buildings $'000	Leasehold improve-ments $'000	Medical equipment $'000	Computers and communi-cation equipment $'000	Furniture and Fittings $'000	Other plant and equipment $'000	Right of use- PPE, F&V $'000	Totals $'000
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**	**-**	**3483**	**59,644**	**5,001**	**705**	**24,673**	**-**	**1,279,018**
Recognition of right-of-use assets on initial application of AASB 16 (note 8.10)	(24,312)	24,312	-	25,598	-	-	-	-	-	2,313	27,911
Adjusted balance 1 July 2019	**248,904**	**24,312**	**912,296**	**25,598**	**3483**	**59,644**	**5,001**	**705**	**24,673**	**2,313**	**1,306,929**
Additions / (transfers)	-	-	35,105	395	738	14,813	(127)	97	6,137	392	57,550
Disposals (WDV)	-	-	-	-	-	(12)	-	-	-	(5)	(17)
Assets received free of charge	-	-	-	-	-	-	-	-	1,799	-	1,799
Revaluation Increments	-	-	-	-	-	-	-	-	-	-	-
Depreciation (note 4.4)	-	-	(61,722)	(5,383)	(235)	(11,587)	(2,642)	(174)	(3,227)	(1,006)	(85,976)
Balance at 30 June 2020	**248,904**	**24,312**	**885,679**	**20,610**	**3986**	**62,858**	**2,232**	**628**	**29,382**	**1,694**	**1,280,285**

Land and buildings carried at valuation

A full revaluation of Alfred Health's land and buildings was performed by the Valuer-General of Victoria (VGV) in May 2019 in accordance with the requirements of Financial Reporting Direction (FRD) 103H Non-Financial Physical Assets. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The effective date of the valuation for both land and buildings was 30 June 2019.

In compliance with FRD 103H, in the year ended 30 June 2020, management conducted an annual assessment of the fair value of land and buildings. To facilitate this, management obtained from the Department of Treasury and Finance the VGV indices for the financial year ended 30 June 2020.

Management regards the VGV indices to be a reliable and relevant dataset to form the basis of their estimates. While these indices are applicable at 30 June 2020, the fair value of land and buildings will continue to be subjected to the impacts of COVID-19 in future accounting periods. The land and building balances are considered to be sensitive to market conditions.

To trigger a managerial revaluation a change in the land or building indices of 10% would be required.

The VGV indices, which are based on data to March 2020, indicate an average increase of 8% across all land parcels and a 2.5% increase in buildings.

As the accumulative movement was less than 10% for land and buildings no managerial revaluation was required.

c) Fair value measurement hierarchy for assets as at 30 June 2020

		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	248,904	-	-	248,904
Total land at fair value	**248,904**	**-**	**-**	**248,904**
Buildings at fair value				
Specialised buildings	872,847	-	-	872,847
Total buildings at fair value	**872,847**	**-**	**-**	**872,847**
Plant & equipment, furniture & fittings at fair value				
Medical equipment	62,858	-	-	62,858
Computers & communication equipment	2,232	-	-	2,232
Furniture & fittings	628	-	-	628
Other equipment	17,527	-	-	17,527
Total plant & equipment and furniture & fittings at fair value	**83,245**	**-**	**-**	**83,245**
Total assets at fair value	**1,204,996**	**-**	**-**	**1,204,996**

There have been no transfers between levels during the period.

Notes to the financial statements (continued)

Note 4.2 – Property, plant and equipment (continued)

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

	Consolidated carrying amount $'000	Fair value measurement at end of reporting period using: 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.

d) Reconciliation of level 3 fair value

30 June 2020	Land $'000	Buildings $'000	Plant & equipment, furniture & fittings $'000	Totals $'000
Balance at 30 June 2019	**273,216**	**901,055**	**78,962**	**1,253,233**
Recognition of right-of-use assets on initial application of AASB 16	(24,312)	-	-	(24,312)
Adjusted balance 1 July 2019	**248,904**	**901,055**	**78,962**	**1,228,921**
Additions / (disposals)	-	33,514	21,930	55,444
Gains or losses recognised in net result	-	-	(17)	(17)
- Depreciation	-	(61,722)	(17,630)	(79,352)
Closing balance	**248,904**	**872,847**	**83,245**	**1,204,996**

There have been no transfers between levels during the period.

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.

Notes to the financial statements (continued)

Note 4.2 – Property, plant and equipment (continued)

e) Fair value determination

Asset class	Likely valuation approach	Significant inputs (level 3 only)
Specialised land	Market approach	Community service obligations adjustments [ii]
Specialised buildings [i]	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment [i]	Depreciated replacement cost approach	Cost per unit Useful life
Vehicles	Market approach	N/A
	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 2020.

(f) Property, plant and equipment revaluation surplus

	Consolidated 2020 $'000	Consolidated 2019 $'000
Property, plant and equipment revaluation surplus		
Balance at the beginning of the reporting period	949,526	635,868
Revaluation increment		
- Land (refer note 4.2(b))	-	35,869
- Buildings (refer note 4.2(b))	-	277,789
Balance at the end of the reporting period*	**949,526**	**949,526**
*** Represented by:**		
- Land	223,952	223,952
- Buildings	725,574	725,574
	949,526	**949,526**

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.

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

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

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.

Right-of-use asset acquired by lessees (under AASB 16 – *Leases* from 1 July 2019) – initial measurement

Alfred Health recognises a right-of-use asset and a lease liability at the lease commencement date. The right-of-use asset is initially measured at cost which comprises the initial amount of the lease liability adjusted for:

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

Subsequent measurement

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.

Right-of-use asset – subsequent measurement

Alfred Health depreciates the right-of-use assets on a straight-line basis from the lease commencement date to the earlier of the end of the useful life of the right-of-use asset or the end of the lease term. The estimated useful life of the right-of-use assets are determined on the same basis as property, plant and equipment, other than where the lease term is lower than the otherwise assigned useful life. The right-of-use assets are also subject to revaluation as required by FRD 103H, however as at 30 June 2020 right-of-use assets have not been revalued.

In addition, the right-of-use asset is periodically reduced by impairment losses, if any and adjusted for certain remeasurements of the lease liability.

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 Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

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

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

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

The revaluation surplus is not transferred to accumulated funds on de-recognition 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.

Notes to the financial statements (continued)

Note 4.2 – Property, plant and equipment (continued)

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 determine 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 was 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 2020.

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).

