wdhs
Western District
Health Service

2012
Annual Report

CLOSING THE GAP WITH CONSUMERS THROUGH PERSON CENTERED CARE

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Health Service

New logo symbolism

The new logo as above was developed to represent the mission, vision and values of Western District Health Service with our ultimate goal to create a more integrated and responsive service system based upon a person centred care model in accord with our adopted 5 to 10 year Service Plan and model of care.

The six outer individual circular links of our logo represent the six potential service components of person centred care (acute, sub acute, mental health, wellness and promotion, aged care and primary care. The small inner circle represents our community members /clients / consumers. This inner circle is located near the wellness and promotion circular link to symbolise the ultimate aim of wellness / good health.

Our Mission

To meet the health and wellbeing needs of our community by delivering a comprehensive range of high quality, innovative and valued, health services.

Vision

Excellence in health care, putting people first

Values

Our community
We recognise their rights, encourage their participation and are committed to their health and wellbeing.

Improving performance
We are committed to a culture of continuous quality improvement and innovation.

Our staff
We are committed to their wellbeing and ongoing education, growth and development.

Strong leadership
We are committed to governance and management that sets sound directions promoting innovation and research.

Safe practice
We are committed to a safe and healthy environment.

→ Front Cover: L-R Allied Health Assistant, Sue Coe, Occupational Therapist, Brianna Deutscher, Dr Geoff Coggins and Clinical Support Nurse, Natalie Jervies tending to the needs of patient Lillian Crotty under the Person Centred Care model of service delivery

→ Back Cover: Person Centred Care is at the core of service delivery at WDHS and provides clients like Mr Charles Wilson with the best possible care at Hamilton Base Hospital. He is attended by Registered Nurse, Deepa Nair and Practice Development Nurse, Tania Stubbs in the ICU

→ Right: Midwife Jenny Sutherland with new mum Amanda Little and baby Aida, and midwife Sonia Shaw (and back) student midwives Jade Roberts and Caroline Russell

Western District Health Service

Annual Report 2012

The Theme of this year's report is ''Closing the Gap with Consumers through Person Centred Care'', which reflects the adopted model of care outlined in the 5 to 10 year Strategic Plan and Model of Care completed in July 2011. The Person Centred Care model focuses on improving the consumer experience by increasing the involvement of consumers in the delivery of their care.

» Victorian Premier's Primary Health Service Finalist 2011

» Victorian Premier's Regional Health Service Finalist 2010

» Victorian Premier's Regional Health Service Finalist 2009

» Victorian Premier's Primary Health Service 2008

» Victorian Premier's Regional Health Service 2007

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

Alternative Format
This Annual Report is also available on the Western District Health Service website at www.wdhs.net

This report

» covers the period 1 July 2011 to 30 June 2012

» is the fourteenth annual report for Western District Health Service (WDHS)

» is prepared for the Minister for Health, the Parliament of Victoria and the community

» is a public document freely available on our website and from WDHS on request

» is prepared in accordance with government and legislative requirements and FRD 30 guidelines

» provides an accurate record of our activities and achievements against key performance measures

» acknowledges the support of our community

» is printed on Evolve Laser - 100% Recycled (TCF)

→ Opposite: Grange Residential Care Volunteer, Gail Darling has enjoyed providing personal care and support to resident, Ruth Warburton and others throughout her many years of association with the health service

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→ Hamilton Base Hospital patient, David McClure with WDHS ICU Registered Nurse Tania Stubbs and Unit Manager Medical Unit, Lisa Livingston

→ WDHS Community Liaison Officer, Leonie Sharrock accepted the Australasian Reporting Awards (ARA) 2012 Gold Award for the Health Service' Annual Report at the June presentation evening in Sydney

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150th Anniversary – ''The Beginning''

In the 1850's the population of Hamilton and District was expanding rapidly and the local citizens had begun agitating for a hospital to treat the increasing number of accidents and illnesses, and supply accommodation for the needy, often for those coming from the goldfields. The first police magistrate, Mr Acheson Ffrench reported in a letter to Governor La Trobe, his attendance at a public meeting held on 11th. August 1853.

His Excellency, Mr La Trobe,

'I do myself the honour as Chairman of a public meeting held at the Grange on 11th. August 1853, for the purpose of forming a Benevolent Society for the district, to request in accordance with one of the resolutions, that your Excellency will be pleased to take into favourable consideration the expedience of allotting a portion of land in the township of Hamilton wheron to erect a Benevolent Asylum.'

This request sadly fell upon deaf ears, as La Trobe had earlier asked Governor Gipps of New South Wales to provide a hospital for Port Phillip. Gipps's reply demonstrated an attitude that prevailed well into the 20th century.

'I cannot consider it the business of the Government to provide a general hospital for the district of Port Phillip or even the town of Melbourne. Such institutions are properly the object of private charity.'

Governments expected citizens to first help themselves! Thus it was clear that Hamilton would not receive assistance from La Trobe at that stage. Rumblings and dissatisfaction within the populous continued throughout the 1850's with articles appearing in the Hamilton Courier from its inception in 1859, (becoming the Hamilton Spectator in 1860) urging some activity, until an anonymous and passionate plea headed 'A Great Want' appeared in the June 19th 1861 issue of the Spectator. This finally stirred a group of locals into immediate action.

'Bushmen frequently remark '' We really wonder that in an extensive populous and flourishing district like the Grange, there is not one hospital or Benevolent Asylum for the relief of sickness and destitution. If we are sick or poor, continue they, we must either go to Portland (hospital opened 1856) or perish!!...Let us urge upon the attention of every sensible man and woman in the district the necessity of immediately putting their shoulders to the wheel and doing their utmost to found and contribute towards the support of a hospital in Hamilton. The building itself might even be made an improvement to the place!'

A meeting was convened for Friday July 5th 1861 in the Concert Room of the Victoria Hotel and reported in the Hamilton Spectator July 6th 1861. Disappointingly, the initial enthusiasm was somewhat lacking but the aim was achieved.

'At the thinly attended meeting, the inclemency of the weather probably being the cause, it was moved to form the Hamilton Hospital and Benevolent Society for the purpose of affording relief to the suffering from destitution and disease.'

A committee was formed, public subscriptions it was decided, would fund the hospital and a Collector, issued with a horse, would regularly travel throughout the district collecting from the subscribers. Much turmoil and endless difficulties ensued but one year later, the Government had finally granted a block of land and the courageous committee had appointed architects to draw up plans for the Hospital and Benevolent Asylum.

On Wednesday 19th November 1862, following a procession from the Council Chambers, the foundation stone was finally laid by Pres. Thomas McKellar. A celebratory public dinner was held that evening at the Victoria Hotel, tickets 7/6d. This was a momentous accomplishment by a group of dedicated citizens who never wavered in the face of enormous setbacks. From their initial achievement 150 years ago, our fine hospital has evolved into the esteemed institution of today and this we shall proudly celebrate in November 2012.

Elizabeth Arthur,
Medical Historian/Curator

Year in Brief

→ **Western District Health Service was announced runner up for the Primary Healthcare Service of the Year Award in the 2011 Public Healthcare Awards. Standing with the awards are WDHS board member, Mark Stratmann; Deakin University's Brendan Crotty; Sustainable Farm Families program manager, Cate Mercer-Grant; WDHS Chief Executive Officer, Jim Fletcher; Primary and Preventative Health director, Rosie Rowe; NCFH lecturer, Scott McCoombe; Primary Care Service manager, Fran Patterson and acting Diabetes educator, Megan McLeish**

Highlights

- Premier's Primary Care Service of the Year runner up
- Top of the Town Charity Ball awarded Hall of Fame status by Shire of Southern Grampians Business Awards
- Achieved all Accreditation requirements through ACHS, Aged Care Accreditation Standards Agency and teaching and training posts
- Excellent results for cleaning, patient satisfaction surveys (VPSM, Palliative Care, Press Ganey for Aged Care)
- Completion of Grange capital redevelopment and associated fundraising campaign
- Stage 1 of $26.5m new health precinct for Coleraine progressing ahead of schedule including commissioning of the Thomas Hodgetts Primary Care Centre
- Construction commenced on upgrade of Hamilton Base Hospital GEM/Rehab service
- Stage 1 of Hamilton Medical Group redevelopment completed
- New Consulting Suites for Cancer Services and Education completed
- Replacement of Hamilton Base Hospital emergency generator, main switchboard and sub mains completed and commissioned
- Opening of new Community Health Centre for Merino
- National Centre for Farmer Health contracted by Queensland Rural Medical Education to deliver Agricultural Health and Medicine Unit. 18 students from four States complete the program in Hamilton
- National Health and Medical Research Council approved $576,727 research grant over three years to National Centre for Farmer Health for farmer hearing loss
- Cancer Services enhanced with allocation of funds for a Cancer Survivorship pilot program, Multidisciplinary Coordinator and commencement of monthly Medical Oncologist service
- Western District Health Service, South West Healthcare and Portland District Health consortium secure a $144,000 p.a. grant to enhance Emergency Medicine services
- Specialist training funding received from the Commonwealth for a Public Health Physician for the National Centre for Farmer Health
- World leader in Genetic diseases Professor Richard Cotton delivers 13th Handbury Lecture
- Outstanding fundraising result of $1.314m
- Operating surplus $303k and entity budget surplus of $11.556m

→ WDHS Volunteers Sharon McLean (left), Gail Darling, Joan Lewis, and Ian McLean, Volunteer Coordinator, Jeanette Ryan, and Leisure & Activities Co-ordinator, Carol Holmes with their 2012 Minister for Health Awards

PERFORMANCE AT A GLANCE	2012	2011	2010	2009	2008
FINANCIAL ($000'S)					
Total revenue	63,318	61,503	55,429	54,565	50,950
Total expenditure	63,015	61,228	55,317	53,948	50,731
Surplus (before capital and specific items)	303	275	112	617	219
Total assets	91,107	77,356	72,663	71,534	70,525
Total liabilities	20,410	18,137	18,577	18,029	16,214
Equity	70,697	59,219	54,086	53,505	54,311
FUNDRAISING ($000'S)					
Income	1,314	1,528	1,162	612	767
Expenditure	19	45	12	13	17
Surplus	1,295	1,483	1,150	599	750
STAFF					
Number of staff employed	777	760	736	708	676
Equivalent full time	555.80	553.12	549.47	541.37	532.99
PERFORMANCE INDICATORS (ACUTE)					
Inpatients treated (separations)	7,562	7,695	6,829	7,415	7,181
Complexity adjusted inpatients (WIES18)*	4,959	5,049	4,976	5,267	5,195
Average stay (days)	2.88	3.10	3.20	3.23	3.37
Inpatient bed days	21,799	24,172	21,861	23,967	24,417
Total occassions of non-admitted patient service	54,951	54,822	60,025	60,342	58,254

* WIES - Weighted Inlier Equivalent Separations

Overview

Reporting against our Strategic Plan

Each year Western District Health Service reports on its major outcomes and proposed future directions against the seven key strategic areas of the 2011-2016 five year strategic plan. A summary of our achievements for 2011/12 together with proposed future directions are outlined below.

Further details can be found throughout this report.

Please refer to the glossary on the inside back cover for abbreviations.

	OBJECTIVE	STRATEGIES	OUTCOMES	FUTURE
LEADERSHIP AND INNOVATION	To be a leader in the provision of Rural Health Services developing innovative service models to meet the population health needs of our community	Lead the planning, development and delivery of innovative health care and support systems in partnership with other service providers	• 2011 Premier's Regional Health Service of the Year Award runner's up (p.3,6,11,25)	
			• Agriculture Health and Medicine Unit delivered under Contract to Queensland Medical Education (p. 6,11,28,55) • 3rd Agriculture Health and Medicine Unit completed in Hamilton by students from four States (p. 6,11,28,55) • Accreditation of National Centre for Farmer Health Graduate Certificate of Agriculture Health and Medicine (p. 9,28) • Registration of Agri-Safe trademark (p. 11,28) • National Centre for Farmer Health presentations at International Conferences in Mexico, Canada and New Zealand (p. 13,28)	• Continue development of National Centre for Farmer Health (NCFH) as a Centre for Excellence
			• Staff presentations at National , State and local forums on innovative models of care (p. 12,13,26) • Care Coordination Model recognised in Victorian Rural and Regional Health Plan (p. 12,25,26)	• Continued development of innovative models of care
			• Director of Primary & Preventative Health completed Statewide Executive Leadership Program (p. 35) • Lead Agency for the development of a Statewide Supply and procurement system (p. 43,45)	• Further development of Sub Regional and Statewide projects
			• Implementation of 5 year strategic and service plans (p. 3,11,37,43,44)	• Continued implementation of 5 year plans
QUALITY IMPROVEMENT AND RISK MANAGEMENT	To improve performance through a culture of continuous quality improvement and innovation	Achieve all accreditation requirements through ACHS, Aged Care Accreditation Standards, Baby Friendly, teaching and training posts	• ACHS self assessment completed (p. 6,21) • Re-accreditation of Coleraine campus Aged Care (p. 6,11,21) • Successful accreditation support visits for all Aged Care facilities (p. 6,21)	• Introduction of new National Standards and ACHS Accreditation • Re-accreditation of Aged Care facilities • Re-accreditation of teaching and training posts
		Increase participation and leadership in research and best practice	• Completion of Indigie Grin Research project (p. 12,22,26) • $576.7k research grant over three years for National Centre for Farmer Health for Farmer Hearing Loss (p. 6,11,12,22,29,55) • National Centre for Farmer Health arthritis research project commenced (p. 12,29,55)	• Continued participation and leadership in research and best practice
		Participate in Statewide and National Consumer Satisfaction Surveys	• High peer group ranking for Victorian Patient Satisfaction Monitor and Palliative Care. (p. 6,11,21,22,56) • High rating for Press Ganey survey of Aged Care (p. 6,11)	• Ongoing participation in patient, resident and client surveys
	To effectively manage risk and provide a safe environment for the wellbeing and protection of consumers, staff and Health Service assets	Implement safe practice and risk management programs to ensure the wellbeing and safety of consumers, staff and assets	• Excellent results for cleaning and food safety audits (p. 22,44,47) • VMIA Risk Management Framework survey completed (p. 21,33,34,47)	• Ongoing implementation of safe environment and risk management strategies

	OBJECTIVE	STRATEGIES	OUTCOMES	FUTURE
SERVICE PLANNING AND DEVELOPMENT	Continue to develop a contemporary health care system which focuses on person centred care and improves the health and wellbeing of our community	To enhance our role as a Sub Regional Referral Centre and provide an integrated range of Specialist services to our community	‣ Cancer services enhanced with establishment of Cancer Survivorship Pilot Program, Multidisciplinary Coordinator and monthly Medical Oncology service (p. 6,23,24,26,55) ‣ Emergency medicine service enhanced through education and support by an Emergency Physician (p. 6,11,23,24) ‣ Two additional Community Transition Care places established (p. 23,24,25) ‣ Telehealth Pain Clinic established with Royal Melbourne (p. 25,26)	‣ Continue to enhance community access to specialist services
		Provide programs supporting healthy ageing and extend the capacity of services for our ageing population	‣ Commissioning of 5 additional beds at the Grange (p. 23,24,48,55) ‣ Implementation of the Birches Dementia Friendly project (p. 24) ‣ Implementation of IC4OP Program (p. 23,24) ‣ Implementation Active Service Model (p. 25)	‣ Continued implementation of IC4OP program ‣ Enhancement of leisure and lifestyle activities for people in residential care
		Provide leadership for the implementation of health, wellbeing and safety programs through National Centre for Farmer Health	‣ Roll out of Sustainable Farm Families and Agri-Safe programs (p. 11,28,55)	‣ Secure recurrent funding for National Centre for Farmer Health and Sustainable Farm Families for research and development of farmer health, wellbeing and safety
		Develop innovative service models to improve person centred care and prevention and management of chronic disease	‣ Improve linkages with WindaMara through delivery of outreach programs and completion of cultural training (p. 11,26,55) ‣ Hamilton Midwifery Model enhanced with additional Allied Health support programs (p. 24) ‣ State Government grant of $120,000 to engage Youth through youth4youth program (p. 27) ‣ Improved Dental Health waiting time (p. 25,26)	‣ Continued development of virtual super clinic model with Hamilton Medical Group ‣ Continued implementation of innovative person centred care models for health and wellbeing
HUMAN RESOURCES	Attract and retain high performing staff committed to the Vision, Mission and Values of the Health Service	Develop and implement workforce plans and recruitment strategies to support our service plan	‣ Recruitment of Physician and G.P. Obstetrician Proceduralist (p. 23,37) ‣ Koorie Allied Health Traineeship (p. 26,55) ‣ Extension of Allied Health Assistant roles into additional disciplines (p. 26) ‣ Establishment of Public Health Registrar for the National Centre for Farmer Health (p. 6,11,28) ‣ Participate in Aged Community Care Victoria Monash University Nurse Graduate program (p. 37,40) ‣ Collaborative Graduate Nurse program established with Portland and Moyne Health Service (p. 40) ‣ Enhancement of Allied Health student placements through video conferencing and resource materials (p. 41) ‣ Undergraduate clinical placements for Nursing, Medical and Allied Health (p. 39,40)	‣ Ongoing development and implementation of workforce plans and strategies
	Provide an environment for motivating and encouraging staff to develop and use their skills to enhance the health, well being and safety of our community	Promote Employer of Choice through work environment, values and culture	‣ Organisational and staff awards including Employee of the Month (p. 4,6,7,11,12,25,37,39,50) ‣ Mentoring program (p. 26,50) ‣ Implementation of O H & S programs (p. 41,44) ‣ Staff WorkHealth and vaccination programs (p.38)	‣ Continued implementation of recognition and healthy workforce initiatives
		Support and encourage education and training of staff directed at optimising skills and enhancing quality of care	‣ Support enrolment and completion of management development courses (p.38,39) ‣ $75.6k workforce grant received for simulated learning (p.40) ‣ Commencement of Graduate Certificate of Agriculture Health and Medicine (p.28,55) ‣ Development of implementation of e-learning strategy (p.39,46)	‣ Ongoing implementation of education and training plans
		Implementation of the 5 year 2012-2017 Human Resource Strategic Plan cycle	‣ Development and implementation of year 1 action plan (p.37)	‣ Continue evaluation and implementation of five year Human Resources strategic plan