Notes to the financial statements (continued)

Note 4.3 – Intangible assets

	Consolidated 2020 $'000	Consolidated 2019 $'000
Computer software at cost	52,415	48,145
Less accumulated amortisation	(40,895)	(30,355)
Total intangible assets	**11,520**	**17,790**

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 2018	**10,973**
Additions	14,272
Disposals	-
Amortisation (note 4.4)	(7,455)
Balance at 1 July 2019	**17,790**
Additions	3,850
Disposals	-
Amortisation (note 4.4)	(10,120)
Balance at 30 June 2020	**11,520**

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 4.4 – Depreciation and amortisation

	Consolidated 2020 $'000	Consolidated 2019 $'000
Depreciation		
Buildings	61,722	53,970
Medical equipment	11,587	10,147
Computers and communication equipment	2,642	3,091
Furniture and fittings	174	215
Other plant and equipment	3,227	2,676
Leased assets		
Right-of-use assets		
- Right-of-use buildings	5,383	-
- Right-of-use plant, equipment, furniture and fittings and motor vehicles	1,006	-
Leasehold improvements	235	160
Total depreciation	**85,976**	**70,259**
Amortisation		
Computer software	10,120	7,455
Total amortisation	**10,120**	**7,455**
Total depreciation and amortisation	**96,096**	**77,714**

Depreciation

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

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.

Right-of-use assets are depreciated over the shorter of the asset's useful life and the lease term.

Where Alfred Health obtains ownership of the underlying leased asset or if the cost of the right-of-use asset reflects that the entity will exercise a purchase option, the entity depreciates the right-of-use asset over its useful life.

Notes to the financial statements (continued)

Note 4.4 – Depreciation and amortisation (continued)

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

	2019/20	2018/19
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
Right-of-use assets (buildings)	1 – 10 years	-
Right-of-use assets (MV and other PPE)	1 – 5 years	-

Amortisation

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

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the 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 3 to 4-year period.

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 and contract assets

5.2 Payables and contract liabilities

Note 5.1 – Receivables and contract assets

	Consolidated 2020 $'000	Consolidated 2019 $'000
Current		
Contractual		
Inter hospital debtors	3,022	2,326
Trade debtors	15,201	9,090
Contract assets (note 5.1b)	17,137	-
Patient fees receivable	17,303	20,025
Accrued revenue – other	-	16,563
Sub total	**52,663**	**48,004**
Less allowance for impairment losses of contractual receivables (a)		
Trade debtors	(326)	(283)
Patient fees	(4,315)	(4,442)
Sub total	**(4,641)**	**(4,725)**
Total receivables and contract assets	**48,022**	**43,279**
Statutory		
GST receivable	3,224	5,865
Accrued revenue – Department of Health and Human Services	-	2,876
Sub total	**3,224**	**8,741**
Total current receivables	**51,246**	**52,020**
Non-current		
Statutory		
Long service leave – Department of Health and Human Services	27,583	23,376
Total non-current receivables	**27,583**	**23,376**
Total receivables	**78,829**	**75,396**
(a) Movement in the allowance for impairment losses of contractual receivables		
Balance at beginning of year	(4,725)	(3,898)
Opening retained earnings adjustment on adoption of AASB 9	-	(510)
Opening loss allowance	(4,725)	(4,408)
Amounts written off/(on) during the year	5,934	5,041
Increase in allowance recognised in net result	(5,850)	(5,358)
Balance at end of year	**(4,641)**	**(4,725)**

Notes to the financial statements (continued)

Note 5.1 – Receivables and contract assets (continued)

Receivables consist of:

- Contractual receivables, which includes mainly debtors in relation to goods and services. 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 which is 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 that are recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. 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*.

Except for the Department of Health and Human Services, 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 5.1(b) – Contract assets

	Consolidated 2020 $'000
Contract assets	
Opening balance brought forward from 30 June 2019 adjusted for AASB 15	-
Add: Additional costs incurred that are recoverable from the customer	17,137
Less: Transfer to trade receivable or cash at bank	-
Less: impairment allowance	-
Total contract assets	**17,137**
Represented by	
Current contract assets	17,137
Non-current contract assets	-

As AASB 15 was first applied from 1 July 2019, there is no comparative information to display

Contract assets relate to the Alfred Health's right to consideration in exchange for goods transferred to customers for works completed, but not yet billed at the reporting date. The balance of the contract assets at 30 June 2020 was impacted by timing of the works completed by contractors and is new compared to last year as it is not billable at this stage. The works are expected to be completed and recovered early next year.

Note 5.2 – Payables and contract liabilities

	Consolidated 2020 $'000	Consolidated 2019 $'000
Current		
Contractual		
Trade creditors [(ii)]	4,145	33,153
Accrued expenses	47,700	40,867
Accrued salaries and wages	27,042	20,934
Deferred grant revenue (note 5.2(a) & 5.2(b))	44,460	-
Contract liabilities – income received in advance (note 5.2(c))	5,621	-
Salary packaging	4,017	4,323
Superannuation	8,221	7,440
Total current payables[(i)]	**141,206**	**106,717**

(i) The average credit period is 42 days (2019: 51 days). No interest is charged on payables. Creditor days are calculated on trade creditors and accrued expenses excluding amounts owing to the Department of Health and Human Services.

(ii) As a result of the COVID-19 pandemic in March 2020 the Department of Health and Human Services requested Alfred Health to assume all trade creditors had payment terms of 5 days. This was still in effect at 30 June 2020.

Payables consist of:

- Contractual payables which are classified as financial instruments and measured at amortised cost. Payables 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 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.

Notes to the financial statements (continued)

Note 5.2 – Payables and contract liabilities (continued)

Note 5.2(a) – Deferred capital grant revenue

	Consolidated 2020 $'000
Grant consideration for capital works recognised that was included in the deferred grant liability balance (adjusted for AASB 1058) at the beginning of the year	18,546
Grant consideration for capital works received during the year	44,978
Grant revenue for capital works recognised consistent with the capital works undertaken during the year	(25,280)
Closing balance of deferred grant consideration received for capital works	**38,244**

Grant revenue is recognised progressively as the asset is constructed, since this is the time when Alfred Health satisfies its obligations under the transfer by controlling the asset as and when it is constructed. The progressive percentage costs incurred are used to recognise income because this most closely reflects the progress to completion as costs are incurred as the works are done (see note 2.1). As a result, Alfred Health has deferred recognition of a portion of the grant consideration received as a liability for the outstanding obligations.

Grant consideration was received from the Department of Health and Human Services to support multiple capital projects.

Note 5.2(b) – Grant consideration

	Consolidated 2020 $'000
Revenue recognised from performance obligations satisfied in previous periods	**-**
Transaction price allocated to the remaining performance obligations from contracts with customers to be recognised in:	
Not longer than one year	6,085
Longer than one year but not longer than five years	131
Longer than five years	-
Total grant consideration	**6,216**

In addition, grant consideration was also received from the State Government in support of medical and associated services .Grant income is recognised as service obligations are met. Differences in the number of some services provided may be adjusted in the funding provided annually. The remaining grant revenue is recognised when the service obligations are delivered in the following year.

Note 5.2(c) – Contract liabilities – income received in advance

	Consolidated 2020 $'000
Opening balance brought forward from 30 June 2019 adjusted for AASB 15	-
Add: Payments received for performance obligations yet to be completed during the period [(i)]	2,010
Add: Grant consideration for sufficiently specific performance obligations received during the year [(ii)]	3,611
Less: Revenue recognised in the reporting period for the completion of a performance obligation	-
Less: Grant revenue for sufficiently specific performance obligations works recognised consistent with the performance obligations met during the year	-
Total contract liabilities	**5,621**
Represented by	
Current contract liabilities	5,621
Non-current contract liabilities	-

(i) Contract liability for a donation with specific performance obligations that have not been met.
(ii) Contract liability for the recognition of performance obligations not met in relation to activity-based funding and COVID-19 grants in the current financial year.

Notes to the financial statements (continued)

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 disclosures.

Structure

6.1 Borrowings

6.2 Cash and cash equivalents

6.3 Commitments for expenditure

Note 6.1 – Borrowings

	Consolidated 2020 $'000	Consolidated 2019 $'000
Current		
Australian dollar borrowings		
- Department of Health and Human Services (v)	-	1,000
- Treasury Corporation Victoria loans (i-iv)	1,812	1,701
- Lease liability (vi)	6,039	-
- Advances from government (vii)	16,020	-
Total current borrowings	**23,871**	**2,701**
Non-current		
Australian dollar borrowings		
- Treasury Corporation Victoria loans (i-iv)	10,705	12,518
- Lease liability (vi)	16,828	-
Total non-current borrowings	**27,533**	**12,518**
Total borrowings	**51,404**	**15,219**

Terms and conditions of borrowings

The following details outline Alfred Health's terms and conditions on 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 2020 is $2.7m.

(ii) Average interest rate applied during 2019/20 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 from September 2007 and with the final instalment due on 15 June 2027. The principal outstanding for this loan at 30 June 2020 is $9.8m.

(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 has repaid the loan in full, there is no further outstanding amount at 30 June 2020.

(vii) Advance provided by the Department of Health and Human Services to fund working capital requirements of departmental policy change to creditor payment terms. This balance is expected to be repaid by 30 June 2021.

Lease liability

(vi) Secured by the assets leased. Leases are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

(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 the net result over the period of the borrowing using the effective interest method.

Lease liabilities

Repayments in relation to leases are payable as follows:

	Minimum future lease payments		Present value of minimum future lease payments	
	Consolidated 2020 $'000	Consolidated 2019 $'000	Consolidated 2020 $'000	Consolidated 2019 $'000
No later than one year	6,510	-	6,039	-
Later than 1 year and not later than 5 years	13,516	-	12,658	-
Later than 5 years	4,343	-	4,169	-
Minimum lease payments	24,369	-	22,866	-
Less future finance charges	(1,503)	-	-	-
Total	**22,866**	**-**	**22,866**	**-**
Included in the financial statements as:				
Current borrowings – lease liability	-	-	6,039	-
Non-current borrowings – lease liability	-	-	16,827	-
Total	**-**	**-**	**22,866**	**-**

The weighted average interest rate implicit in the lease is 5.5%.

Leases

A lease is a right to use an asset for an agreed period of time in exchange for payment. All leases are recognised on the balance sheet, with the exception of low value leases (less than $10,000 AUD) and short-term leases of less than 12 months.

Alfred Health's leasing activities

Alfred Health has entered into leases related to various properties, equipment and motor vehicles.

For any new contracts entered into on or after 1 July 2019, Alfred Health considers whether a contract is, or contains a lease. A lease is defined as 'a contract, or part of a contract, that conveys the right to use an asset (the underlying asset) for a period of time in exchange for consideration'. To apply this definition Alfred Health assesses whether the contract meets three key evaluations which are whether:

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

This policy is applied to contracts entered into, or changed, on or after 1 July 2019.

Notes to the financial statements (continued)

Note 6.1 – Borrowings (continued)

Separation of lease and non-lease components

At inception or on reassessment of a contract that contains a lease component, the lessee is required to separate out and account separately for non-lease components within a lease contract and exclude these amounts when determining the lease liability and right-of-use asset amount.

Recognition and measurement of leases as a lessee (under AASB 16 from 1 July 2019)

Lease Liability – initial measurement

The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease if that rate is readily determinable or Alfred Health's incremental borrowing rate.

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

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

Lease Liability – subsequent measurement

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

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

Short-term leases and leases of low value assets

Alfred Health has elected to account for short-term leases and leases of low value assets using the practical expedients available under the AASB 16 *Leases*. Instead of recognising a right of use asset and lease liability, the payments in relation to these are recognised as an expense in profit or loss on a straight-line basis over the lease term.

Presentation of right-of-use assets and lease liabilities

Alfred Health presents right-of-use assets as 'property, plant and equipment' unless they meet the definition of investment property, in which case they are disclosed as 'investment property' in the balance sheet. Lease liabilities are presented as 'borrowings' in the balance sheet.

Recognition and measurement of leases (under AASB 117 until 30 June 2019)

In the comparative period, leases of property, plant and equipment were classified as either finance lease or operating leases.

Alfred Health determined whether an arrangement was or contained a lease based on the substance of the arrangement and required an assessment of whether fulfilment of the arrangement is dependent on the use of the specific asset(s); and the arrangement conveyed a right to use the asset(s).

Leases of property, plant and equipment where Alfred Health as a lessee had substantially all of the risks and rewards of ownership were classified as finance leases. Finance leases were initially recognised as assets and liabilities at amounts equal to the fair value of the leased property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The leased asset is accounted for as a non-financial physical asset and depreciated over the shorter of the estimated useful life of the asset or the term of the lease. Minimum finance lease payments were apportioned between the reduction of the outstanding lease liability and the periodic finance expense, which is calculated using the interest rate implicit in the lease and charged directly to the consolidated comprehensive operating statement.