	OBJECTIVE	STRATEGIES	OUTCOMES	FUTURE
FACILITIES AND EQUIPMENT	To modernise and maintain facilities, equipment and infrastructure to improve the health and wellbeing of our community	Implement capital master plans to complete the modernisation of facilities across Western District Health Service	‣ Opening of new Community Health Centre for Merino (p.6,11) ‣ Completion of Grange redevelopment (p.6,11,12,14,44,46,48) ‣ Stage 1 of new health precinct for Coleraine ahead of schedule (p.6,11,12,14,44,46) ‣ Stage 1 redevelopment of Hamilton Medical Group (HMG) building completed (p.6,11,12,14,44,46) ‣ New consulting suites for Cancer Services completed (p.6,11,12,23,24,44,46) ‣ Construction commenced on upgrade of GEM/ Rehabilitation service at HBH (p.6,11,12,24,44,46) ‣ Master Plan completed for Hamilton and Penshurst campuses (p.12,46)	‣ Completion of stage 1 of the new Coleraine Health precinct and commencement of stage 2 ‣ Completion of stage 2 redevelopment of HMG ‣ Completion of HBH GEM/rehabilitation upgrade ‣ Submission of Hamilton and Penshurst campuses master plan to Department of Health
		Continue to modernise and upgrade infrastructure	‣ Replacement of HBH emergency generator, main switchboard and sub mains (p.6,14,46,47,57) ‣ Replacement of HBH Theatre flooring (p.14) ‣ Replacement of laundry equipment to establish HBH as a Sub Regional distribution centre (p.44,45,47,55) ‣ Replacement of catering equipment (p.14)	‣ Replacement of fire ring main, steam/ heating and catering equipment
		Modernisation of major clinical equipment	‣ Replacement of Steris Sterilizers (p.14) ‣ Replacement of medical and theatre equipment (p.12,14,23,41,48)	‣ Continue modernisation of major clinical equipment
COMMUNITY ENGAGEMENT	To enhance community participation and involvement in the development and growth of our Health Service	Foster and encourage consumer participation	‣ Support Community Advisory Committee participation in National and State presentations (p.22,25) ‣ Awards to Volunteer programs (p.11,12,50) ‣ Consumer participation in development of service models and systems (p.21,22,25,56) ‣ Implementation of Diversity Culture Plan (p.22) ‣ Acute to Community consumer pathway projects commenced (p.25)	‣ Foster and encourage participation of consumers and volunteers
		Continue fundraising and donor initiatives and ensure recognition of community support	‣ Outstanding fundraising result with $1.314m raised (p.6,12,14,48) ‣ Top of the Town Charity Ball awarded Hall of Fame status (p.6,11) ‣ Grange fundraising appeal target of $2.2m achieved (p.6,11,12,14,44,48,55) ‣ Coleraine Health Service redevelopment appeal reaches $158k (p.12) ‣ Hospital Doorknock and Christmas appeals raise $52.5k and $25k respectively (p.12,48)	Ongoing implementation of major fundraising and donor initiatives
		Provide regional forums for the community, focusing on education, health and wellbeing	‣ 13th Handbury Lecture (p.6,11) ‣ Carers Forum (p.25)	‣ Provision of regional and educational forums
		Communicate and engage with our community via media, internet, newsletters, brochures and annual reports	‣ Gold Award for Annual Report (p.4,11) ‣ Annual and Quality Care Reports, publications, newsletters, National and State presentations (p.44,48)	Inform and involve the community via media, internet, newsletters and publications
BUSINESS SUSTAINABILITY AND INNOVATION	To develop and implement innovative practices to strengthen our governance, business and financial capacity to deliver efficient and effective high quality healthcare to our community	Support innovation to improve quality and efficiency of clinical, ICT, work practices and business systems	‣ Progress the implementation of new Patient Management Systems (p.44,45) ‣ Development and implementation of redesign of clinical and business systems (p.43,44,45,46,47)	‣ Continued development of innovative practices and systems
		Continue to maintain financial and Health Service viability and accountability	‣ Operating and entity budget surplus achieved (p.6,7,13,14,15) ‣ Development and implementation of a Sub Regional Linen Service (p.43,45,47,55)	‣ Update three year budget strategy and implement efficiencies

President and CEO's Report

→ WDHS Board President, Mary Ann Brown and Chief Executive Officer, Jim Fletcher, committed to "Person Centred Care"

On behalf of the Board of Directors, Management, staff and our community, we are pleased to present the 14th Annual Report for Western District Health Service (WDHS)

WDHS is striving to fulfil its mission and vision for its community through the adoption of a Person Centred Care Service Model, which is embedded into our Strategic and Service Plans.

By taking a leadership and innovative approach to the coordination and integration of care in partnership with consumers, WDHS is aiming to enhance the health care journey of patients, residents, clients and carers.

The achievements and progress to date with respect to improving the coordination and integration of care were recognised with finalist status for the 2011 Primary Health Service of the Year and VHA Population Health Awards.

"Closing the Gap with Consumers through Person Centred Care"

Other Major Highlights for the Year Include:

- Top of the Town Charity Ball awarded Hall of Fame status by the Shire of Southern Grampians as an outstanding fundraising and tourism event for the three charity balls held to date
- Opening of a new Community Health Centre for Merino
- Stage 1 of $26.5m new health precinct for Coleraine progressing ahead of schedule with completion due at the end of 2012
- Completion of the $2.85m Grange redevelopment and $2.2m fundraising target achieved
- Construction commenced on the $4.1m upgrade of Hamilton Base Hospital inpatient GEM/Rehabilitation service
- Implementation of an integrated Cancer Service Model with expanded service and new consulting suite
- National Centre for Farmer Health continues to grow as a centre for excellence for farmer health, wellbeing and safety through attraction of research grants, delivery of Agriculture Medicine Unit, registration of Agrisafe Clinic trademark and rollout of Sustainable Farm Families Flood recovery program
- Completion of stage 1 upgrade of Hamilton Medical Group building
- Enhancement of Emergency Medicine through a Sub Regional consortium
- National, State and local awards including Minister for Health individual and team achievement Volunteer awards
- Public Health Physician trainee position established at National Centre for Farmer Health
- World leader in Genetic Disease, Professor Richard Cotton delivers the 13th Handbury Lecture

Quality Performance, Innovation and Research

The highlights of our quest for continuous improvement and best practice included the:

- Re-accreditation of Aged Care services at Coleraine
- High ratings for the Victorian Patient Satisfaction, Press Ganey Aged Care Residential and Statewide Palliative Care Surveys
- Improved linkages with Windamarra through outreach programs and cultural training
- Increased participation of consumers in the development of service models and systems to assist with closing the gap in service delivery for patients, residents, clients and carers

→ **Murray to Moyne riders, Peter Smith, Dion Rhook and Hilary King working hard raising funds at the annual Rideathon for WDHS**

To further enhance our learning and development as an organisation, we have completed the Indigie Grin research project focusing on the oral health care of indigenous children aged five to 12 years.

In addition, three new research projects have commenced through the National Centre for Farmer Health relating to arthritis in partnership with Arthritis Victoria, hearing loss in farmers through a National Health and Medical Research Council grant and the level of farmers' exposure to hazards in partnership with Massey University New Zealand.

A feather in the cap for the National Centre for Farmer Health and Sustainable Farm Families program was the outcome of the Rural Industries Research Development Corporation evaluation of its funded research projects, which assessed the Sustainable Farm Families program as its most successful.

In terms of other best practice innovations, the WDHS care coordination 'Service First Intake Model', focusing on a client centred approach to identifying needs has attracted national and statewide interest with presentations at a number of conferences and the development of a plan with the Barwon South Western Department of Health to roll out the model to other agencies.

Our People

Our staff and volunteers continue to do us proud with their leadership, innovation and commitment to caring for patients, residents, clients and carers recognised through many awards including:

» Minister for Health Volunteer Awards for an Outstanding Individual - Mr. Ian McLean, and team achievement for the Grange Volunteers

» Australian Government Wannon Electorate Award for the Birches Volunteer team

» Dr. Dale Ford finalist for National Primary Care Award

» Ms. Natalie Rhook – Rotary Pride of Workmanship Award

» Heart Safe Award for our Coleraine Community Health team

» Ms. Jennifer Neaves Community Service Awards from the Shire of Southern Grampians and Lions Club

Our Employee of the Month Award continues to be sponsored by Darriwill Farm with 12 of our unsung heroes receiving this award. The prestigious Clinical and Non Clinical Excellence and Innovation Awards were awarded to Hamilton Midwifery Model of Care and Community Liaison teams respectively.

Our Community

We were privileged and honoured to receive outstanding support from our community both through volunteering and fundraising activities. WDHS is extremely proud of our 320 volunteers who generously and unselfishly give of their time to help their fellow citizens.

On the fundraising front, our major fundraising campaign for the $2.85m redevelopment of the Grange reached its funding target of $2.2m after a three year campaign. We thank our appeal patron Dr. Geoff Handbury AO, all financial donors and the volunteers who contributed to the outstanding success of this campaign.

Other major fund raising activities and event successes included the Grange Fun Run and Golf Day, the Arctic Blast, which raised over $45,500 and the Annual Door Knock and Christmas Appeals.

A large and very generous donation of $448,657 was received from Mr. Leo (Sandy) O'Brien, a life time resident of Penshurst, for the next stage of the upgrade and redevelopment of the Penshurst campus.

The Coleraine redevelopment fundraising appeal is well on the way to reaching its target of $200k with in excess of $158k raised to date. Significant contributions to our fundraising efforts were received from Trusts and Foundations including the Collier Charitable Fund, Ian Rollo Currie Estate, Marion and EH Flack Trust and ANZ Trustees, Freemasons and the James Charitable Trust. A bequest of $51,547 was also received from the Estate of Dorothy Mary Mildon.

Thanks to these contributors, the success of our fundraising activities and those of our regular supporters including the Aged Care Trust, Hamilton, North Hamilton, Coleraine and Penshurst Auxiliaries, Hospital Opportunity Shop, Murray to Moyne, regular benefactor Dr.Geoff Handbury and many other businesses and hundreds of individuals our fundraising result for the year was an outstanding $1.314m.

Facilities and Equipment

We are in the midst of an exciting $35m capital development program with some projects coming to a conclusion and others beginning.

By far our largest project, the construction of a new $26.5m plus health precinct for Coleraine, is making rapid progress with stage 1 consisting of the Thomas Hodgetts Primary Care Centre, acute hospital, aged residential care, administration, catering and supply services on schedule for completion at the end of 2012; some three months ahead of schedule.

Our other major projects included the completion of the $2.85m Grange redevelopment providing a new seven bed wing, new kitchen, upgrade of Home 3 wing and increased activity areas and the commencement of a $4.1m redevelopment and upgrade of sub acute GEM/rehabilitation inpatient services consisting of upgrades to bedrooms and ensuites, a new assisted daily living skills kitchen, gymnasium and gait training areas.

A number of smaller projects were also completed including a $760k upgrade to the Hamilton Medical Group and $185k conversion of a trade workshop for Cancer Consulting and Education suites.

To assist our capital planning for the next 10 to 15 years, master planning was completed for the Hamilton and Penshurst campuses.

→ Mrs Elsie Dyke of Casterton with her husband Albie, is feeling "relaxed and comfortable" in one of seven newly completed rooms that make up the new wing at the Grange, providing residents with spacious, comfortable and light filled accommodation, and views over landscaped gardens

Leadership and Management
Western District Health Service's reputation as an innovative leader in healthcare continued to build with our achievements and service models for Farmer Health, Care Coordination, and Indigenous Oral Healthcare showcased at many National and State forums.

The National Centre for Farmer Health also continues to attract growing international interest with invitations to present on its work received from New Zealand, Canada and Mexico

The shared learning from International, National and Statewide exposure not only enhances our leadership role in healthcare but also provides opportunities for our staff to learn from the experience and developments of other organisations to benefit our community.

The handing down of the 2012/13 State budget brought an unexpected and devastating development with no funding allocated for the continuation of the National Centre for Farmer Health. Whilst this is a significant setback you can rest assured that WDHS is pulling all stops out to secure either Commonwealth or State funding to continue the outstanding work of one of our flagship programs whose reputation and work is widely recognised at a National and International level.

Our financial performance for the year was exceptional considering the challenging circumstances with an operating surplus of $303,000 and an entity surplus of $11,566m.

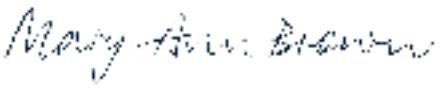
Acknowledgements
The support we receive from many individuals, businesses, service clubs, support groups, auxiliaries, Aged Care Trust and volunteers is outstanding. Their support is greatly valued and appreciated as it is critical to our ongoing success and development as a Health Service.

We also recognise the outstanding contribution of our Board Members, Staff, Visiting Medical Officers, Development Council, local Parliamentarians, the Victorian Government, Regional and Central Department of Health Staff, Local and Commonwealth Governments and local radio and print media outlets.

Future Outlook
It is with great excitement and confidence that we look ahead to a period of growth in terms of our capital program together with the ongoing evolution of a person centred care service model in partnership with consumers.

It is also with some trepidation that we enter a period of change at a National level which is heavily focused on unit pricing with little attention to service integration and coordination.

WDHS has a strong and robust service system which will stand us in good stead to meet the challenges ahead as we continue to strive for the best long term service outcome for our community.



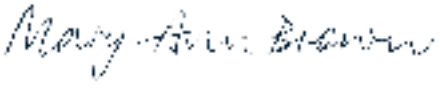
Mary-Ann Brown

President

Jim Fletcher

Chief Executive Officer

Responsible Bodies Declaration
In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for the Western District Health Service for the year ending 30 June 2012.



Mary-Ann Brown

President

09 August 2012

Financial Overview

Western District Health Service (WDHS) aims to increase service provision in a financially sustainable way, and utilises several key result areas to monitor performance. These key result areas include:

- operating performance – achieving activity targets and a surplus from operations
- liquidity – maintenance of sufficient assets to meet commitments as they fall due – a ratio in excess of 0.8
- asset management – ensuring that sufficient levels of investment are undertaken to maintain the asset base

Financial Overview

The financial statements have been prepared in accordance with Standing Direction 4.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards and Australian Accounting Interpretations and other mandatory professional reporting requirements for the year ended 30 June 2012.

WDHS achieved a comprehensive entity surplus of $11.5m for the 2011/12 financial year, maintained overall liquidity and expanded the asset base with an investment in fixed assets of $15.3 million and achieved all activity targets with the exception of acute throughput which was 1.65% below target. The outstanding comprehensive entity surplus is largely attributable to Capital Grants of $11.4m associated with the three year $35m Capital Works program commenced in the previous year. Excluding these Capital Grants, the health service would have achieved a modest entity surplus of $41,000.

Operating Performance

With the exception of residential aged care, funding provided in funding formulae excludes any contribution towards the cost of depreciation. Funds are traditionally allocated by government capital grant to fund significant asset replacement and the health service continues to rely on community fundraising to provide for equipment replacement.

In reviewing operating performance capital purpose income comprising Capital Grants ($11,437,000), Residential Aged Care Capital Contributions ($1,575,000) and Specific Purpose Donations and Bequests ($1,314,000) is excluded. Also excluded in the current year was interest earned on restricted capital funds held for the HBH Sub-Acute Redevelopment ($209,000). These funds are provided for specific capital purposes and are not available to support operations. Depreciation and the gain on disposal of non-current assets ($86,000) are also excluded being predominantly funded from capital income sources.

The accepted indicator of performance is the result from continuing operations prior to Depreciation and Capital Purpose Income. In the current year, this result was a surplus of $303,000 ($275,000 in 2011), which represents 0.48% of operating revenue.