Contingent rentals associated with finance leases were recognised as an expense in the period in which they are incurred.

Assets held under other leases were classified as operating leases and were not recognised in the Alfred Health balance sheet. Operating lease payments were recognised as an operating expense in the Statement of Comprehensive Income on a straight-line basis over the lease term.

Operating lease payments up until 30 June 2019 (including contingent rentals) are recognised on a straight-line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset.

From 1 July 2019, the following lease payments are recognised on a straight-line basis:

- Short-term leases – leases with a term less than 12 months; and
- Low value leases – leases with the underlying asset's fair value (when new, regardless of the age of the asset being leased) is no more than $10,000.

Variable lease payments not included in the measurement of the lease liability (i.e. variable lease payments that do not depend on an index or a rate, initially measured using the index or rate as at the commencement date). These payments are recognised in the period in which the event or condition that triggers those payments to occur.

Note 6.2 – Cash and cash equivalents

	Consolidated 2020 $'000	Consolidated 2019 $'000
Cash on hand (excluding monies held in trust)	24	26
Cash at bank (excluding monies held in trust)	513	170
Cash at bank (held in trust)	6,474	69
Cash at bank – CBS (excluding monies held in trust)	52,077	15,442
Total cash and cash equivalents	**59,088**	**15,707**
Represented by		
Cash held for:		
Health service operations	7,640	(2,452)
Pre-funded capital projects	42,645	15,466
Employee salary packaging	2,329	2,624
Total cash excluding funds held in trust	**52,614**	**15,638**
Monies held in trust on behalf of patients	72	69
Cash at bank (monies held in trust) [(i)]	6,402	-
Total cash held in trust	**6,474**	**69**
Total cash and cash equivalents	**59,088**	**15,707**

(i) At 30 June 2020 Alfred Health had $6.4m of cash that has been classified as restricted cash as it is the donation monies received for the John F Marriott Trust to be invested at a later date.

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.

Notes to the financial statements (continued)

Note 6.3 – Commitments for expenditure

	Consolidated 2020 $'000	Consolidated 2019 $'000
Capital expenditure commitments:		
Not later than one year	19,234	24,524
Total capital expenditure commitments	**19,234**	**24,524**
Other expenditure commitments:		
Not later than one year	44,784	50,736
Later than one year but not later than five years	45,921	78,532
Later than five years	4,977	5,415
Total other expenditure commitments	**95,682**	**134,683**
Total commitments for expenditure (inclusive of GST)	**114,916**	**159,207**
Less GST recoverable from the Australian Tax Office	**(10,447)**	**(14,473)**
Total commitments for expenditure (exclusive of GST)	**104,469**	**144,734**

All amounts shown in the commitments note are nominal amounts inclusive of GST (unless otherwise stated).
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 entered into commercial leases on certain medical equipment, computer equipment and property where it is not in the interest of Alfred Health to purchase these assets. These leases have an average life of between one and five years with renewal terms included in the contracts. Renewals are at the option of Alfred Health. There are no restrictions placed upon the lessee by entering into these leases.

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

Consolidated 2020	Note	Financial assets at amortised cost 2020 $'000	Financial assets at fair value through net result 2020 $'000	Financial liabilities at amortised cost 2020 $'000	Total 2020 $'000
Financial assets					
Cash and cash equivalents	6.2	59,088	-	-	59,088
Receivables					
- Trade debtors	5.1	14,875	-	-	14,875
- Other receivables	5.1	33,147	-	-	33,147
Investments and other financial assets					
- Managed funds	4.1	2,712	51,196	-	53,908
Total financial assets [(i)]		**109,822**	**51,196**	**-**	**161,018**
Financial liabilities					
Payables	5.2	-	-	91,125	91,125
Borrowings	6.1	-	-	51,404	51,404
Other liabilities		-	-	72	72
Total financial liabilities [(ii)]		**-**	**-**	**142,601**	**142,601**

(i) The total amount of financial assets disclosed here excludes statutory receivables (i.e. amounts owing from the Victorian State Government and GST input tax credit recoverable).
(ii) The total amount of financial liabilities disclosed here excludes statutory liabilities (i.e. amounts payable or deferred grant liability recognised against State Government and taxes payable).

Notes to the financial statements (continued)

Note 7.1 – Financial instruments (continued)

a) Financial instruments: categorisation (continued)

Consolidated 2019	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 2019 $'000
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 funds	4.1	2,746	56,888	-	59,634
Total financial assets (i)		**61,732**	**56,888**	**-**	**118,620**
Financial liabilities					
Payables	5.2	-	-	106,717	106,717
Borrowings	6.1	-	-	15,219	15,219
Other liabilities		-	-	69	69
Total financial liabilities (ii)		**-**	**-**	**122,005**	**122,005**

(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. amounts payable or deferred grant liability recognised against State Government and taxes payable).

Alfred Health applies AASB 9 and classifies all of its financial assets based on the business model for managing the assets and the asset's contractual terms.

Categories of financial assets

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 at 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 at 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 funds as well as certain 5-year government bonds as fair value through net result.

Categories of financial liabilities

Financial liabilities at amortised cost

Financial liabilities at amortised cost 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. Alfred Health recognises the following liabilities in this category:

- Payables (excluding statutory payables); and
- Borrowings (including lease liabilities).

Offsetting financial instruments

Financial instrument assets and liabilities are offset and the net amount presented in the consolidated balance sheet when, and only when, Alfred Health has a legal right to offset the amounts and intends to either settle on a net basis or to realise the asset and settle the liability simultaneously.

Some master netting arrangements do not result in an offset of balance sheet assets and liabilities. Where Alfred Health does not have a legally enforceable right to offset recognised amounts, because the right to offset is enforceable only on the occurrence of future events such as default, insolvency or bankruptcy, they are reported on a gross basis.

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

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

Derecognition of financial liabilities

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

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

Reclassification of financial instruments

Subsequent to initial recognition reclassification of financial liabilities is not permitted. Financial assets are required to be reclassified between fair value through net result, fair value through other comprehensive income and amortised cost when and only when Alfred Health's business model for managing its financial assets has changed such that its previous model would no longer apply.

Notes to the financial statements (continued)

Note 7.1 – Financial instruments (continued)

Note 7.1 (b) – Maturity analysis of financial liabilities as at 30 June 2020

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				
2020	**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 at amortised cost								
Payables	5.2	91,125	91,125	87,223	1,627	2,275	-	-
Borrowings	6.1	51,404	51,404	513	1,460	21,898	21,684	5,849
Other financial liabilities		72	72	72	-	-	-	-
Total financial liabilities		**142,601**	**142,601**	**87,808**	**3,087**	**24,173**	**21,684**	**5,849**

				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 at amortised cost								
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		69	69	69	-	-	-	-
Total financial liabilities		**122,005**	**122,005**	**102,299**	**3,539**	**3,649**	**7,785**	**4,733**

Note 7.1 (c) - Contractual receivables at amortised cost

	30-Jun-20	Current	Less than 1 month	1–3 months	3 months –1 year	1-5 years	Total
Expected loss rate		0.9%	7.0%	14.9%	29.9%	32.8%	
Gross carrying amount of contractual receivables	($'000)	31,419	5,139	6,184	6,165	3,756	**52,663**
Loss allowance		**285**	**358**	**923**	**1,845**	**1,230**	**4,641**

	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**

Impairment of financial assets Under AASB 9

Alfred Health records the allowance for expected credit loss for the relevant financial instruments, in accordance with the AASB 9s 'Expected Credit Loss' approach. Subject to AASB 9, impairment assessment includes the 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, any identified impairment loss would be immaterial.

Contractual receivables at amortised cost

Alfred Health applies the AASB 9 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 select 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.

Notes to the financial statements (continued)

Note 7.1 – Financial instruments (continued)

Reconciliation of the movement in the loss allowance for contractual receivables

	Consolidated 2020 $'000	Consolidated 2019 $'000
Balance at beginning of the year	**(4,725)**	**(3,898)**
Opening retained earnings adjustment on adoption of AASB 9	-	(510)
Opening loss allowance	**(4,725)**	**(4,408)**
Modification of contractual cash flows on financial assets	5,934	4,800
Increase in provision recognised in the net result	(5,850)	(5,117)
Balance at end of the year	**(4,641)**	**(4,725)**

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.

Note 7.2 – Contingent assets and contingent liabilities

No contingent assets or liabilities are present for the year ended 30 June 2020 (2019: 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

Notes to the financial statements (continued)

Note 8.1 – Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities

	Consolidated 2020 $'000	Consolidated 2019 $'000
Net result for the year	**(36,880)**	**(45,471)**
Non-cash movements:		
Depreciation	85,976	70,259
Amortisation of intangible assets	10,120	7,455
Provision for doubtful debts	(84)	317
Department of Health and Human Services loan discount	-	37
Non-cash investment income	(2,366)	(3,663)
Assets and inventory received free of charge	(2,883)	-
Movements included in investing and financing activities		
Net loss from disposal of non-financial physical assets	(5)	126
Capital donations received	(500)	(1,500)
Movements in assets & liabilities		
- Increase in employee benefits	23,545	22,185
- Increase/(decrease) in payables	15,943	(1,905)
- Increase/(decrease) in other liabilities	3	(7)
- (Increase)/decrease in receivables	(3,350)	(10,177)
- (Increase) in prepayments	(3,644)	(686)
- (Increase)/decrease in inventories	(2,851)	27
Net cash inflows/(outflows) from operating activities	**83,024**	**36,997**

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 Jenny Mikakos, Minister for Health and Minister for Ambulance Services	01/07/2019 – 30/06/2020
The Honourable Martin Foley, Minister for Mental Health	01/07/2019 – 30/06/2020
The Honourable Luke Donnellan, Minister for Child Protection, Minister for Disability, Ageing and Carers	01/07/2019 – 30/06/2020
Governing Board	
Mr Michael Gorton AM (Chair) BCom LLB	01/07/2019 – 30/06/2020
Ms Kaye McNaught BA (PSYCH, CRIM) LLB (MELB)	01/07/2019 – 30/06/2020
Dr Benjamin Goodfellow FRANZCP MBBS MPM CAPC	01/07/2019 – 30/06/2020
Ms Miriam Suss OAM BA MSW, GAICD	01/07/2019 – 30/06/2020
Ms Melanie Eagle BA BSW LLB, GAICD, GradDip (International Development)	01/07/2019 – 30/06/2020
Dr Victoria Atkinson MBBS, FRACS, AFRACMA, Masters of Health Management	01/07/2019 – 30/06/2020
Ms Sally Campbell LLB/BA, GAICD	01/07/2019 – 30/06/2020
Ms Anne Howells BCom CA, MB (Corporate Governance), GAICD, FGIA	01/07/2019 – 30/06/2020
Mr Lynton Norris FCPA, GAICD, BBus (Acc) BBus (IntTrade)	01/07/2019 – 30/06/2020

	Period
Accountable Officer	
Prof Andrew Way AM (Chief Executive) RN BSc (Hons) MBA FAICD,FACHSM	01/07/2019 – 30/06/2020

Remuneration of responsible persons

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

Income band	Consolidated 2020	Consolidated 2019
$50,000 – $59,999	8	8
$100,000 – $109,999	1	1
$500,000 – $509,999	-	1
$590,000 – $599,000	1	-
Total number	**10**	**10**
Total remuneration received or due and receivable by responsible persons from the reporting entity amounted to:	**$1,170,178**	**$1,045,172**

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.

Notes to the financial statements (continued)

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.

All executives received an annual bonus as per the terms of their individual employment contracts.

Remuneration of executive officers (including key management personnel disclosed in note 8.4)	Consolidated 2020 $	Consolidated 2019 $
Short-term employee benefits	2,308,873	2,244,588
Post-employment benefits	183,248	171,866
Other long-term benefits	136,716	74,802
Total remuneration (i) (ii)	**2,628,837**	**2,491,256**
Total number of executives	**7**	**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 while 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	KMPs	Position title
Alfred Health	Mr Michael Gorton	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	Mr Lynton Norris	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-Phyland	Executive Director, Nursing Services & Chief Nursing Officer
Alfred Health	Mr Paul Butler	Deputy CEO & 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 Amy McKimm	Executive Director, Information Development
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	Ms Jennifer Williams (resigned 1 October 2019)	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
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	Mr Michael Gordon (appointed 4 September 2019)	Trustee
Marriot for HIV LTD as Trustee for John F Marriott Trust	Mr William O'Shea	Director
Marriot for HIV LTD as Trustee for John F Marriott Trust	Prof Jennifer Hoy	Director
Marriot for HIV LTD as Trustee for John F Marriott Trust	Ms Ann Larkins	Director
Marriot for HIV LTD as Trustee for John F Marriott Trust	Ms Natalie McDonald	Director

Notes to the financial statements (continued)

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

Compensation - KMPs	Consolidated 2020 $'000	Consolidated 2019 $'000
Short-term employee benefits	3,384	3,203
Post-employment benefits	258	244
Other long-term benefits	157	90
Total	**3,799**	**3,537**

KMPs are also reported in note 8.2 responsible person's disclosures or note 8.3 executive officers disclosures

Significant transactions with government-related entities

Alfred Health received funding from the Department of Health and Human Services of $1.075b (2019: $928.9m) and indirect contributions of $6.2m (2019: $8.5m).