In the 2011/12 financial year, depreciation charges of $3,302,000 were recorded reflecting the cost associated with the use of buildings and equipment in delivering services. In order to maintain the Health Service asset base, operating surpluses and capital purpose income must exceed depreciation charges and periodic non-current asset valuation changes. In the current year, Capital Income was $11,267,000 more than the depreciation and valuation charges principally due to Capital Grants associated with the Coleraine Redevelopment. Financial asset fair value losses of $87,000 and impairment losses of $14,000 were recognized in calculating the comprehensive result for the year. Including all items, the Health Service net assets increased by $11,478,000 for the year, which represents an increase of 19.4% (increase of $5,133,000 – 9.5% in 2011).

Liquidity Position

During 2011/12, the Health Service generated negative cash flows from operations of $2,311,000 and received $14,326,000 in Capital Purpose Income. $15,293,000 of these funds was used to purchase property, plant and equipment during the year. The entity generated a positive cash flow of $1,344,000 for the year after capital items and elimination of cash flows of $77,000 from the redemption of investments.

At the end of the year, the ratio of current assets to current liabilities (excluding Patient Trust funds) was 1.67:1, an expected reduction from the ratio of 1.78:1 at the start of the year due to expenditure associated with the Grange Residential Care redevelopment.

The current asset ratio of 1.67:1 is considerably in excess of the 0.8 target ratio, but this will decline significantly in the next year as funds continue to be expended on major capital works associated with the Coleraine and Hamilton Base Hospital Sub-Acute redevelopment projects.

Asset Management

$15.2m was invested during the year in building works ($13.4 m) and equipment upgrades ($1.8m) in accordance with the capital works budget adopted in August 2011 by the Board of Directors. The investment in equipment was $607,000 greater than the depreciation on equipment items and the investment in buildings $11.3m greater than the depreciation expense for the year.

The $15.2m expended on building works represents the second year of a three year $35m upgrade program. Major components in the current year included the completion of the Grange Residential Care Redevelopment $2.85m, completion of Stage 1 upgrade of Hamilton Medical Group $760,000, HBH Generator & Switchboard upgrade $495,000, progress payments for the Coleraine Redevelopment $9.3m and preconstruction works associated with the HBH Sub-Acute Redevelopment $400,000. Expenditure under the upgrade program in the coming year is expected to exceed $13m.

In addition to the major capital works program, other significant items included installation of a ceiling track system at The Birches and Grange Residential $105,000, replacement of floor vinyl in Theatre $74,000, replacement of ADASS Bus $119,000, new steris sterilsers in Theatre $67,000 , kitchen equipment $129,000, new Orthopaedic Drill $27,300 and replacement of defibrillators $39,800.

The Future

The continued support of the community, as indicated by the outstanding $1.314m received from donations and bequests in 2011/12, provides the opportunity for WDHS to continue to invest in buildings, medical equipment and technology, which would not otherwise be possible. It is important to maintain the level of investment to provide a strong base for the Health Service to improve service delivery and efficiency and comply with increasingly rigorous service standards.

The substantial $35m building program, commenced in 2010/11, will continue in the coming year and will provide a significant upgrade to health service building infrastructure and enhance service provision

in the Southern Grampians Shire for the next 50 years. While there will be a further decline in liquidity levels as a consequence of the redevelopments, continuation of strong community support and the delivery of operating surpluses will ensure there is no impact on the Health Service financial position.

In the 2012/13 financial year, the Health Service will face significant challenges with the introduction of the ''National Fair Price'' and the new activity based funding system under a National Pricing System from 1st July 2012, the introduction of the new mandatory National Safety and Quality Standards from 1st January 2013, and substantial changes in Residential Aged Care Services under the ''Living Longer, Living Better ''10 year plan.

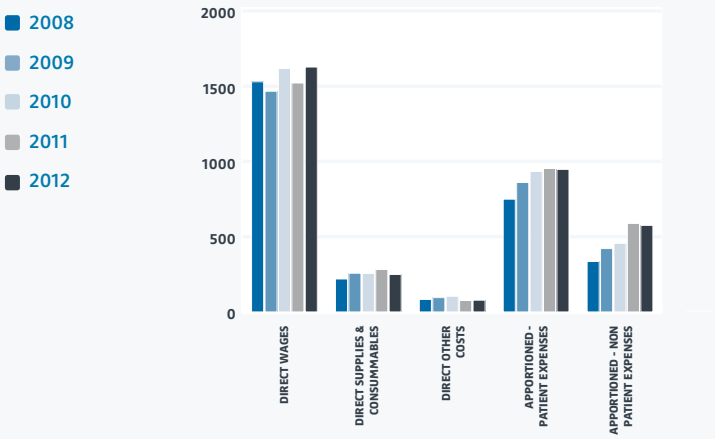
These changes to policy directions in a challenging economic environment with increased productivity demands, the continued implementation of new clinical information systems and medical technology and constantly increasing demand for high quality services will challenge the Health Service as it strives to continually improve service provision in a financially sustainable way.

Financial analysis of operating revenue and expenses

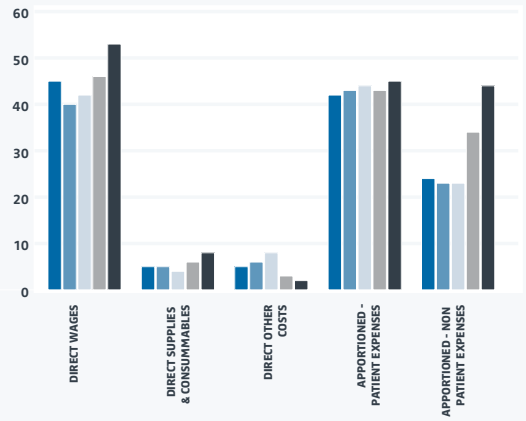
REVENUE	2012 ($000S)	2011 ($000S)	2010 ($000S)	2009 ($000S)	2008 ($000S)
SERVICES SUPPORTED BY HEALTH SERVICE AGREEMENT					
Government grants	50,030	46,923	43,645	42,891	39,884
Indirect contributions by Department of Human Services	142	1,494	1,137	740	963
Patient fees	5,358	5,414	4,828	4,772	4,395
Other revenue	950	957	683	707	927
	56,480	**54,788**	**50,293**	**49,110**	**46,169**
SERVICES SUPPORTED BY HOSPITAL/COMMUNITY INITIATIVES					
Business Units	1,048	1,235	1,193	1,189	1,129
Property income	708	672	642	623	575
Other revenue	5,082	4,808	3,301	3,643	3,077
	6,838	**6,715**	**5,136**	**5,455**	**4,781**
Total revenue	**63,318**	**61,503**	**55,429**	**54,565**	**50,950**
EXPENDITURE					
SERVICES SUPPORTED BY HEALTH SERVICE AGREEMENT					
Employee entitlements	41,620	39,618	36,752	35,373	33,728
Fee for service medical officers	3,298	3,311	2,981	3,046	2,869
Supplies and consumables	5,740	6,008	5,192	5,588	4,911
Other expenses	10,716	10,362	8,341	8,002	7,169
	61,374	**59,299**	**53,266**	**52,009**	**48,677**
SERVICES SUPPORTED BY HOSPITAL/COMMUNITY INITIATIVES					
Employee entitlements	1,166	1,400	1,487	1,419	1,377
Supplies and consumables	150	155	163	145	148
Other expenses	325	374	401	375	529
	1,641	**1,929**	**2,051**	**1,939**	**2,054**
Total Expenditure	**63,015**	**61,228**	**55,317**	**53,948**	**50,731**
Surplus for the year before capital purpose income, Depreciation and specific items.	**303**	**275**	**112**	**617**	**219**
Capital Purpose Income	11,646	5,513	1,318	736	831
Donations and bequests	1,314	1,528	1,162	612	767
Residential Aged Care - Capital Purpose Income	1,575	1,387	1,124	1,046	1,062
Surplus/(Loss) on disposal of fixed assets	34	(416)	(59)	(149)	29
Impairment of Financial Assets	(14)	(12)	(54)	(142)	
Assets Provided Free of Charge		459			
Revaluation Decrement on Non Current Assets				(1,425)	
Depreciation	(3,302)	(3,618)	(3,575)	(2,354)	(2,287)
Entity surplus for the year	**11,556**	**5,116**	**28**	**(1,059)**	**621**

* See page 14 for Financial Overview

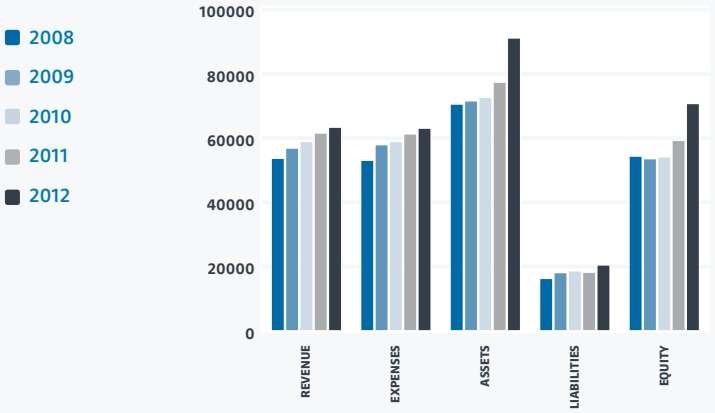
Average Cost Acute Inpatient



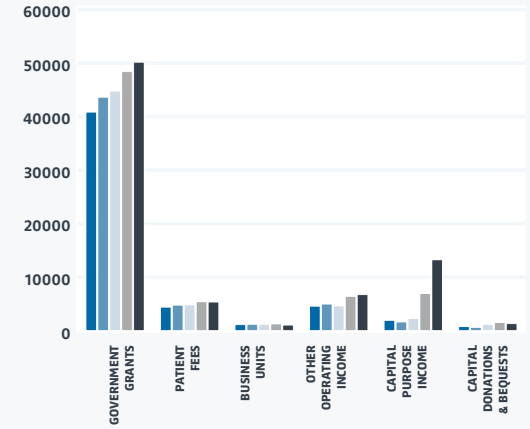
Average Cost Non-admitted Occasion of Service



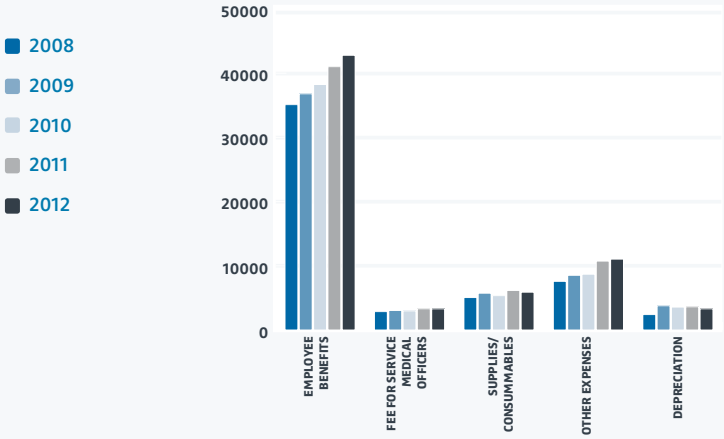
Analysis of Financial Position 30 June ($'000s)



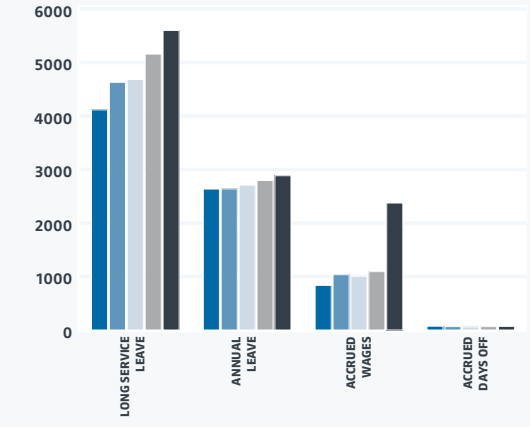
Income by category ($'000s)



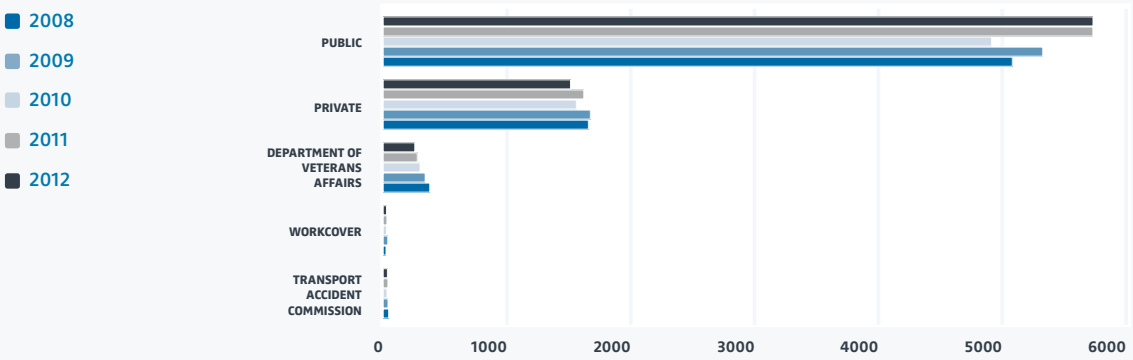
Expenditure by category ($'000s)



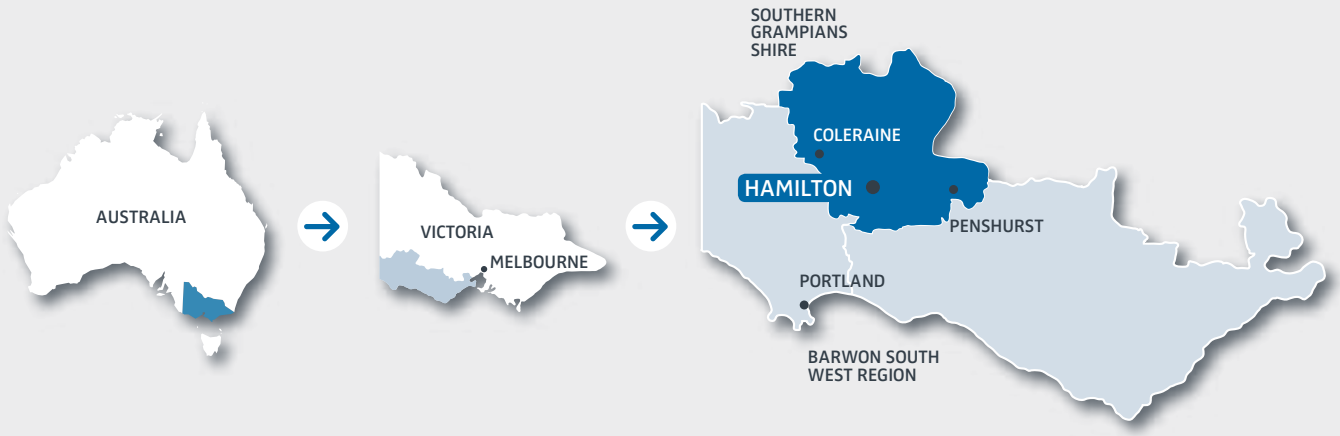
Employee Benefits as at 30 June ($'000s)



Inpatients treated by patient classification



About our Organisation



Western District Health Service (WDHS) has played a central role in its community for the past 150 years, since the Hamilton Base Hospital and Benevolent Asylum was first established in 1862 to provide care for people suffering from illness and accidents and for victims of personal tragedy and social distress.

One hundred and fifty years later, WDHS reflects the community it now serves - a major centre in a prosperous rural environment, looking forward to a positive future.

WDHS is based in Hamilton with campuses at Coleraine and Penshurst in the Southern Grampians Shire (SGS) and Merino in the Glenelg Shire (GS). WDHS incorporates the Frances Hewett Community Centre (FHCC), Grange Residential Care Service, Hamilton Base Hospital (HBH), Coleraine District Health Service (CDHS), Penshurst and District Health Service (PDHS), Merino Community Health Centre, the National Centre for Farmer Health (NCFH) and youth4youth.

The Health Service provides 91 acute beds, 175 high and low level extended care and residential aged care beds, 35 Independent Living Units, primary care, community and allied health services, and youth services.

WDHS is a member of the Southern Grampians Glenelg Sub Region of the Department of Health's Barwon - South Western Region. Other member health services are Casterton Memorial Hospital, Heywood Rural Health, Portland District Health, Balmoral and Dartmoor Bush Nursing Centres.

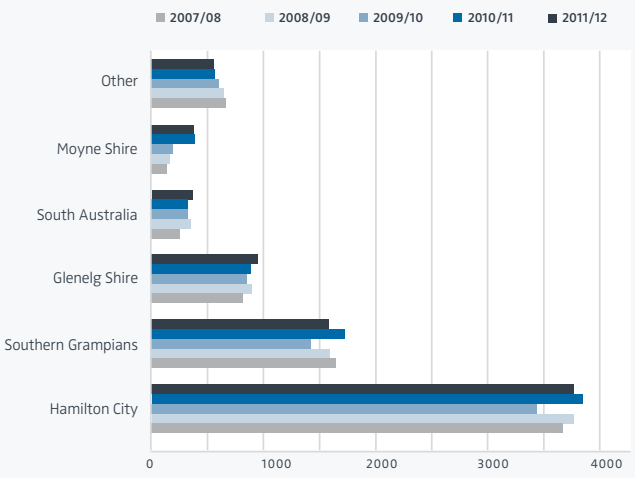
Southern Grampians Shire is located in the centre of Victoria's Western District. It is home to 17,000 people, with approximately 10,000 residents living in Hamilton. The remainder are serviced by smaller townships and farming communities.

Our Past, Present & Future

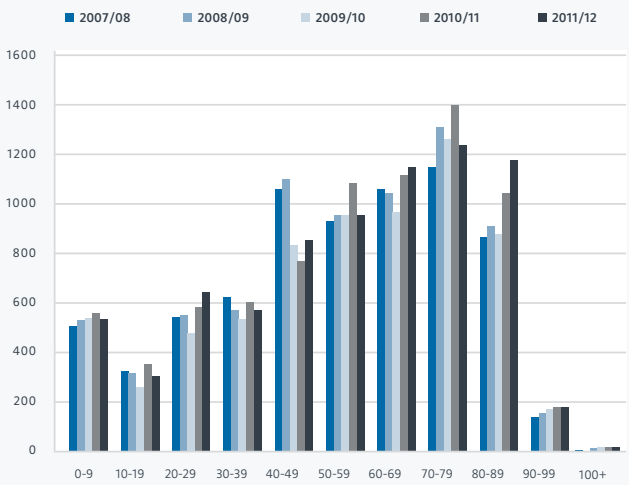
WDHS was established in 1998, with the amalgamation of Hamilton Base Hospital, Southern Grampians Community Health Services and Penshurst and District War Memorial Hospital, now PDHS. In 2005 CDHS amalgamated with WDHS.

Patient Demographics

Total number of admissions



Number of patients by age group



→ Dr Craig de Kievit, WDHS Maternity Services Program Co-ordinator, Pauline Kearns, AGM Guest Speaker, Trisha Broadbridge and HMMC Midwife, Sarah Murch with the WDHS Clinical Excellence Award presented at the 2011 AGM

The HBH site is also the location for the Birches Extended Care facility, which provides 45 beds for mainly high-care use and caters for people with special needs.

The Penshurst Hospital was built in 1957 and provides acute care, residential aged accommodation and community services and manages Independent Living Units at Penshurst and Dunkeld.

The Coleraine District Health Service commenced in 1935. It provides acute care, residential aged accommodation and community services, manages Independent living units in Coleraine and has a Community Health Centre at Merino.

Frances Hewett Community Centre joined WDHS in 1998, and provides a broad range of primary care and community based services. The Grange was built as a private hospital in 1927 and became an aged care hostel in 1956. Redevelopments occurred in 2002 and 2012, and it now provides 50 beds of modern aged residential care accommodation and 30 Community Aged Care packages (CACPs).

Youth services (YouthBiz) were established in 1997 by Southern Grampians Community Health Services Inc, which amalgamated with HBH in 1998. The YouthBiz program was managed as a drop in centre model until 2011, when it was redeveloped as an outreach service and renamed youth4youth. The youth4youth program provides a wide range of health and recreational services to the young people of our community from a variety of locations. WDHS took over management of Dental Services in July 2008 and a new public dental clinic building on the Frances Hewett Community Centre site was completed in June 2009. It has four dentists' chairs, with potential for future expansion.

→ Now working with the WDHS Dental Clinic after 40 years of dentistry in both public and private practices, Tony Buc has dramatically reduced Hamilton's public dentistry waiting times.

National Centre for Farmer Health

The National Centre for Farmer Health is a partnership between WDHS and Deakin University, which commenced operations in October 2008 with funding from the Victorian Government and the Handbury Trust.

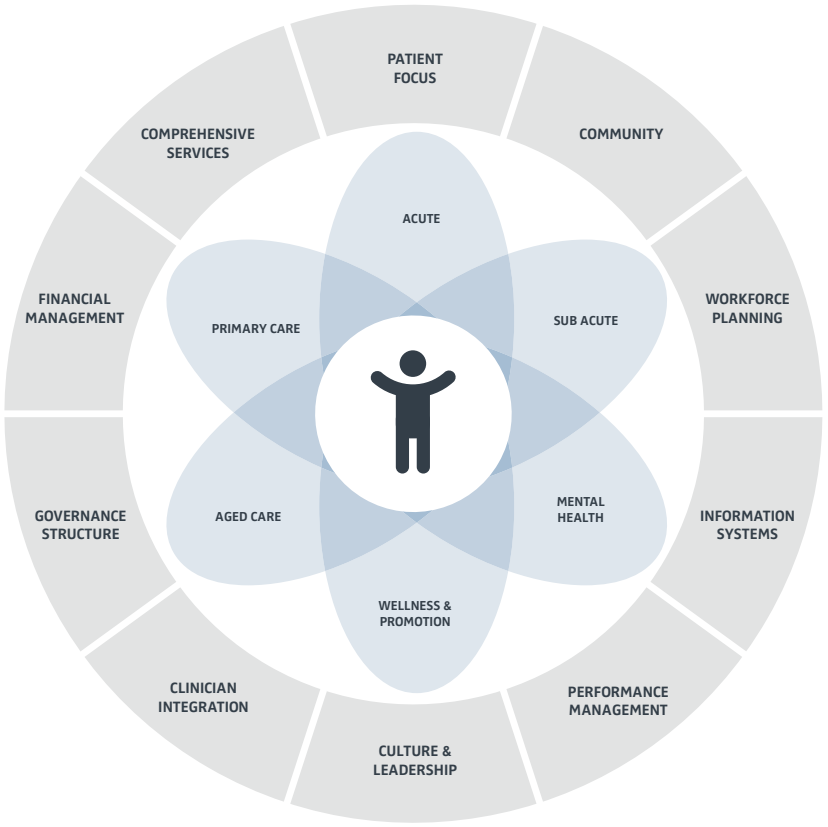
Launched by the Premier of Victoria, it was established to provide national leadership to improve the health, wellbeing and safety of farmers, farm workers and their families across Australia through research, service delivery and education.

Our Services

Acute/Sub Acute Services
- Anaesthetics
- Chemotherapy
- Coronary Care
- Day Procedure
- Ear, Nose and Throat
- Emergency
- Endoscopy
- General Medicine
- General Surgery
- Geriatric Evaluation Management (GEM)
- Gynaecology
- Haemodialysis
- High Dependency Care
- Hospital in the Home
- Infection Control
- Intensive Care
- Improving Care for Older Patients
- Maxillofacial Surgery
- Obstetrics
- Oncology
- Operating Suite
- Ophthalmology
- Oral Surgery
- Orthopaedics
- Paediatrics
- Pre-admission Service
- Pharmacy
- Psychiatry
- Rehabilitation
- Specialist Medicine
- Specialist Nursing
- Transition Care
- Urology
- Private Services - Pathology, Radiology and Sleep Clinic

Extended Care
(The Grange, The Birches, Kolor Lodge, Penshurst Nursing Home, Valley View Nursing Home, Wannon and Mackie Hostels)
- Community Aged Care Packages
- Dementia Specific Residential Aged Care
- Lifestyle and Leisure
- Men's Out & About activities
- Palliative Care
- Psycho Geriatric Care
- Residential Aged Care
- Residential Extended Care
- Respite

Primary & Preventative Health
- Adult Day Activity and Support Service
- Audiology
- Blood Services
- Breast Cancer Support Group
- Cancer Link Nurse
- Cancer Support Group
- Cancer Support Services
- Cardiac Rehabilitation
- Cardiac Support Group
- Carer's Support Group
- Chronic Disease Management
- Coordinated Care



→ **The WDHS "Person Centred Care Service Model" is representative of a service framework, which aims to deliver person centred health care that is integrated and coordinated around the needs of people rather than service types, professional boundaries, organisational structure, funding and reporting requirements. Implementation of this service model in partnership with our consumers will enhance health outcomes for our community.**

- Community Rehabilitation Centre (CRC)
- Continence Service
- Counselling
- Day Centre
- Dermatology
- Dental Services
- Diabetes Education
- District Nursing Service
- Domiciliary Midwifery
- Family Planning
- Hamilton Community Transport
- HARP (Hospital Admission Risk Program)
- Home Referred
- Hospital in the Home
- Maternity Enhancement
- Meals on Wheels
- Men's Health
- Nutrition and Dietetics
- Occupational Therapy
- Palliative Care
- Physical Activity Programs
- Physiotherapy
- Podiatry
- Post Acute Care
- Pulmonary Rehabilitation
- Quit Fresh Start
- Rehabilitation in the Home
- Respiratory Education
- Respiratory Support Group
- Sexual and Reproductive Health
- Social Work
- South West Community Transport Service
- Speech Pathology
- Stomal Therapy
- Women's Health
- Work Health
- youth4youth

National Centre for Farmer Health
- Agri-Safe
- Applied Research and Development
- Information and Knowledge Hub
- Professional Training and Education
- Sustainable Farm Families

Administrative
- Auxiliaries
- Business Support and Innovation
- Community Liaison
- Facility Management
- Finance
- Health Information
- Hotel Services
- Human Resources
- Learning and Education
- Library
- Linen Services
- Occupational Health and Safety
- Quality Improvement
- Reception
- Security
- Volunteer Program

Service Performance at a Glance

	2012	2011	2010	2009	2008
INPATIENT STATISTICS (ACUTE PROGRAM)					
Inpatients Treated	7,562	7,695	6,829	7,415	7,181
Average Complexity (DRG Weight)	0.67	0.68	0.73	0.71	0.74
Complexity Adjusted Inpatients (WIES 18)*	4,959	5,049	4,976	5,267	5,195
Inpatient Bed Days	21,799	24,172	21,861	23,967	24,417
Average Length of Stay (days)	2.88	3.1	3.2	3.23	3.37
HITH Bed Days	492	758	678	578	664
Nursing Home Type Bed Days	1,823	2,544	2,385	2,659	3,669
Operations	2,764	3,014	3,029	3,088	3,006
Births	219	235	223	237	221
Available Bed Days	27,854	27,191	27,191	30,172	30,907
Occupancy Rate	84.80%	88.90%	80.40%	79.40%	79.0%
Average Cost per Inpatient	$3,476	$3,420	$3,366	$3,099	$2,915
AGED CARE STATISTICS - (AGED PROGRAM)					
HIGH CARE					
Residents Accommodated	198	178	158	166	167
Resident Bed Days	51,696	49,268	40,547	40,756	43,448
LOW CARE					
Residents Accommodated	26	26	80	88	93
Resident Bed Days	7,137	10,070	18,071	18,907	16,504
RESPITE					
Residents Accommodated	142	151	133	145	102
Resident Bed Days	1,967	1,629	1,755	1,676	1,532
Occupancy Rate	97.72%	98.25%	97.30%	98.95%	99.19%
Community Aged Care Package (CAPs) clients	40	39	39	38	44
CAPs Occasions of Service	10,891	10,857	10,908	10,854	10,672
ACCIDENT/EMERGENCY OCCASIONS OF SERVICE	**7,221**	**6,693**	**5,949**	**5,792**	**6,154**
OUTPATIENT (NON-ADMITTED) OCCASIONS OF SERVICE					
Physiotherapy	11,087	8,552	7,567	8,094	8,033
Rehabilitation & Day Centre	3,872	4,566	4,605	5,095	5,256
Speech Pathology	681	873	851	1,030	887
Podiatry	2,321	2,884	2,810	2,012	2,150
Social Welfare	510	520	2,946	4,025	3,829
Occupational Therapy	4,857	4,417	4,053	4,266	4,749
Palliative Care	3,693	2,065	1,893	1,056	776
District Nursing Service	27,930	30,945	35,300	34,764	32,574
Total Non-admitted Occasions of Service	54,951	54,822	60,025	60,342	58,254
Cost per Non-admitted Occasion of Service	$152	$132	$122	$117	$121
Meals on Wheels	32,346	35,309	37,770	39,613	34,005
Quality Assurance					
Full Accreditation Status	YES	YES	YES	YES	YES

* WIES - (Weighted Inlier Equivalent Separations) are based on the Australian Refined - Diagnostic Groups (AR-DRG) further refined in Victoria by the addition of a few additional DRGs by the Vic-DRG version 52.

* Our Target WIES for 2011/12 (excluding those funded under the Small Rural Health Services Program) was 4,817. We were below target by 79.34 WIES (1.65%)

Improving Performance

→ **WDHS Hotel Services Coordinator, Norm Saligari and colleagues, Allied Health Assistant, Tammy Barker, Medical Ward Assistant, Graham Marnell, Surgical Ward Assistant, Eileen Robertson, Hotel Services Assistants, Leeanne Ryan and Jill Jackson and Pharmacy Technician, Christine Jeal analysing cleaning audit results**

Strategy: To pursue best practice through a culture of continuous quality improvement and increased consumer participation in health care and evaluation.

Achievements

- Completion of recommendations following Australian Council on Healthcare Standards Periodic Review
- Successful Aged Care Re-accreditation at Coleraine Aged Care Facilities
- Successful Aged Care Accreditation support visits
- Participation of consumers in development of service model and systems
- Completion of the Victorian Managed Insurance Authority (VMIA) Risk Framework Quality review
- Review of Risk Management Strategy
- Review of Risk Register
- Victorian Patient Satisfaction Survey results overall care index level rated higher than peer group and State averages
- Completion of research projects
- Food safety certification achieved at all campuses
- Implementation of Infection Control strategies
- Quality of Care Report completed

The Future

- Implementation of the National Safety and Quality Health Service Standards
- The re-accreditation of Hamilton and Penshurst Aged Care facilities
- Completion of research projects
- Implementation of Infection Control strategies

Accreditation

The Australian Council of Healthcare Standards (ACHS) conducted a two day onsite survey for our midterm accreditation (periodic) review during June 2011. The recommendations and suggestions for further improvement have been implemented in readiness for a full re-accreditation survey. The Evaluation and Quality Improvement Program (EQuIP) has been the measure for health care accreditation for many years and will be revised in line with the introduction of new national standards from 01 January 2013.

The Australian Commission on Safety and Quality in Healthcare has developed 10 National Safety and Quality Health Service Standards, which are to be implemented from 01 January 2013. The Standards will provide a nationally consistent and uniform set of measures of safety and quality for application across a wide variety of health care services. We have completed a gap analysis of the Standards in order to identify any gaps to be addressed in readiness for the 2013 accreditation process.

During the year, Coleraine aged care facilities achieved Aged Care Re-accreditation and all WDHS aged care facilities were visited by the Aged Care Standards and Accreditation Agency. All visits were successful with ongoing compliance with accreditation standards achieved.

Risk Management

The Board, Executive and staff are aware that the identification, assessment, and prioritisation of risks are critical to the safety of patients, residents, clients, visitors and staff at WDHS. The team works towards monitoring, minimising and controlling the probability and impact of unplanned events. The VMIA conducted a Risk Framework Quality Review in December 2011 which is an independent review of the quality, comprehensiveness and maturity of our risk management strategy at WDHS. This resulted in the development of nine recommendations to support the improvement of risk management across the organisation.

The Risk Register is monitored closely by the Executive and regularly reviews the controls in place to minimise risks and maximise opportunities. A risk management framework has been developed to embed the principles

of the risk management standard AS/NZS 31000:2009.

Victorian Health Incident Management System

The Victorian Health Incident Management System, known as Riskman, is well entrenched across WDHS as a system that reports, manages and reviews incidents occurring across the health care environment. The patient feedback and Risk Register are also incorporated into the Riskman system and Quality Improvement activities are gradually being entered into the system across all divisions.

Consumer Participation, Feedback and Satisfaction

Feedback from the community we serve is received via internal and external processes and includes the active involvement of the Community Advisory Committee.

Consumer Forums were conducted by the Primary and Preventative Health Division to engage community members in the development of the new model of Coordinated Care. Consumers have been actively involved in the review of 'The Patient Journey' Program, patient information brochures and outcomes of our feedback processes. Patient feedback forms and regularly conducted consumer satisfaction surveys inform the Community Advisory Committee, Executive and Board about the level of patient satisfaction.

The Victorian Patient Satisfaction Monitor results for July - December 2011 gave us a rating score of 83, which was top of our Peer Group range and above state average of 79. We were rated at the top of the range for our peer group and all health services for all eight indicators.

Community Advisory Committee

It is acknowledged that actively encouraging and involving consumers in health care improves safety and quality of services, improves health outcomes, encourages an active role for consumers in managing their own health and provides more equitable, effective and accessible health services.

The Consumer Advisory Committee promotes consumer involvement in healthcare planning, delivery and evaluation throughout WDHS. It provides input into service needs, feedback on performance indicators relating to service quality and represents the community by making consumer perspectives known to staff, management and the Board of Directors.

This year the Consumer Advisory Committee participated in the development of service and strategic plans, accreditation activities, the Diversity and Participation Action Plan, and members have been taken on hospital tours to develop a better understanding of the day to day operations of the organisation.

→ **WDHS physiotherapist, Kathy Guan using safe hand hygiene procedures under the eye of Infection Control Consultant, Mark Stevenson. All staff are required to complete competency training in Hand Hygiene**

Members of the Consumer Advisory Committee are actively involved in the gap analysis of the National Standards, particularly Standard 2 – Partnering with Consumers.