Alfred Health has an advance to fund working capital requirements from the Department of Health and Human Services at 30 June 2020 of $16m (30 June 2019: nil).

Alfred Health has a receivable to partially fund Long Service Leave obligations with the Department of Health and Human Services at 30 June 2020 of $27.6m (30 June 2019: $23.4m).

Alfred Health also provided services to other government-related entities that were not individually significant totaling $10.1m (2019: $11.8m), and received services that were not individually significant totaling $14.6m (2019: $9.3m).

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 of Victoria 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 scarce resources.

There were no related party transactions with Cabinet Ministers required to be disclosed in 2020 (2019: nil).

There were no related party transactions required to be disclosed for Alfred Health's Board of Directors and executive directors in 2020 except for the following as noted below (2019: nil).

Alfred Health's Board member Michael Gorton is also a Board member of Ambulance Victoria and Chair of Wellways Australia. The transactions between Alfred Health and Ambulance Victoria form part of the services to/from government-related entities disclosed in note 8.4. The transactions between the Alfred Health and Wellways Australia relate to reimbursements made by Alfred Health to Wellways Australia for the provision of goods and services and the transfer of funds by way of distributions made to Alfred Health. All dealings are in the normal course of business and are on normal commercial terms and conditions.

Alfred Health has an agreement to provide management services to WTMS Trust, in 2020 an amount of $0.1m was charged (2019: $0.1m). WTMS provides donation funding for the benefit of Alfred Health and its employees, in 2020 this was $1.1m (2019 $2.2m).

Alfred Health has an agreement to provide management services to John F Marriott Trust which will be effective from 1 July 2020.

Note 8.5 – Remuneration of auditors

	Consolidated 2020 $'000	Consolidated 2019 $'000
Victorian Auditor-General's Office		
Audit of financial statements	260	257
Total remuneration of auditors	**260**	**257**

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 the 30 June 2020 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 2020, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Alfred Health has not and does not intend to adopt these standards early.

Standard/ Interpretation	*Summary*	*Applicable for annual reporting periods beginning on*	*Impact on public sector entity financial statements*
AASB 2018-7 *Amendments to Australian Accounting Standards – Definition of Material*	This Standard principally amends AASB 101 *Presentation of Financial Statements* and AASB 108 *Accounting Policies, Changes in Accounting Estimates and Errors*. The amendments refine and clarify the definition of material in AASB 101 and its application by improving the wording and aligning the definition across AASB Standards and other publications. The amendments also include some supporting requirements in AASB 101 in the definition to give it more prominence and clarify the explanation accompanying the definition of material.	1 January 2020	The standard is not expected to have a significant impact on the public sector.
AASB 2020-1 *Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-Current*	This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. A liability is classified as non-current if an entity has the right at the end of the reporting period to defer settlement of the liability for at least 12 months after the reporting period. The meaning of settlement of a liability is also clarified.	1 January 2022. However, ED 301 has been issued with the intention to defer application to 1 January 2023.	The standard is not expected to have a significant impact on the public sector.

The following accounting pronouncements are also issued but not effective for the 2019-20 reporting period. At this stage, the preliminary assessment suggests they may have insignificant impacts on public sector reporting

- AASB 2018-6 *Amendments to Australian Accounting Standards – Definition of a Business.*
- AASB 2019-1 *Amendments to Australian Accounting Standards – References to the Conceptual Framework*.
- AASB 2019-3 *Amendments to Australian Accounting Standards – Interest Rate Benchmark Reform*.
- AASB 2019-5 *Amendments to Australian Accounting Standards – Disclosure of the Effect of New IFRS Standards Not Yet Issued in Australia*.
- AASB 2019-4 *Amendments to Australian Accounting Standards – Disclosure in Special Purpose Financial Statements of Not-for-Profit Private Sector Entities on Compliance with Recognition and Measurement Requirements*.
- AASB 2020-2 *Amendments to Australian Accounting Standards – Removal of Special Purpose Financial Statements for Certain For-Profit Private Sector Entities*.
- AASB 1060 *General Purpose Financial Statements – Simplified Disclosures for For-Profit and Not-for-Profit Tier 2 Entities (Appendix C)*.
- *Conceptual Framework for Financial Reporting* (to be applied by For-Profit private sector entities. Application by other For-Profit entities is optional).

Notes to the financial statements (continued)

Note 8.7 – Events occurring after the balance sheet date

The COVID-19 pandemic has created unprecedented economic uncertainty. Actual economic events and conditions in the future may be materially different from those estimated by Alfred Health at the reporting date. As responses by government continue to evolve, management recognises that it is difficult to reliably estimate with any degree of certainty the potential impact of the pandemic after the reporting date on Alfred Health's operations, its future results and financial position. The state of emergency in Victoria was extended on 16 August 2020 until 11 October 2020 and the state of disaster is still in place.

No other matters or circumstances have arisen since the end of the financial year which significantly affected or may affect the operations of Alfred Health, the results of the operations or the state of affairs of Alfred Health in the future financial years.

Note 8.8 – Economic dependency

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 the 2020/2021 financial year. 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 (2020: 0.33 and 2019: 0.26) while cash generated from operations has increased from a $39.4m surplus in 2019 to a $77.8m surplus in 2020, and cash has moved from $15.5m in 2019 to $52.1m in 2020 (based on the parent entity results). A letter confirming adequate cash flow was also provided in the previous financial year.

Note 8.9 – Controlled entities

Name of entity	Country of residence	Ownership Interest %
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	Australia	100%
John F Marriott for HIV Trust	Australia	100%
Marriot for HIV Ltd	Australia	100%

Controlled entities contribution to the consolidated results	2020 $'000	2019 $'000
Net result for the year		
Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	(2,190)	(1,139)
John F Marriott for HIV Trust	6,383	-
Marriot for HIV Ltd	(3)	-

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.