Research Projects

The establishment of the National Centre for Farmer Health has increased our participation in research projects across Western District Health Service. A grant spread over three years will fund research into farmer hearing loss.

Our Primary and Preventative Health team has completed its oral health project 'Indigie-Grins' which related to indigenous oral health for children aged five to twelve years. This study revealed an overall improvement in oral health behaviour, awareness and a trend to improvement in key oral health indicators.

Food Safety Certification

The annual external food safety audit was conducted across all WDHS facilities and full compliance was achieved in all.

Infection Control

Our Infection Control program promotes awareness of correct behaviour and practice, and monitors outcomes through auditing and analysis of any related incidents. The program educates and provides correct principles of infection prevention to all healthcare workers, monitoring outcomes through auditing and analysing incidents. It is also responsible for providing a consultancy service to other health services in the Southern Grampians/Glenelg sub region.

Food safety, cleanliness of facilities and hand hygiene, and correct use of antibiotics are core to an effective infection control program.

WDHS continues to rate well with catering facilities achieving full compliance with food safety certification and achieving well above the State benchmark average for cleaning standards, hand hygiene and compliance with antibiotics use.

Over the next 12 months the Hamilton Base Hospital campus will be taking part in a research project on methods used to improve the correct use of antibiotics.

Quality of Care Report

WDHS is required to produce an annual Quality of Care Report as a means of providing the extended community with information on systems, processes and outcomes in our endeavour to ensure delivery of the highest possible quality of care and services.

The report includes information on consumer feedback, external reviews and clinical practice as well as data on the outcomes of quality improvement activities.

The Quality of Care Report is reviewed by the Department of Health with feedback available to WDHS on opportunities for improvement.

Further information on improving performance is available in our Quality of Care Report, which is available in either printed or audio formats at all campuses, and at **www.wdhs.net**

Clinical Services

→ **WDHS management and staff, Clinical Teacher, Russell Armstrong, Grange Unit Manager, Pam Vince, Director of Nursing, Janet Kelsh, CEO, Jim Fletcher, Deputy Director of Nursing, Bronwyn Roberts, Birches Unit Manager, Lee Vause and Penshurst Manager/Director of Nursing, Alastair Doull will lead a Person Centred model of care research project for the aged in partnership with Deakin University**

Strategy

To enhance our Sub Regional role providing an integrated range of high quality services to meet the population health needs of our community.

Achievements

- Recruitment of a new Physician and GP Obstetrician Proceduralist
- Enhancement of emergency medicine
- Commencement of construction of upgrade to sub acute inpatient services
- Expansion of transition care
- Expansion of integrated cancer services
- Enhancement of maternity services
- Improvements to care for older people
- Opening of five additional beds at the Grange
- Completion of a framework for governance of aged residential care

The Future

- Recruitment of Specialist Medical staff Physician and Obstetrician Gynaecologist
- Completion of the HBH sub acute inpatient upgrade
- Implementation of the care plan coordination service model for sub acute services
- Further enhancement of sub acute and cancer services
- Implementation of aged residential care governance framework
- Completion of Australian Safety Quality Council National Medication Chart Pilot including VTE
- Completion of Emergency Care Improvement and Innovation Clinical Network (ECIICN) project for COPD

At Western District Health Service (WDHS, our staff are committed to providing our community with a positive experience through their health care journey. Our staff are mindful of the apprehension faced by some patients during hospital stays and treat each with respect and care. There were 7,562 inpatients treated during the past 12 months, and 54,951 outpatient occasions of service provided.

The Operating Theatres at WDHS served by leading medical and surgical Proceduralists and Nursing staff, assisted by state of the art equipment operated on 2,764 patients this past year. The Midwifery Unit shared the joy of welcoming 219 babies in 2011/12, while our staff provided support and care for 7,221 patients who attended the HBH Emergency Department and those who attended the Primary Care treatment service provided at CDHS and PDHS for minor injuries and illnesses.

We are proud of our staff and facilities which allow us to extend this care across the geographic region we serve. The 75 acute beds at Hamilton Base Hospital provide Emergency, Medical, Surgical, Sub Acute, Midwifery, Paediatrics and Intensive Care services, together with a broad range of Allied Health services. Penshurst Campus has six acute beds and Coleraine Campus 10 acute beds. Both provide general medical care.

Our sub acute services GEM, rehabilitation, palliative and transition care provided 3,338 bed days and community contacts.

WDHS' six aged care facilities, The Birches and The Grange in Hamilton; Penshurst Nursing Home and Kolor Lodge in Penshurst; Valley View Nursing Home and Wannon Court and Mackie Hostels in Coleraine cater for residential needs of the elderly. Thirty Community Aged Care Packages (CACPS) are administered from the Grange. The staff who support our residents and their carers in these facilities are predominantly Division 1 and Division 2 nurses supported by Personal Care Workers. We accommodated 198 high care residents, 26 low care residents 142 respite residents and our occupancy rate in our aged care facilities was 97.72%. We serviced 40 CACPs clients.

Medical and Surgical Services

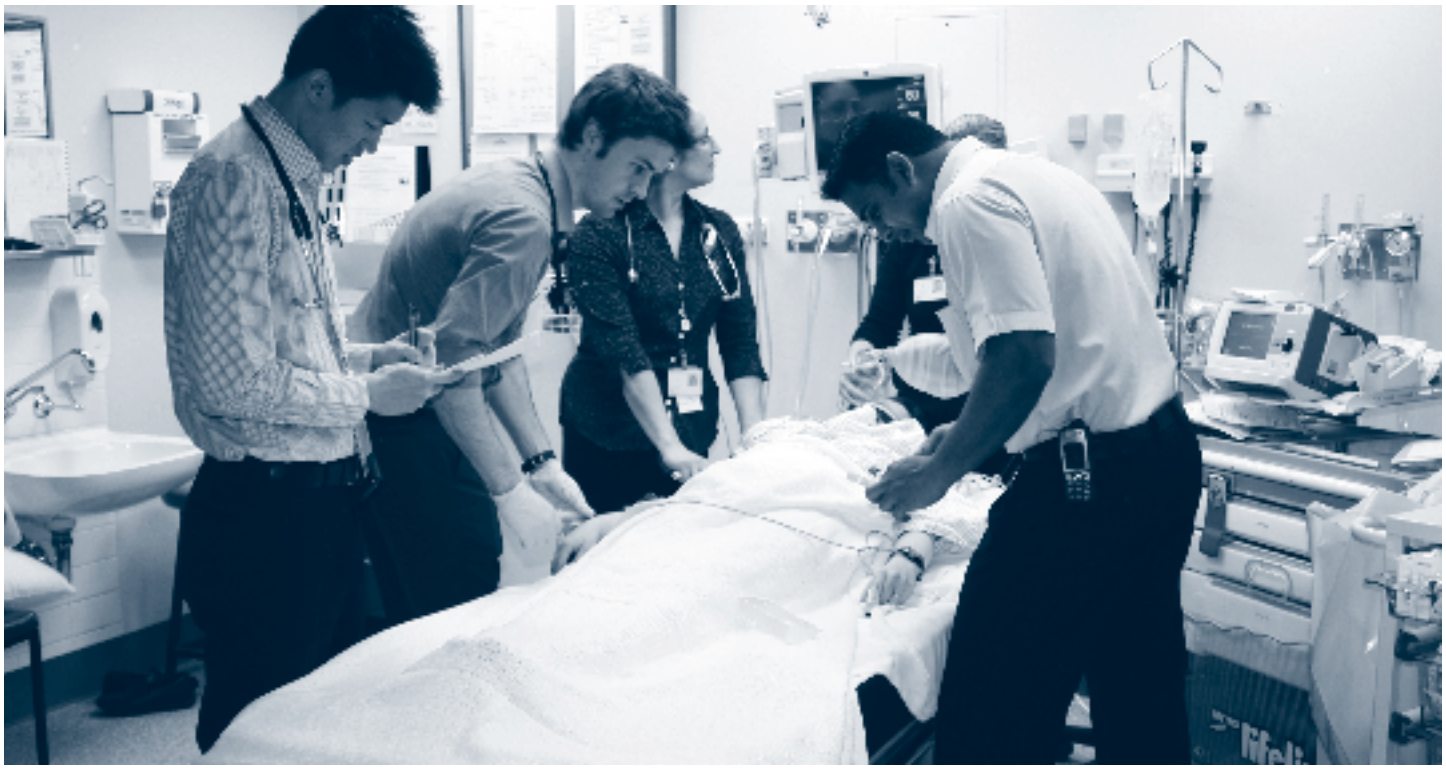
After 12 months of navigating through the tedious and torturous bureaucratic process of the Australian College of Physicians and APHRA, Dr. Trevor Branken arrived from the Emirates to take up a Specialist Physician position. We were also fortunate to recruit a General Practitioner and Obstetric Proceduralist to bolster our Maternity Services and to cover the replacement of Dr. Robey Joyce who has retired from obstetrics, but remains working as a General Practitioner with the Hamilton Medical Group.

The recruitment of Specialist Medical staff remains high on our agenda and we are making progress with the recruitment of a Specialist Obstetrician/Gynaecologist and another Physician to pick up the load arising from Dr. Geoff Coggins move to part-time employment.

Emergency Care

In a boost to our emergency medicine services a consortium of WDHS, South West Healthcare and Portland District Health successfully attracted a grant of $144,000 p.a.

This will provide additional services and education for Hamilton Base Hospital with an emergency Physician providing onsite services and education one day per



→ The Hamilton Base Hospital Accident & Emergency Department provided 7,221 occasions of care in 2011/12

fortnight and also facilitate one of our HMO's completing an emergency medicine certificate course through Deakin University School of Emergency Medicine.

Sub Acute Services
The redevelopment of our GEM/Rehabilitation inpatient facilities is underway involving an upgrade to bedrooms and ensuites, the provision of a new assisted daily living skills kitchen, a new gymnasium and gait training area. It is expected that the new and upgraded facilities will be commissioned in April/May 2013.

Sub acute services were further expanded with two additional transition care places for use in the community.

Cancer Services
The development of an integrated cancer service model progressed with the establishment of a visiting monthly Medical Oncologist outpatient service from the Andrew Love Cancer Centre Geelong, funding for a one day per week Multidiscipline Coordinator for cancer care and our participation in a pilot cancer survivorship with Barwon Health and the Regional Integrated Cancer Service consortium. These developments together with the establishment of a new consulting and education suite complemented by existing services of the Cancer Link Nurse, Men's and Women's Health, Surgical and Chemotherapy services have significantly enhanced the integration and coordination of cancer care for our community.

Maternity Services
The Hamilton Model of Midwifery Care (HMMC) provides one to one support to mothers during pregnancy, birth and post natal care across a very diverse geographical area.

HMMC also provides a comprehensive domiciliary care program.

This year additional Allied Health service programs were incorporated into the HMMC to further enhance support to expecting and prospective new mums.

With an increasing trend in obesity and gestational diabetes (GD) the HMMC pregnancy weight management program has been incorporated into routine antenatal and postnatal care to reduce likely complications associated with excessive weight gain and GD.

Improvements to Care for Older People
Further implementation of our person centred care framework has brought about further improvement to the care for older people in both our acute hospital and aged residential care settings. The framework for improving care for older people includes implementation of:

» partners with consumers policy

» behavioural management guidelines preventing functional decline of older people whilst hospitalised

» national standards and best practice for cognitive impairment and assessment

Within the aged residential care setting the Birches has been involved in and implemented best practice strategies to enhance the environment and range of activities for people with dementia.

The completion of redevelopment and upgrade of the Grange has increased our number of aged residential beds by five and improved the functionality of the 13 bed Home 3 wing to provide for the more complex and high care needs of our current and future residents.

Governance for Aged Residential Care
The WDHS Board adopted a framework for governance of quality in its aged residential care in line with the Victorian Government's "beyond compliance strategy". The WDHS framework has set the following four key objectives in line with our strategic and service plans:

» care is person centred focusing on the individual resident's rights, needs, capabilities, choices and preferences

» care is focused on the safety of residents

» care is evidenced based, individually designed and implemented to achieve the best possible health and wellbeing outcome for each resident

» the resident experiences seamless care planned and delivered by a coordinated team

These objectives will be further strengthened by our participation in a teaching and research project with Deakin University called the Tri-Focal Model of Care, which is an evidence-based best practice program in line with a person centred care service model.

Primary and Preventative Health

"A diverse range of services were delivered by the Primary and Preventative Health Division in the last 12 months with over 11,000 client events."

Achievements

- Enhancing partnerships with consumers
- Further expansion of the Care Coordination model and recognition by Department of Health
- Improved linkages with indigenous health services provided through research, outreach programs, employment support and cultural training
- Telehealth pain clinic trial
- Improved Dental waiting times
- Redesign of Allied Health roles and increased student placements
- Enhancement of cancer services and chronic diseases
- Implementation of Preventative Health Plan
- Awards – Finalist VHA Award 2011 and Premier's Primary Care Service of the year finalist

Partnering with Consumers

Over the last 12 months, a network of consumers and carers who are interested in participating in quality activities including those to design, implement and evaluate service activities was established.

Consumers/carers can join the network at any time with invitations made via local newsletters, newspapers, community groups and to all clients via the intake process.

This year, 75 consumers/carers participated in formal and informal processes to have their say, via surveys, forums, staff meetings and individual discussions. Very positive feedback was received about the participation processes, particularly the appointment of a consumer to conduct phone surveys with other consumers.

Input included:

- evaluation of new intake processes and client care plan under the Care Coordination model
- identification of 'Home and Community Care' (HACC) client needs in conjunction with Shire HACC staff
- review of a Medical Travel Guide
- review of our Better Health Self-Management program
- user testing of surveys and consumer processes
- review of brochures and other consumer information

Consumer participation in the Care Coordination model was presented at the National Consumers Reforming Health conference in July 2011.

→ Shanalie Marshall-Hume and Trephilia Barker were willing participants in the Indigie Grins research project

Care Coordination Model

Navigating health services can be difficult, particularly for people with complex or chronic needs requiring coordination across multiple services. The WDHS Care Coordination model aims to improve navigation by:

- early identification of client needs
- coordination of care for people with complex and chronic conditions
- improving information flow between services

This has been achieved by enhancing linkages across/between different parts of the system, including acute, primary care, Shire Home and Community Care Services (HACC) and private General Practitioners. This approach was developed using the Wagner Chronic Care framework; Guidelines developed by the Victorian Department of Health (Active Service Model and Health Independence Guidelines) and from best practice identified by the Canadian Quality Council. Much of the model however is unique to WDHS and has been developed around partnering with consumers/carers to design a system that meets their needs.

Changes have been made to:

- reporting structures and inter-agency agreements
- staff roles and functions
- policies and work practices

For consumers, this has resulted in a consistent and proactive approach to identifying their needs and a coordinated response to their care or treatment. Complex or chronic needs are coordinated via a care plan shared between different disciplines, which resulted in increased communication and information sharing.

Progress over the last 12 months includes:

- centralised appointments for all Allied Health departments
- evaluation of the Service First Intake process and co-location of Shire HACC assessment staff
- new client care plan and staff training
- increased care coordination and follow up of diabetes clients
- introduction of intake form at pre-admission
- enhanced information sharing with Practice Nurses at Hamilton Medical Group enabling improved care for diabetes clients
- introduction of a 24 hour follow-up phone call to patients discharged via the Discharge Planning Unit

Outcomes:

- 45% increase in the number of diabetes clients seen
- 70% increase in the number of diabetes clients with a care plan and active clients reviewed in timeframes consistent with National Guidelines for Diabetes Management
- 30%-40% of clients received additional follow-up assistance and service referral as a result of Service First Intake
- Feedback has revealed that consumers regard the new Service First Intake as easy, timely and of great assistance in identifying their service needs. One hundred percent of consumers surveyed reported that the process significantly assisted them
- Evaluation of the co-location of Shire HACC assessment staff and WDHS Discharge Planners has reported an 80% improvement in client outcomes due to communication improvements between staff, resulting in improved knowledge of services and individual client needs

The Care Coordination model has been received positively at regional, state and national conferences. Regular requests to speak and 18 different agency contacts in 2011/2012 are indicative of the interest it has created. The high regard is also indicated by:

- inclusion as a case study in the Victorian Rural/Regional Health Plan 2012-2022
- finalist in the Victorian Healthcare Association's Health Award 2011
- funding support from the Department of Health Regional office to transfer the principles of the model to other health services in Barwon - South Western Region

Indigenous Health

Welcoming place

Monthly morning teas and informal discussions have ensured linkages continue to develop with Winda Mara Aboriginal Corporation. Two artworks have been installed in our reception areas at Frances Hewett Community Centre and the Allied Health Building. Winda Mara presented the artworks in recognition of our shared commitment to improving the health of our Indigenous community.

Research

A 12 month, 'Indigie Grins' research project evaluated the outcomes of an educational intervention on the oral health status of a sample of Indigenous children aged five to 12 years. The project was funded by Dental Health Services Victoria in collaboration with the University of Melbourne and Winda Mara.