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

The John F Marriott for HIV Trust is a charitable trust set up principally for the benefit of Alfred Health. Marriott for HIV Ltd is the corporate trustee of the Trust and Alfred Health has the powers noted above due to its ability to appoint and remove the majority of the directors of the trustee company.

Control was deemed to have occurred on 29 May 2020, when Alfred Health appointed the trustees. At that time, the Trust had net assets of $6.4m

Marriott for HIV Ltd a wholly owned entity was established on 29 May 2020 to act as the Trustee of John F Marriott for HIV Trust.

Note 8.10 - Changes in accounting policy

Leases

This note explains the impact of the adoption of AASB 16 *Leases* on Alfred Health's financial statements.

Alfred Health has applied AASB 16 with a date of initial application of 1 July 2019. Alfred Health has elected to apply AASB 16 using the modified retrospective approach, as per the transitional provisions of AASB 16 for all leases for which it is a lessee. The cumulative effect of initial application is recognised in retained earnings as at 1 July 2019. Accordingly, the comparative information presented is not restated and is reported under AASB 117 and related interpretations.

Previously, Alfred Health determined at contract inception whether an arrangement is or contains a lease under AASB 117 and Interpretation 4 – '*Determining whether an arrangement contains a Lease*'. Under AASB 16, Alfred Health assesses whether a contract is or contains a lease based on the definition of a lease as explained in note 6.1.

On transition to AASB 16, Alfred Health has elected to apply the practical expedient to grandfather the assessment of transactions which are leases. It applied AASB 16 only to contracts that were previously identified as leases. Contracts that were not identified as leases under AASB 117 and Interpretation 4 were not reassessed for whether there is a lease. Therefore, the definition of a lease under AASB 16 was applied to contracts entered into or changed on or after 1 July 2019.

Leases classified as operating leases under AASB 117

As a lessee, Alfred Health previously classified leases as operating or finance leases based on its assessment of whether the lease transferred significantly all of the risks and rewards incidental to ownership of the underlying asset to Alfred Health. Under AASB 16, Alfred Health recognises right-of-use assets and lease liabilities for all leases except where an exemption is available in respect of short-term and low value leases.

On adoption of AASB 16, Alfred Health recognised lease liabilities in relation to leases which had previously been classified as operating leases under the principles of AASB 117 *Leases*. These liabilities were measured at the present value of the remaining lease payments, discounted using Alfred Health's incremental borrowing rate as of 1 July 2019. On transition, right-of-use assets were measured at the amount equal to the lease liability, adjusted by the amount of any prepaid or accrued lease payments relating to that lease recognised in the balance sheet as at 30 June 2019.

Alfred Health has elected to apply the following practical expedients when applying AASB 16 to leases previously classified as operating leases under AASB 117:

- Applied a single discount rate to a portfolio of leases with similar characteristics;
- Adjusted the right-of-use assets by the amount of AASB 137 onerous contracts provision immediately before the date of initial application, as an alternative to an impairment review;
- Applied the exemption not to recognise right-of-use assets and liabilities for leases with less than 12 months of lease term;
- Excluded initial direct costs from measuring the right-of-use asset at the date of initial application; and
- Used hindsight when determining the lease term if the contract contains options to extend or terminate the lease.

For leases that were classified as finance leases under AASB 117, the carrying amount of the right-of-use asset and lease liability at 1 July 2019 are determined as the carrying amount of the lease asset and lease liability under AASB 117 immediately before that date.

Leases as a Lessor

Alfred Health is not required to make any adjustments on transition to AASB 16 for leases in which it acts as a lessor. Alfred Health accounted for its leases in accordance with AASB 16 from the date of initial application.

Notes to the financial statements (continued)

Note 8.10 - Changes in accounting policy (continued)

Impacts on financial statements

On transition to AASB 16, Alfred Health recognised $27,911,375 of right-of-use assets and $27,911,375 of lease liabilities.

When measuring lease liabilities, Alfred Health discounted lease payments using its incremental borrowing rate at 1 July 2019. The weighted average rate applied is 5.5%.

	1 July 2019 $'000
Total Operating lease commitments disclosed at 30 June 2019	30,225
GST	(2,748)
Total operating lease commitments excluding GST	**27,477**
Discounted using the incremental borrowing rate at 1 July 2019 (excluding outgoings)	**19,570**
Recognition exemption for:	
Add: Adjustments as a result of a different treatment of extension and termination options	7,607
Add: Contracts reassessed as lease contracts	1,227
Less: Residual value guarantees	(413)
Less: Short-term leases	(80)
Lease liabilities recognised at 1 July 2019	**27,911**

In addition Alfred Health also reclassified parcel of land under peppercorn lease arrangement from land to right-of-use land amounting to $24,312,000 as at 1 July 2019.

Revenue from contracts with customers and Leases

In accordance with FRD 121 requirements, Alfred Health has applied the transitional provision of AASB 15, under the modified retrospective method with the cumulative effect of initially applying this standard against the opening retained earnings at 1 July 2019. Under this transition method, Alfred Health applied this standard retrospectively only to the contracts that were not 'completed contracts' at the date of initial application. Alfred Health has not applied the fair value measurement requirements for the right-of-use assets arising from leases with significantly below market terms and conditions principally to enable the entity to further its objectives as allowed under temporary option under AASB 16 and as mandated by FRD 122.

Comparative information has not been restated.

Note 2.1 includes details about the transitional application of AASB 15 and how the standard has been applied to revenue transactions.

Income of not-for-profit entities

In accordance with FRD 122 requirements, Alfred Health has applied the transitional provision of AASB 1058, under the modified retrospective method with the cumulative effect of initially applying this standard against the opening retained earnings at 1 July 2019. Under this transition method, Alfred Health applied this standard retrospectively only to the contracts and transactions that were not completed contracts at the date of initial application.

Comparative information has not been restated.

Note 2.1 includes details about the transitional application of AASB 1058 and how the standard has been applied to revenue transactions.

The adoption of AASB 1058 did not have an impact on other comprehensive income and the cash flow statement for the financial year.

Transition impact on financial statements.

This note explains the impact of the adoption of the following new accounting standards for the first time, from 1 July 2019:

- AASB 15 *Revenue from Contracts with Customers*;
- AASB 1058 *Income of Not-for-Profit Entities*; and
- AASB 16 *Leases*.

Impact on the balance sheet due to the adoption of AASB 15, AASB 1058 and AASB 16 is illustrated with the following reconciliation between the restated carrying amounts at 30 June 2019 and the balances reported under the new accounting standards (AASB 15 and AASB 16) at 1 July 2019:

	Note	Before new accounting standards- opening 1 July 2019 $'000	Impact of new accounting standards- AASB 16, 15 & 1058 $'000	After new accounting standards- opening 1 July 2019 $'000
Property, plant and equipment	4.2b	1,279,018	27,911	1,306,929
Total other assets		182,045	-	182,045
Total assets		**1,461,063**	**27,911**	**1,488,974**
Payables and contract liabilities	5.2	106,717	18,546	125,263
Borrowings	6.1	15,219	27,911	43,130
Provisions and other liabilities		234,220	-	234,220
Total liabilities		**356,156**	**46,457**	**402,613**
Net assets		**1,104,907**	**(18,546)**	**1,086,361**
Accumulated surplus/(deficit)		(296,954)	(18,546)	(315,500)
Physical revaluation surplus		949,526	-	949,526
Other items in equity		452,335	-	452,335
Total equity		**1,104,907**	**(18,546)**	**1,086,361**

Notes to the financial statements (continued)

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 no economic benefits of equal value are receivable or payable in return.

Depreciation

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

Effective interest method

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

Employee benefits expenses

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

Financial asset

A financial asset is any asset that is:

(a) cash;

(b) an equity instrument of another entity;

(c) a contractual or statutory right:

- to receive cash or another financial asset from another entity; or
- to exchange financial assets or financial liabilities with another entity under conditions that are potentially favourable to the entity; or

(d) a contract that will or may be settled in the entity's own equity instruments and is:

- a non-derivative for which the entity is or may be obliged to receive a variable number of the entity's own equity instruments; or
- a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments.

Financial instrument

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

Financial liability

A financial liability is any liability that is:

(a) A contractual obligation:

- to deliver cash or another financial asset to another entity; or
- 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:

- 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
- 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.

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.

Notes to the financial statements (continued)

Note 8.11 – Glossary of terms and style conventions (continued)

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 start-up 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.

Supplies and services 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 the inventories are distributed.

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.

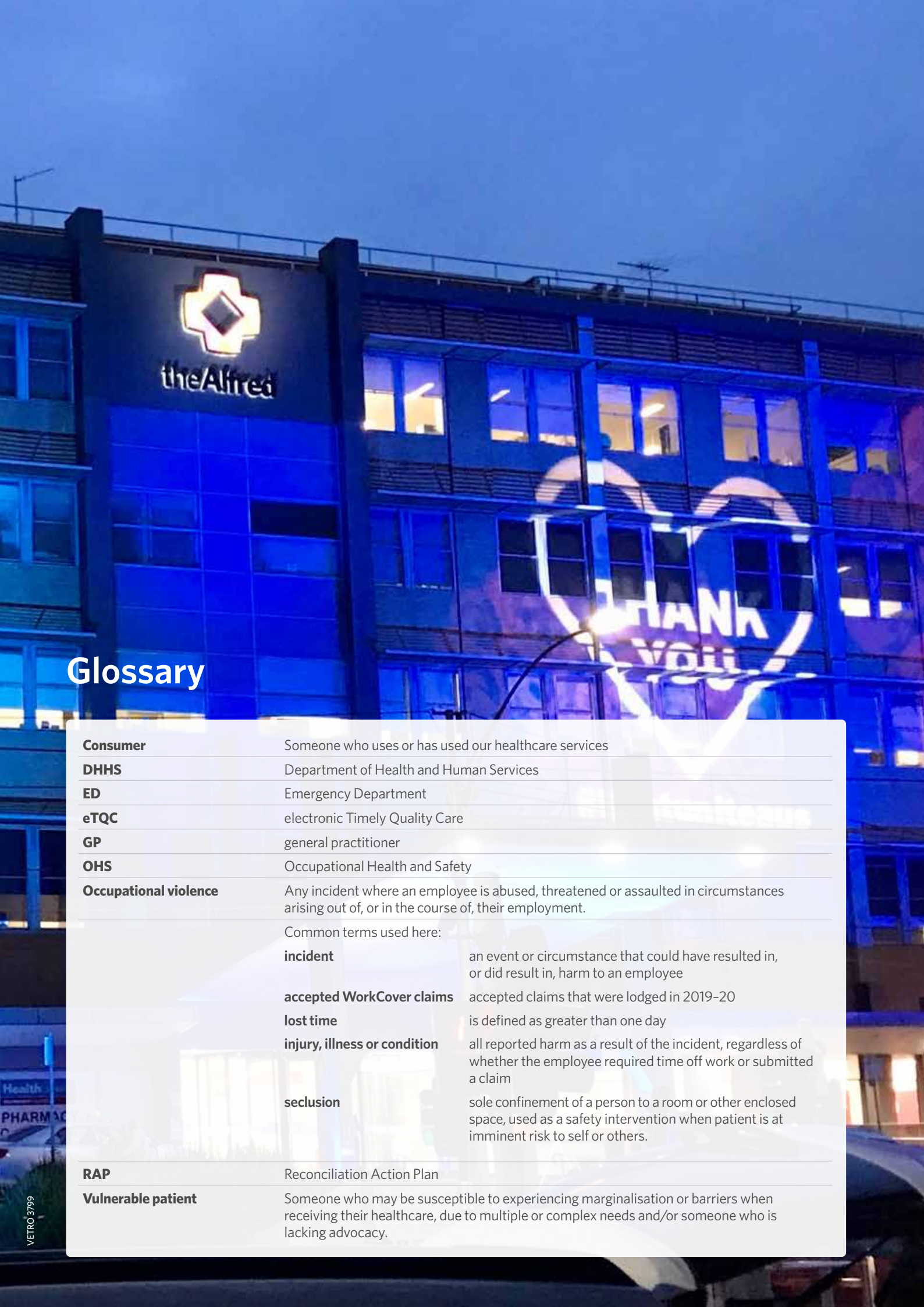
The notation used in the tables is as follows:

zero, or rounded to zero

(000) negative numbers

2020 current year period

2019 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 2019–20
	lost time — is defined as greater than one day
	injury, illness or condition — all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim
	seclusion — sole confinement of a person to a room or other enclosed space, used as a safety intervention when patient is at imminent risk to self or others.
RAP	Reconciliation Action Plan
Vulnerable patient	Someone who may be susceptible to experiencing marginalisation or barriers when receiving their healthcare, due to multiple or complex needs and/or someone who is lacking advocacy.

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