→ WDHS Men's Health Coordinator, Stu Willder and Iluka staff involved in the Health Education Program

Seventeen children participated in pre and post clinical assessments with WDHS Dental Therapist, Joanne Nelson, and an educational program with WDHS Men's Health Manager, Stuart Willder and Winda Mara staff. The results, now published, show an improvement in oral health status, including reduction in gum disease and tooth decay. Local community member, Rebecca Grey, designed motifs on toothbrushes and brushing charts and timers, proving to be simple but effective ways to engage the children in oral health messages. Presentations on the 'Indigie Grins' Project have included a Dental Health Services Victoria research Showcase seminar in March, and the Victorian Aboriginal Health Conference in May 2012.

Ongoing research opportunities to further develop a larger sample and control group are being considered.

Podiatry and Dietetic Services

Podiatry and dietetic services have been provided on a three to four weekly basis to the Winda Mara community, funded by Rural Workforce Agency of Victoria. WDHS clinical staff, Sophie Roberts, Jess Nobes and Phuong Huynh welcomed the opportunity to work with Indigenous clients at Winda Mara community house or within the Allied Health facility.

Aboriginal Employment Plan

Tammy Barker will commence a Certificate III in Allied Health Assisting via funding from the Department of Health, providing a welcome opportunity to support the up-skilling of staff. Other actions under the Aboriginal Employment Plan include the involvement of staff in cultural training and potential mentoring opportunities.

Other highlights

Telehealth Trial – Pain Clinic Trial

Patients suffering from chronic pain have few options to access specialist services, other than travelling long distances. A Telehealth trial has commenced to link local patients by video to a pain specialist in Melbourne. This is coordinated by a WDHS chronic pain nurse and the patient's local GP.

Dental wait list

The adult dental wait list has been reduced from 25 months to 15 months, the lowest rate for over 10 years and due to a visiting dentist from Melbourne providing a mix of public and private services. Business planning for a sub-regional workforce model is working towards achieving a sustainable dental service.

Allied Health workforce review

A review of Allied Health assistants has identified ways to enhance the use of these vital roles. A new assistant role was introduced into podiatry in February 2012 to increase the capacity of the podiatry team to meet service demand. The review will also result in an increase in Allied Health assistants working across a variety of disciplines.

Cancer Services and Chronic Disease

Ninety two clients received support from WDHS Cancer Link Nurse, Jane Sharp, in the second year of the Cancer Link service funded by the Barwon South West Integrated Cancer Service (BSWRICs). The service assists in providing information on the range of services and support available for cancer patients and their families.

State Government funding will expand cancer support under a Cancer Survivorship pilot project over 18 months in conjunction with Barwon Health, and aims to assist with the ongoing needs of cancer patients as they complete their treatment.

→ Mum and children enjoying the chance to learn to swim with the Young Mum's program

→ Holiday program-learn to surf lessons at Port Fairy program

Hospital Admission Risk Program - HARP continues to achieve strong results in reducing rates of admission and Emergency Department presentations for those with a chronic condition. Eighty nine clients and their carers have been supported to deal with the complexity of their condition. The program has achieved a 46% reduction in presentations to the Emergency Department and a 58% reduction in readmission rates to hospital.

Preventative Health

Implementation of a three year Preventative Health Plan has commenced with a focus on increasing physical activity, healthy eating and social connection. Some of the activities include:

Workplace Health

Three workplaces participated in the highly successful 'Health Education Program' delivered by Men's Health Coordinator, Stuart Willder. This includes:

» Wannon Water - with 89% of their 200 employees in Hamilton, Warrnambool and Portland

» Iluka resources – with 70% of staff at Hamilton, Douglas and Ouyen

» Murray Goulburn Dairy Corporation

The 'fee for service' program incorporates practical education sessions, clinical support and in depth health assessments. Evaluation has been very positive with 100% of employees reporting benefits to themselves and the workplace.

Men's and Women's Health Clinics

A fortnightly Men's Health clinic at Hamilton Medical Group has been operating since February 2011. To date, 100 men have received preventative health assessments by Stuart Wilder with proactive referral to their GP, as needed. Funded under the Medicare Benefit Scheme or by WDHS' Men's Health program, this clinic is reducing barriers to accessing health assessments for local men.

In its 10th year of operation, the weekly Well Women's Clinic provides pap smears and other women's health services by a visiting GP and Women's Health nurse, Sue Watt. Additional evening sessions have been introduced this year enabling greater access, particularly for working women.

youth4youth

A range of activities organised by WDHS Youth Services Coordinator, Briana Picken, have enabled a diversity of young people to participate in our youth4youth programs this year. Activities include:

» The 'Lights, Camera, Action!' project funded by Optus involving 70 young people. Activities included workshops and skills development in filming, editing and promotions with final presentation of their stories at a community film festival. The project was chosen to feature in Optus' national television advertising

» Engagement with Young Mums has provided support, fun and service linkages to 15 young mums aged between 18 and 21. Grant funding has enabled a range of activities, including a professional photo shoot of mum and baby with a treasured framed photo to take home

» Holiday programs – with 485 participants in 25 different activities, including paintballing, laser strike, learn to surf sessions, ice skating, visits to Melbourne and Adventure Park Geelong

» Five FreeZa events and weekly Zumba sessions

» Partnership and planning activities with other youth services, employment, education and Southern Grampians Shire has commenced the year with a coordinated effort towards positive outcomes.

Our youth4youth program was successful in securing a $120,000 State government grant to support its activities for the next three years. These funds are complemented by an annual donation from Dr Geoff Handbury AO to ensure that young people in our Shire are provided with a complete range of health, wellbeing and recreational activities.

Community Kitchen

This year the Dietetics Department piloted a Community Kitchen with the Hamilton Community Church. Community Kitchens aim to increase social connection and healthy eating. The eight week pilot involved six people who came together on a regular basis to socialise and cook affordable and nutritious meals. Participants reported positive outcomes with the following changes being reported by participants as a result of their participation:

» 60% increased their fruit and vegetable intake

» 100% increased their knowledge of healthy eating

» 80% increased confidence to meet new people

Plans are underway to continue the initiative.

Heatwave Response

Heatwaves can have serious impacts on those who are elderly and chronically ill due to a reduced ability to regulate their body temperature. As a result, a coordinated plan has been established to educate and prepare elderly and chronically ill clients to respond to heatwaves.

Health workers make contact with vulnerable clients during heatwave conditions to ensure they are taking necessary actions to maintain their health. This includes clients in our Hospital Admission Risk Program (HARP) and Adult Day Activity Support Service (ADASS).

National Centre for Farmer Health

→ The NCFH Agricultural Health and Medicine, Hamilton Class of 2012

The National Centre for Farmer Health (NCFH) is a Hamilton-based partnership between WDHS and Deakin University encompassing university research, service delivery and education, providing national leadership to improve the health, well-being and safety of farm men and women, farm workers and their families.

The NCFH is funded by the Victorian State Government and the Helen and Geoff Handbury Trust.

Major achievements of the centre over the past year include continued delivery and expansion of the Sustainable Farm Families™ program nationally, finalisation and development of new research projects, our inaugural Graduate Certificate Agricultural Health and Medicine (GCAHM), development of VET sector competencies in agricultural health, expansion of **www.farmerhealth.org.au** and planning for the 2012 biennial Farmer Health conference.

The NCFH also continues to play an active role in promoting farmer wellbeing and safety at many events from local major events such as Sheepvention and Hamilton Weaner Sales to guest speaking at international conferences in Melbourne, New Zealand and Mexico.

Sustainable Farm Families™
The most important aspect of a healthy Australian farm? A healthy farming family

Achievements
The award winning SFF continues to expand with the delivery of ten flood recovery programs in Victoria. Service delivery will continue in the form of final year workshops as part of the roll out of previous programs and an additional two programs are being delivered as part of some efficiency generated through previous programs. The data pertaining to the SFF programs has also been successfully amalgamated into a single dataset allowing for greater research opportunities.

Future activities include use of new technologies and expanding the program across Australia.

AgriSafe™
The AgriSafe™ clinic has been in operation at the NCFH since February 2011, with many local farmers taking the opportunity to have full occupational health and safety check-ups. Major achievements include the registration of the AgriSafe trademark and the commencement of the AgriSafe network in Australia with the first partnership with Robinvale District Health Services.

Future plans for AgriSafe™ will include expansion of the network across Australia and further promotion of the Hamilton AgriSafe™ clinic.

Professional Training and Education

Achievements
Commencing in 2010, the only Agricultural Health and Medicine subject in Australia has now had 66 students complete the subject. These students have come from every state in Australia to attend the week intensive course based at Western District Health Service. The subject can also provide a credit towards Masters of Public Health, Nursing, Health Promotion or Agriculture which has added to its appeal and helps to broaden the knowledge of Agricultural Health into other disciplines. In 2012 the NCFH partnered with Queensland Rural Medical Education to deliver Agricultural Health and Medicine under contract to rural general practitioners. This partnership has been positive with further development underway to include the subject as a core part of rural GP's study. Further development has now seen the first post Graduate Certificate in Agricultural Health and Medicine in Australia being accredited and offered through Deakin University, School of Medicine with first graduates expected in 2012.

An exciting new area for the NCFH is also developing units of competency in agricultural health for students in the vocational and education training (VET) sector. This project funded by the Department of Health Victoria is being piloted with Rural Industries Skills Training (RIST), Hamilton.

The NCFH also broke new ground in getting better medical services for rural and remote areas, with Victoria's only regional placement in the Australasian Faculty of Public Health Medicine's (AFPHM) Specialist Training Program.

Future activities will include the growth and expansion of professional training and education at all levels to improve skills,

knowledge and competencies in farmer health, well-being and safety to the highest level.

Applied Research and Development

Achievements
This year has been very busy with a number of research projects being completed and new projects commencing

Projects that have been completed include:

» Farming fit research project (beyondblue research grant)

Projects that are still in progress include:

» Sustainable Dairy Farm Families™ - Future Directions 2010 - 2012 (Geoffrey Gardiner Foundation and Colac Community Enterprise)

» Alcohol Intervention Training Program (Australian Research Council)

Two manuscripts were published in peer reviewed journals

1. Brumby, S., A. Chandrasekara, S. McCoombe, S. Torres, P. Kremer, and P. Lewandowski, Reducing psychological distress and obesity in Australian farmers by promoting physical activity. BMC Public Health, 2011 11(1): p. 362
2. Brumby, S., A. Chandrasekara, S. McCoombe, P. Kremer, and P. Lewandowski, Cardiovascular risk factors and psychological distress in Australian farming communities. Australian Journal of Rural Health 2012, 20(3): 131-137

Two exciting new research projects have commenced:

» Shhhearing in a farm environment (National Health and Medical Research Council), this project is being delivered in partnership with Australian National University and National Acoustics Laboratory. This projects looks at early intervention hearing services for farming families

» Active farming (Arthritis Victoria) this project aims to ascertain the baseline data, quality of life and health status including medications and out of pocket costs of farmers with arthritis and musculoskeletal conditions, and secondly to assist participants in their management of arthritis

→ NCFH Research Fellow Ananda Chandresekara performs health checks at Hamilton Weaner Sales

→ NHMRC Shhh hearing Research Assistant, Heidi Mason and Dr Anthony Hogan check farmers hearing at a Casterton workshop

Farmer Health Website **www.farmerhealth.org.au**

Achievements
The number of visits to the Farmer Health website has seen an increase of 45% in traffic since the website first went live in April 2010. Farmer focused topic pages relating to health, well-being and safety remain popular along with Sustainable Farm Families™, and conference information pages.

The Farmer Health website has an ongoing partnership with Better Health Channel as a content partner and maintains accreditation from the international Geneva based, non-profit, non-governmental organisation, Health on the Net (HON). Visitors to the website can be assured that processes and standards are in place to ensure that Farmer Health delivers quality health information online.

Southern Grampians & Glenelg Primary Care Partnership

Primary Care Partnership (PCP) Members:

- ASPIRE, a Pathway to Mental Health Inc
- Balmoral Bush Nursing Centre Inc
- Brophy Family & Youth Services Inc
- Casterton Memorial Hospital
- Community Connections (Vic) Ltd
- Dartmoor & District Bush Nursing Centre Inc
- Dhauward Wurrung Elderly & Community Health Services Inc.
- Glenelg Shire Council
- Hamilton Community House Inc
- Heywood Rural Health
- Kyeema Centre Inc
- Mullerateronq Centre Inc
- Old Courthouse Community Centre Inc
- Otway Division of General Practice Inc
- Portland District Health
- Portland Neighbourhood House Inc
- Southern Grampians Shire Council
- South West Healthcare (Psychiatric Services)
- Western District Health Service Hamilton, Coleraine and Penshurst campuses
- WindaMara Aboriginal Corporation

Overview

In the midst of a changing environment with the National Health agenda to establish Medicare Locals including a Great South Coast Group, SGGPCP has adapted and built new partnerships to achieve better outcomes for our community.

Our priority themes for keeping people well by undertaking integrated health promotion planning and activities continue:

- physical activity
- food security – access and affordability
- social connection
- oral health
- transport

Five working groups continue to meet and plan for collaborative health promotion across our catchment.

Achievement Highlights

Great South Coast Medicare Local

In April 2012, advice was received that the submission for the Great South Coast Medicare Local (GSCML) was successful. The GSCML will improve information about local health care systems, better coordinate primary health care services and find solutions to health care gaps in the region.

A consortium of the Otway Division of General Practice, Southern Grampians Glenelg Primary Care Partnership and the South West Primary Care Partnership developed the successful submission to gain Federal funding for the new organisation.

The Great South Coast Medicare Local will cover the LGAs of Corangamite, Glenelg, Moyne and Southern Grampians Shires and Warrnambool City Council.

This success is the culmination of tireless effort and significant contribution from agencies across the region.

In summary, Medicare Locals will be responsible for a range of functions, including:

- making it easier for patients to navigate the local health care system
- providing more integrated care
- ensuring more responsive local GP and primary health care services that meet the needs and priorities of patients and communities
- making primary health care work as an effective system as part of the overall health system

The GSCML will commence operations on 1st July 2012.

Increasing Energy Efficiency

SGGPCP continues its local action on climate change through the Pass the Parcel project, funded through the Victorian Government Sustainability Fund, which is an innovative project to assist residents across the Glenelg and Southern Grampians Shires to save money by being more energy efficient. Over the past two years, Pass the Parcel has engaged over 370 community members so far who have passed a package of information containing an ''i-button'' (an in-home temperature data logger) and sustainability information or attended workshops and information sessions. Through this project, SGGPCP is partnering

→ **PCP Project Officer, Abbie Lawrence, at the Bike Valet service as part of the Southern Grampians Sustainability Expo**

with RMIT University to investigate the findings from this methodology and inform future local adaptation projects.

Telehealth

SGG PCP is undertaking a scoping project, called Virtually Healthy: Making Telehealth Happen, which will develop detailed plans for initiatives that can be undertaken within the region to progress the implementation of teleconsultations. In addition, a summary of current state and federal funding, existing telehealth initiatives in the Southern Grampians and Glenelg Shires and examples of initiatives in use in other Primary Care Partnership catchments have been compiled.

Broadly applied, the term telehealth applies to the use of telecommunications to share healthcare services and information. In the Great South Coast, clients with chronic conditions stand to benefit the most from the development of telehealth initiatives. In 2011, the Federal Government announced that financial incentives would be available through Medicare to eligible practitioners and aged care services who help patients participate in a video consultation with a specialist, consultant physician or consultant psychiatrist.

SGGPCP member agencies were invited to participate in the project by helping to identify opportunities, barriers and challenges to implementing telehealth initiatives in

→ The PCP team - Back row L-R: Robyn Holcombe, Office Coordinator; Claire Nailon , Project Officer; Janette Lowe, Executive Officer; Nathalie Davis, Project Coordinator. Front row L-R: Jenny Williams, Project Officer; Emma Woolley, Project Officer; Rowena Wylie, Project Officer; Jo Brown, Team Leader; Penny Fraser, Project Officer; Absent- Erin White

their local areas. Selected members are also invited to work with SGGPCP to develop plans for local solutions. Six agencies were successful and workshops are underway with all participating agencies. These workshops will be used to formulate a project plan for implementation from July 2012.

Get Active Glenelg2Grampians

In February 2011, the SGGPCP developed a collaborative application titled ''Get Active Glenelg2Grampians'' for the Federal funding for the Healthy Communities Initiative on behalf of Glenelg and Southern Grampians Shires. It was announced in May that this application for $703,000 over two years had been successful. The project officially commenced in August 2011 and progressed its establishment phase and undertaking of further detailed planning with all partners. The SGGPCP co-ordinates the delivery of the project across both Shires, ensuring involvement with a broad range of partners.

Project Aim: To increase healthy eating and physical activity of the target groups within the Glenelg and Southern Grampians Shires.

Target groups:

- adults not in the paid workforce that includes:
- recently or long term unemployed
- Aboriginal and Torres Strait Islander background
- people with a disability and carers
- people at risk of weight-related chronic disease
- residents in the locally identified low socio-economic status areas

Most recently, the project has commenced a Community Kitchen in Hamilton, a 10 week pilot program that provides participants with skills and knowledge regarding healthy and affordable ways to improve eating habits. An eight week Health Eating Active Living Program has been delivered at Heywood with 15 participants, who are now driving new initiatives in Heywood to continue to support their behaviour changes.

For further information regarding the SGG PCP, go to **www.sggpcp.com**

Corporate Governance

→ WDHS Board members L – R: Mark Stratmann, Ian Whiting, Lisa Robertson, Hugh Macdonald, Jenny Hutton, Mark McGinnity and Mary-Ann Brown (President)

WDHS was incorporated in July 1998 under The Health Services Act 1988 and is governed by a seven-member Board of Directors (BOD), appointed by the Governor in Council upon the recommendation of the Minister for Health.

Board structure, role and responsibilities

BOD terms of appointment are usually three years, with one third of terms expiring in June each year. Members are eligible for reappointment.

BOD members serve in a voluntary capacity. The balance of skills and experience within the BOD is kept under continual review. The BOD orientation and evaluation process introduced in 2003 was continued in the 2011/12 year and has assisted greatly in evaluating the effectiveness and performance of the Board Chair, individual Directors and the Board as a team. All current Board Members have undertaken additional governance training.

The BOD is responsible for the governance and strategic direction of the Service and is committed to ensuring that the services WDHS provides comply with the requirements of the Act and the Objectives, Mission and Vision of the Service, within the resources provided. In the course of their duties, the BOD and Executive may seek independent advice from a range of sources. The BOD reviews operating information monthly in order to continually assess the performance of WDHS against its objectives and is also responsible for appointing and evaluating the performance of the Chief Executive Officer. In order to ensure the effective operation of the BOD, the Board has membership on 10 committees, which meet as required and report back to the BOD.

Board of Directors

Mary-Ann Brown
BEcs(Tas),GradDipLibSc(KCAE), MBA (Newcastle)
Mary-Ann lives on a Merino sheep stud at Dunkeld and is the office manager of financial planning firm, Robert W Brown and Associates. She is Chairperson of the Dunkeld Community Centre Committee, member of the Performing Arts Centre Advisory Committee and Dunkeld Visitor Information Centre volunteer. Appointed to WDHS board in November 2002, current term expires 30 June 2015.

Jenny Hutton B.Ed
Jen is Director of Community Relations and Development at The Hamilton and Alexandra College. She is actively involved in fundraising in the community having been involved recently in the Grange and Mulleraterong fundraising appeals. She is the Regional representative on the Vic/Tas Executive Committee of ADAPE (Association of Development and Alumni Professionals in Education). Appointed to WDHS Board in November 2002, current term expires 30 June 2015.

Hugh Macdonald BBacc
Hugh is Regional Manager Hamilton and Director for the Southern Financial Group. He has worked in the finance industry since 1982. Hugh is Chairman and Director of The Hamilton and Alexandra College Foundation, a trustee for The Hamilton and Alexandra College Old Collegians, and President of the committee of the Hamilton Regional Business Association, and member of the National Centre for Farmer Health since its inception. He is a past President of the Hamilton Race Club, and Hamilton Junior Basketball Association. He chaired the Hamilton Indoor Leisure and Aquatic Centre Fundraising Committee. Appointed to WDHS Board in November 2006, current term expires 30 June 2015.

Mark Stratmann BA Dip T, LLB, JP
Mark is principal of Stratmann & Co Lawyers. He has a background in education and has been practicing law since 1999. Mark and his wife Sally have four sons and a daughter. He is currently a Board Member of the WestVic Division of General Practice and a past board member of Monivae College Limited. Mark and his family have lived in Hamilton for twelve years after relocating from Melbourne. Appointed to WDHS Board on 01 July 2010, current term expires 30 June 2013.

Lisa Robertson Dip Des
Lisa is currently studying a Bachelor of Nursing/International Development (RMIT) and has been involved in small business in Hamilton and heavily committed to the South West community through volunteer activities. Lisa was the Chairperson for 'Kids at Risk' council, Victorian rural/regional liaison officer for the MS Society, Chairperson RMIT Collective Arts Collaborative, State Federal representative for South West community events/programs, fundraising coordinator for the Anti-Cancer Council in the Western District and a participant in the Standing Tall program. Appointed to WDHS Board on 22 March 2011, term expires 30 June 2013.

Mark McGinnity
BA (Behav Sc), Dip Teach (Science), Dip Rel Ed, M Ed (Teach & Curric), MACE, MACEL.
Mark is currently Principal of Monivae College and a member of the College's Board of Directors. Mark is Chair of the Board of

Management of the Hamilton District Skills Centre, a member of the Parish Pastoral Council of St Mary's Parish Hamilton, Chair of the Ballarat Diocesan Secondary Principals Group, and a member of the RMIT Hamilton Advisory Group. Mark is also a member of the Association of Heads of the Independent Schools of Australia and the Principals' Association of the Victorian Catholic Secondary Schools. Appointed July 2011, current term expires June 2014.

Ian Whiting
Ian recently retired from farming after 25 years in primary production and lives on a property at Branxholme with his wife Sally. Ian is Managing Director of Bassett Estate Pty Ltd and currently employed as a Rural Correspondent with the Hamilton Spectator. Ian is President of the Morven CFA Rural Fire Brigade, Chair of the Branxholme Progress Development Group Fundraising Committee and was Chair of the Top of the Town Charity Ball 2010. Ian was Deputy Chair of the South West Academy of Sport, VCFL Regional Manager South West Border and Chair of the VCFL South West Border Regional Board. He is a past President of the Hamilton Junior Football League and College Magpies Junior Football Club, a past Founding President of the Smokey River Landcare Group and past Captain of the Morven CFA RFB. Appointed to the WDHS Board on 01 July 2011, current term expires 30 June 2014.

Governance Statement

"The Board is a strong advocate of corporate and clinical governance and seeks to ensure that the Health Service fulfils its governance obligations and responsibilities to all its stakeholders."

The Board is committed to:

- sound, transparent corporate governance and accountable management
- provision of high quality and innovative care, reflective of its Mission and Vision
- conduct that is ethical and consistent with the Health Service values and community values and standards
- management of risk and protection of health service staff, clients and assets
- due diligence in complying with statutory requirements, acts, regulations and codes of practice
- continuous quality improvement, innovation and research

Ethics
Board members are required by the Health Services Act, 1988 to act with integrity and objectivity at all times. They are required to declare any pecuniary interest or conflict of interest during Board debate and to withdraw from proceedings if necessary.

There were no instances requiring declaration this year.

Executive Role
The members of the Executive Team are Chief Executive Officer, Deputy CEO/Director of Corporate Services, Director of Medical Services, Director of Nursing, Director of Primary and Preventative Health, Human Resources Manager, Manager/Director of Nursing, Coleraine Campus, Manager/Director of Nursing, Penshurst Campus, Director, National Centre for Farmer Health

The Executive met 25 times during the year, providing regular reports to the BOD.

Risk Management
Risk management is an all of organisation activity and requires appropriate action to be taken to minimise or eliminate risk that could result in personal injury, damage to, or loss of assets.

During 2011/12, WDHS in partnership with our insurer, WMIA conducted a risk management framework review as an independent assessment of the maturity of our risk management strategy.

A total of nine recommendations have been adopted including the updating of our Risk Management Framework policy to support the improvement of risk management across the organisation's programs. An important part of the review was the provision of education for key staff throughout WDHS through VMIA.

Attestation on Compliance with Australian/New Zealand Risk Management Standard
I, Jim Fletcher, certify that the WDHS has risk management processes in place consistent with the Australian/New Zealand Risk Management Standard and an internal control system is in place that enables the executive to understand, manage and satisfactorily control risk exposures. The audit committee verifies this assurance and that the risk profile of the WDHS has been critically reviewed within the last 12 months.

Jim Fletcher

CHIEF EXECUTIVE OFFICER
Hamilton

09 August 2012

BOARD MEMBER	BOARD MEETINGS ATTENDED	COMMITTEE MEMBERSHIP AS AT 30 JUNE 2012	COMMITTEE MEETINGS ATTENDED
Mary-Ann Brown	10 of 11	Audit & Compliance Community Advisory Medical Appointments Advisory Medical Consultative Remuneration	3 of 4 1 of 1 1 of 2 3 of 4 1 of 1
Jenny Hutton	10 of 11	Community Advisory Development Council Medical Appointments Advisory Penshurst Advisory	3 of 4 6 of 6 2 of 2 3 of 6
Hugh Macdonald	10 of 11	Development Council Medical Consultative Project Control Remuneration	4 of 6 1 of 1 11 of 11 1 of 1
Mark McGinnity	8 of 11	Development Council Medical Appointments Advisory Quality Improvement	6 of 6 2 of 2 5 of 6
Lisa Robertson	9 of 11	Community Advisory Project Control Quality Improvement	2 of 2 1 of 1 4 of 6
Mark Stratmann	9 of 11	Audit & Compliance Quality Improvement Remuneration	3 of 4 6 of 6 1 of 1
Ian Whiting	9 of 11	Audit & Compliance Project Control	3 of 4 10 of 11

Committees of the Board

Audit and Compliance Committee
Advises the BOD on all aspects of internal and external audits, financial and asset risk, accounting procedures, financial reporting, and compliance with statutory requirements

Four meetings were held during the year.

Jodie Missen and Tim Pietschmann were the external committee representatives. The committee received an internal audit report on the risk assessment for the implementation of the new Patient Record System, adopted a revised procurement and contract management policy and manual and audit and compliance charter. Committee members also participated in the VMIA risk framework quality review.

Medical Appointments Advisory Committee
Advises the BOD on appointments, reappointments, suspensions and terminations of visiting medical practitioners.

Two meetings were held during the year.

Medical Consultative Committee
Makes recommendations on matters relating to medical staff and clinical services provided, and ensures effective communication between the Board, Senior Management and the Medical Staff Association.

Four meetings were held during the year.

Quality Improvement (QI) Committee
Provides support and direction for Continuous Quality Improvement and performance monitoring. Ensures systems are in place for internal/external review. Ms Chris Phillips is the community representative.

Six meetings were held during the year.

Development Council
Oversees and guides WDHS fundraising strategy. The Council operates in compliance with the Fundraising Appeals Act 1984.

Rachel Malseed, Philip Baulch, Vicki Whyte, Megan Campbell, Renae Porter, Libby MacGugan and Lisa McIntosh) were the community members on the committee in 2011/12.

Six meetings were held during the year.

Penshurst (PDHS) Advisory Committee
Reviews operation, performance and strategic planning for the Penshurst campus.

Community representatives are:

Tom Nieuwveld, Les Paton, Wendy Williams, Margaret Eales, Jennifer Kinnealy, Mary Johnson, Don Adamson and Western District Health Service Board Member Jen Hutton.

Six meetings were held during the year.

Coleraine (CDHS) Management Committee
Reviews operation, performance and strategic planning for the Coleraine campus.

Community representatives are Ron Jones, Sandra Adams, John McMeekin, Gabrielle Baudinette, John Northcott, Grant Little, Alan Millard and Anne Pekin.

Six meetings were held during the year.

Community Advisory Committee
Provides consumer views and advice to the Board on planning, implementation and evaluation of health services.

Kay Scholfield, Rev. Peter Cook, Chris Phillips, Dorothy McLaren and Sherryn Jennings were the community representatives.

Four meetings were held during the year.

Project Control Committee
Makes recommendations on the design, management and construction of major building projects.

Eleven meetings were held during the year.

Remuneration Committee
Oversees and sets remuneration policy and practice for Executive staff, under the principles of the Government Sector Executive Remuneration Panel.

One meeting was held during the year.

→ **NCFH Director, Susan Brumby, Heidi Mason, Research Assistant and Mark Newell, Advanced Trainee in Public Health Medicine with a new Audiometer provided via a 'Shh, hearing grant' from NHMRC**

Executive Team

Chief Executive Officer

JIM FLETCHER BHA, AFCHSE, CHE, MIPAA

Jim has held a number of senior executive positions within the human services field across the Loddon Mallee, Grampians, Northern Metropolitan and Barwon South Western Regions. His background includes the role of Chief Executive Officer at three of the State's largest regional psychiatric hospitals and community services, leading these agencies through significant reform and change. Jim commenced as CEO of WDHS on July 17, 2000. Jim is Chair of a number of sub regional committees.

Deputy Chief Executive Officer, Director of Corporate Services

PATRICK TURNBULL BBus, BHA, FCPA

Patrick has been with Hamilton Base Hospital since 1982. He has been the Hospital's principal accounting officer since 1987 and was appointed to his current role in 1993. Financial and business support of patient services is managed through the Corporate Services Division. Among Patrick's commitments with WDHS are his roles as Chair of the SWARH Finance Sub-Committee and the FMIS Rural Alliance Implementation Committee.

Director of Nursing

JANET KELSH RN, ICUCert, BAppSci (NAdmin),CertMgt (Deakin), GradDipAgedServicesMgt, MRCNA

Janet commenced her role as Director of Nursing at Hamilton Base Hospital in 1987. With experience in New Guinea and London, Janet worked predominantly in intensive care and neurosurgery in a number of major city hospitals across Australia and overseas before moving to Hamilton. Janet represents WDHS on a number of regional committees, including palliative care, infection control, sub acute rehabilitation and nurse education through collaborative relationships with a number of Universities.

Director of Primary and Preventative Health

ROSIE ROWE BNatRes, MBA

Rosie was appointed as Director in May 2009. Prior to this appointment, Rosie was the Deputy Director of Community Services from October 2008 and for five years, the Executive Officer of Southern Grampians and Glenelg Primary Care Partnership. She has held senior positions in both the public and private sectors, including in natural resources and telecommunications. She is a graduate of the Department of Health's 2011 Executive Program.

→ WDHS Executive members L-R Patrick Turnbull, Rosie Rowe, Alastair Wilson, Jim Fletcher, Janet Kelsh, Sue Brumby, Hilary King, Tim Pitt-Lancaster and Alastair Doull

Director of Medical Services (DMS)

ALASTAIR WILSON BScMB. ChB.,FRNZCGP,DipObst.,Dip.Occ.Health,Dip. HSM

Alastair Wilson was a general practitioner in Wanganui, New Zealand for 24 years during which he achieved post graduate diplomas in obstetrics, occupational health and health service management. He also developed interests in adolescent health and minor surgery. After leaving general practice in 2003, he was appointed to a number of clinical management roles in primary care, hospitals and workplaces. In 2007 he was appointed the Corporate Medical Advisor for the Accident Compensation Corporation in NZ, including the clinical management role. He joined Western District Health Service in May 2011.

Director, National Centre for Farmer Health

ASSOCIATE PROFESSOR SUSAN BRUMBY RN, RM, DipFMgt, GradDipWomen's Studies, MHMgt, CertIV Workplace Trainer, AFCHSE, MRCNA, PhD in progress

Sue commenced as founding Director of the National Centre for Farmer Health in November 2008 – a partnership between WDHS and Deakin University. The centre focuses on education for rural professionals, farmer health research, service delivery, specialist clinics aimed at farm men and women and dissemination of information through www.farmerhealth.org.au.She has continued as Principal Investigator with the award winning Sustainable Farm Families project and has presented and published on farmer health throughout Australia and internationally. Previously she was Director of Community Services at WDHS from 2002 where she oversaw the introduction of new and innovative service delivery models for consumer involvement and health promotion. Sue is a graduate of the Australian Rural Leadership Program.

Human Resources Manager

HILARY KING MBA, Grad Dip HRM, Dip Physio, CAHRI

Hilary commenced work at WDHS in October 2007. She had previously worked at Alcoa in Portland in a broad range of Human Resource, safety management and production roles. Hilary has extensive experience in conflict resolution, diversity management, mentoring and coaching and management development. Hilary has worked as a physiotherapist and rehabilitation consultant for State and Federal governments.

Coleraine Manager/Director of Nursing

TIM PITT-LANCASTER RN BN Cert Perioperative Nursing, GradDip Nursing Science

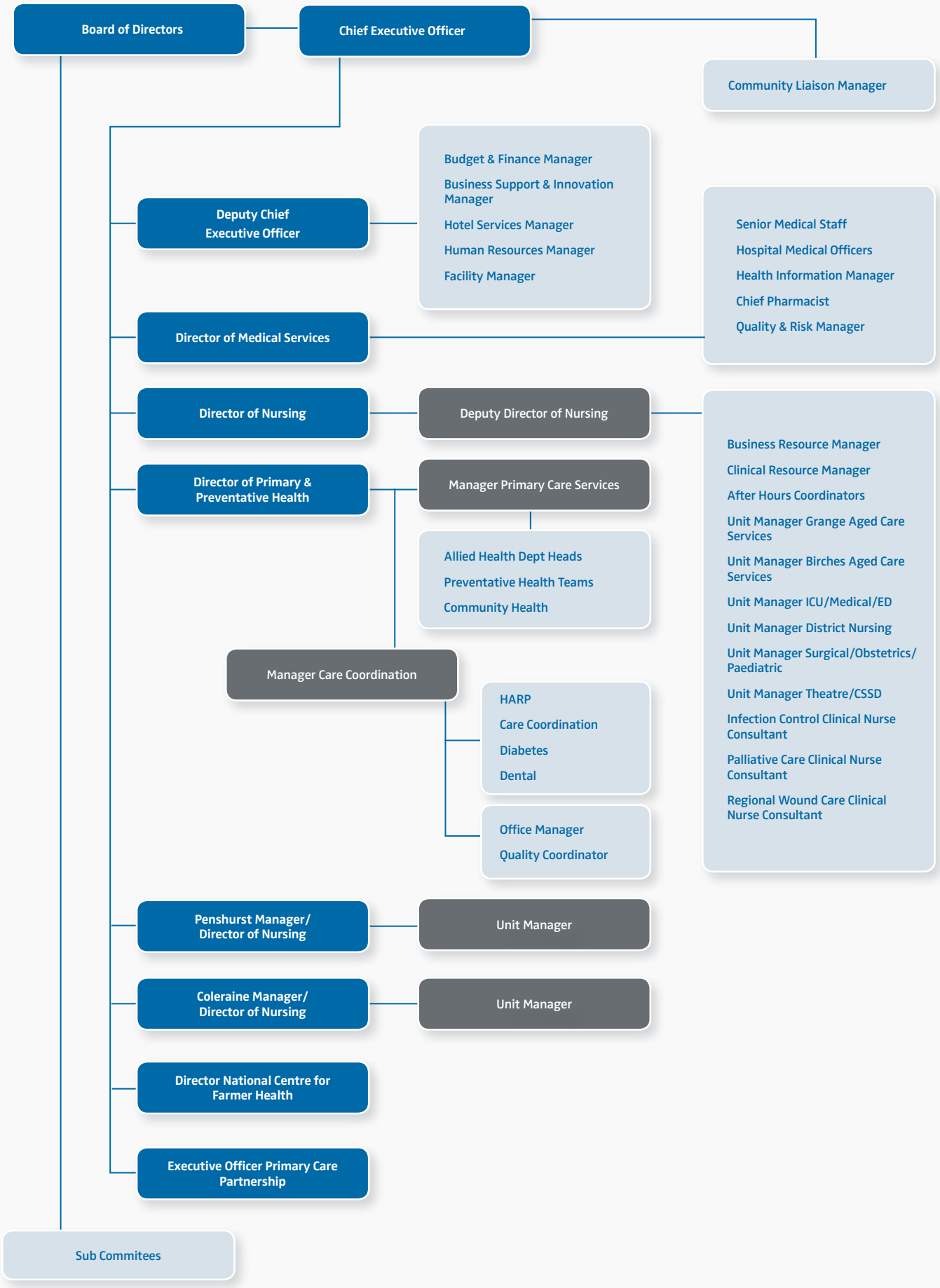
Tim commenced his role in Coleraine in July 2005. Prior to this appointment Tim was the Nurse Unit Manager of the Operating Theatre Suite of the Mount Gambier and District Health Service, a role he filled from 1998 to 2005. During 2005, Tim was also the Acting Director of Nursing and Patient Services of the Mount Gambier Hospital.

Penshurst Manager/Director of Nursing

ALASTAIR DOULL RN MBA

Alastair commenced his role at Penshurst in March, 2011. He has worked in a range of acute, and community healthcare settings as well as Residential Care. Just prior to Penshurst he worked in Portland overseeing the Aged Care Services of Portland District Health. He has also held senior positions in both public and private sectors including Residential Aged Care and Community Health.

Organisational Structure



Our people in the workplace

→ WDHS Employees of the Month for 2011/2012 are L-R Tracey Hatherall, Erika Fisher, Donna Spong, Ruth Fatone, Demogene Smith, Fran Patterson, Lorraine Hedley, Craig Richardson and Darren Mulley Absent are - Maryann Howard, Rhonda Hamilton, Ian Powlton, Tania Stubbs

Strategy

» attract and retain high performing staff committed to the Vision, Mission and Values of the Health Service

» provide an environment for motivating and encouraging staff to develop and use their skills to enhance the health, well being and safety of our community

Achievements

» development and launch of the 2012-2017 Human Resource Strategic Plan

» successful recruitment to Physician, GP Obstetrics and Specialist Obstetrician and Gynaecologist positions

» implementation of Health and Wellbeing Workforce programs

» continuation of work experience placements and careers forums

» participation in the College of Health Service Executives Residency Programs

» staff recognition awards

» implementation of education and learning strategy including clinical placements, continuing education and graduate programs

» completion of orientation for new staff and volunteers

» implementation of Occupational Health and Safety strategy

Future

» implementation of 2012-2017 Human Resources Strategic Plan

» implement workforce and recruitment strategies to support our Strategic Plan

» continued development of healthy workforce initiatives

» implementation of occupational health and safety initiatives

» development of three year learning and education Strategic Plan

HR Strategic Plan 2012-2017

A new five year Human Resources Strategic Plan was adopted by the Board early in 2012.

The strategic imperatives for this next five year Human Resources plan include:

» redesigning and resourcing Western District Health Service for the future

» developing organisational culture and commitment to excellence

» growing research and innovation capability and readiness

» using technology to support client care, staff management and corporate services functions

» developing strategic partnerships to maximise impact

A yearly action plan will be developed and implemented to progress these strategic objectives during the life cycle of the Strategic Plan.

Recruitment

Recruitment and retention of professional staff continues to be challenging for WDHS as it is for most healthcare providers. Recent research by Health Workforce Australia indicates that although the situation in regards to the medical and midwifery workforce seems to be starting to correct itself, major shortfalls in the registered nursing workforce will continue to impact on service provision across rural and regional Australia for the next decade (Health Workforce 2025, Vol. 1)

At the beginning of 2012, both WDHS and the Hamilton Medical Group were very pleased to have secured the services of Dr. Trevor Branken, a very experienced physician who has moved to Hamilton from South Africa. In addition, both WDHS and Hamilton Medical Group were also able to secure the services of Dr. Anita Lindell, a GP obstetrician who has returned to Australia after working in the United States for many years.

Our search for an experienced Obstetrician and Gynaecologist has been successful with a job offer accepted. It is anticipated that the successful applicant will commence late 2012 early 2013. In the meantime we will continue to be well serviced and supported by Dr. Chris Beaton and his Warrnambool team together with our GP obstetricians and we thank all for their assistance throughout the year.

Progress with the recruitment of further physicians in partnership with Hamilton Medical Group is well underway and we expect to make further appointments towards the end of 2012.

Unfortunately, we still have some long term vacancies at the Nurse Unit Manager level. Currently we are recruiting to the Surgical and Theatre positions. In the meantime this has given other senior staff an opportunity

Workforce Profile

LABOUR CATEGORY	% WORKFORCE	FEMALE	MALE	TOTAL 2012	TOTAL 2011	TOTAL 2010	EFT 2012	EFT 2011	EFT 2010
Managers	2.19%	6	11	17	15	17	16.35	15.54	16.67
Professionals	44.27%	297	47	344	313	286	237.5	227.9	215.93
Associate Professionals	12.48%	93	4	97	109	107	69.91	77.84	78.36
Trades & Related Workers	2.83%	6	16	22	24	25	20.03	21.03	20.2
Advanced Clerical/Sales/Service	0.00	0	0	0	5	5		4.2	4.2
Intermediate Clerical/Sales/Service	23.42%	170	12	182	170	173	122.72	119.24	118.94
Intermediate Production/Transport	0.90%	2	5	7	9	10	6.12	7.53	8.88
Elementary Clerical/Sales/Service	1.80%	7	7	14	16	19	11.96	13.53	14.95
Labourers & Related Workers	12.10%	72	22	94	99	94	71.21	66.31	71.84
Total	**100.00%**	**653**	**124**	**777**	**760**	**736**	**555.80**	**553.12**	**549.97**

to step into these roles to determine whether this is a future career option for them. A structured leadership development program for Associate Nurse Unit Managers, Nurse Unit Managers and Registered Nurses in Aged Care should ensure a greater management competency enabling our senior nurses to more easily move to management roles if this is their future career choice.

As expected, WDHS is now starting to see increasing numbers of staff retiring, although fortunately a number are continuing to work beyond the traditional retirement age by considering some of our flexible work options such as casual work, reduced hours or consultancy work. The ageing workforce (60% of our workforce are over 45) reinforces the business case behind WDHS's commitment to business innovation and embracing the use of technology throughout our health service. Less people in the labour market means we have to continue to be smarter at what we do and use our specialist resources more efficiently.

Healthy Workforce Initiatives

The health and wellbeing of our workforce is a key strategy of our HR Strategic Plan. In 2012 all staff were encouraged to participate in free work health checks with 157 staff taking up this opportunity.

A new corporate membership arrangement with the Hamilton Aquatic and Leisure Centre has resulted in an increase in staff memberships and participation in activities at the centre.

Our two Murray to Moyne teams were well supported with over half the riders and support teams coming from staff across our three campuses.

Work Experience Program

During 2011/2012 21 students completed Work Experience at WDHS. Most students completed placements in nursing and allied health. WDHS also offers work experience placements in Administration (finance, public relations and human resources), Maintenance and Community Health. The careers forum was again held for senior regional students in July with an excellent attendance. This is always a great opportunity for students to interact with some of our new graduates to gain a better understanding of the career options in health.

Australian College of Health Service Executives Residency Program

Our support of the ACHSE rural management residency program continued in 2011/12. This program allows for graduate business students to be placed within rural health services and the Department of Health for two years. They are rotated through a range of functions over the two years while they complete their post graduate studies in management. During the second half of 2011, Owen Drummond continued to work with Business Support and Innovation department, completing a 12 month placement at WDHS. Owen was then rotated back to complete his second year at another regional hospital and a six months placement with the Department of Health.

Staff and Volunteer Service Milestones

10 Years

Kelvin Anderson
Mark Atcheson
Shirley Broad
Tamara Barker
Susan Brumby
Leanne Cameron
Rae Christie
Valarie Cooper
Carla DeAngeles
Tonia Evans
Claire Goldby
Hayley Hiatt
Paula Lucas
Margaret Meulendyks
Suzanne Millard
Leah Moore
Monica Neeson
Sharon Oliver
Karen Payne
Jennifer Price
Deidre Spencer
Jennifer Sutherland
Elizabeth Talbot
Michael Taylor
Michelle Walkely
Troy Young

15 Years

Lynette Holden
Sharon Logan
David McCabe
Leanne Porter
Susan Surridge
Carolyn Templeton

20 Years

Katherine Armstrong
Leanne Dyke
Sonja Gould
Walter Joosen
Norman Saligari

25Years

Judy Hammond
Tanya Stubbs
Craig Richardson

30 Years

Neil Bell
Tony Dyson
Kim Hearn
Sally Hicks
Anita Holmes
Karin McRae
Beverley Robinson
Tracy Ross
Wendy Wathen

35 Years

Denise Dyson

→ Flinders medical student, Rory Jago with Nurses Casey Irving and Chiedza Mahanda undertaking training in CPR on mannekin "Big Jack" in the WDHS Education Centre

Employee of the Month Program

This program has continued to grow and most months now see about three to four very strong nominations for the coveted employee of the month award sponsored by Darriwill. It is pleasing to see the broad range of staff nominated for this award. In the past 12 months almost every department has had a staff member nominated. The employees who received the award were:

JUN	**Erika Fisher**	Palliative Care
JUL	**Maryann Howard**	Primary and Preventative Health
AUG	**Ruth Fatone**	Continence Nurse
SEPT	**Craig Richardson**	Hotel Services – Gardening
OCT	**Rhonda Hamilton**	Penshurst
NOV	**Darren Mulley**	Theatre
DEC	**Ian Powlton**	Hotel Services
JAN	**Donna Spong**	The Grange
FEB	**Tracey Hatherall**	National Centre for Farmer Health
MAR	**Lorraine Hedley**	Nursing Administration
APR	**Tania Stubbs**	Medical ICU
MAY	**Fran Patterson**	Occupational Therapy
JUN	**Demogene Smith**	Business Support and Innovation

Industrial Relations

In 2011/2012, a number of major Enterprise Bargaining Agreements (EBA) have been negotiated. These have included the Nurses EBA and the Health and Allied Staff EBA.

No work hours were lost at WDHS as a result of industrial action during 2011/12.

Whistleblowers and Equal Opportunity Acts

In the current year there were no Complaints under the Whistle Blowers Act or the Equal Opportunity Act.

Public Sector Values and Employment Principles

Public Sector Values and Employment Principles are integral to Western District Health Service's Leadership and Employee Orientation programs. The employment principles have also been incorporated into our recruitment and selection training programs to ensure that all employment decisions are based on merit and equity. Western District Health Service is an Equal Opportunity Employer.

Statutory Compliance

The new Australian Health Professional Registration Authority (AHPRA) has now been in operation for 12 months and after the initial major workload of ensuring all registered health professionals were moved to the new system, the system is generally working well. In June 2012 the Occupational Therapists will join the system as registered health professionals for the first time.

During 2011/12, WDHS made two mandatory reports to AHPRA in regards to health professionals.

Human Resource staff continues to monitor and manage legal compliance with OH&S, Equal Opportunity, Industrial Law, Whistle Blower compliance and similar legislation. Policies are regularly reviewed and updated as legislation or case law requires, ensuring best practice.

Code of Conduct

All staff receive training in the code of conduct and expected standards of behavior on a regular basis. This training is completed in conjunction with the prevention of bullying and harassment training.

Education and Learning

Professional Development

The WDHS Education Centre continues to facilitate a range of professional development opportunities targeting all staff members. Training in customer service, time management, defensive driving, risk management, workplace wellness, and in programs specific to the Health Service has been provided. In addition, in-service programs are provided regularly in all clinical units.

The provision of online training has continued to help staff maintain competency in areas relevant to their roles and in areas of interest. There are six competencies required to be completed by all staff, four of which are available online. Courses are developed in-house based on our local policies and procedures and are also accessed from external agencies. Currently there are 46 courses available via the online system.

Studies in VET sector qualifications have been pursued by 18 staff members. Study was undertaken in business administration,

→ WDHS Librarian, Louise Milne with Clinical Teacher, Leah Swainston, provides valuable resources to complement online training for the annual intake of student doctors and nurses

frontline management, theatre technician, sterilisation, allied health assistance, community services coordination, aged care, pharmacy support and leisure and lifestyle.

Clinical Student Placements
This year, a total of 300 nursing undergraduates, comprising Bachelor, Diploma and Certificate students attended clinical placements in acute, extended, community, primary and preventative health units throughout WDHS campuses. WDHS hosted five students in pharmacy, four in Occupational Therapy, three in Dietetics, three in Physiotherapy and two in Health Information. There were nine medical students at WDHS this year. Clinical placements allow students to experience learning encounters with all relevant aspects of the health industry, to enable them to reinforce and consolidate the theoretical component of their training.

Clinical Supervision Training
In mid-2011, a group of nine nursing and allied health staff participated in the Australian Clinical Educator Preparation Program. The program was developed by academic staff from five universities and aims to equip clinical supervisors or preceptors with the skills to provide high quality learning experiences for undergraduate students and graduate health professionals. The online delivery mode enabled staff to undertake the course at a pace and place that suited them.

Continuing Nursing Education
WDHS is the fund holder for Continuing Nurse Education in the South West Region of Victoria. During the last twelve months, topics have included midwifery, paediatric illnesses, pain management, intensive care and emergency department topics, plus assessment and recognition of changes in patient's condition. Over 260 nurses from the South West Region and surrounding districts were able to attend these events in Hamilton.

Graduate Nurse Programs
The Registered Nurse (RN) and Enrolled Nurse (EN) Graduate Programs are designed to consolidate nursing skills and increase professional awareness under the guidance of experienced and competent nurses. Both programs provide challenging clinical experiences for newly registered graduates.

Three RNs were recruited into the twelve month program in mid- 2011 and twelve commenced the 2012 program in February. Rotations are undertaken in acute care, aged care and community settings. Of the nine participants who completed the graduate program in February 2012, five continued their employment with the Health Service.

A new initiative for 2012 is the commencement of the Victorian South West Collaborative Graduate Nurse Program. Three participants commenced in February. This program provides the participants with the experience of rotating throughout three organisations; Western District Health Service, Portland District Health and Moyne Health Service. In a first for WDHS one of our Graduate Nurses participated in the Aged Community Care Victoria program.

Our EN Program operates across all facilities of WDHS over twelve months. Five participants commenced mid-year in September 2011. The four graduates who completed the program in February 2012 are now participating in the second year EN program.

Clinical teachers have been attending careers expo's throughout the region to promote the programs and recruitment. Information Open Days are also held for prospective graduates.

Hindson Professional Development Fund
In 2012, the Hindson Professional Development Fund was used to support two nurses in attending an extensive trauma course facilitated by the College of Emergency Nurses in Warrnambool. The fund provided an opportunity otherwise not available to send a total of four nurses from the organisation to this valuable course, allowing them to come back and pass on current best practice in this vital area.

Interprofessional Learning
A new initiative has been introduced to establish a learning forum that will foster interprofessional clinical development, communication and teamwork according to local guidelines, policies and procedures, in a simulated, emergency setting. Four sessions were conducted to date with excellent feedback received from participants, including medical and nursing staff and paramedics.

Simulated Learning
WDHS was successful in obtaining funding to facilitate a simulated learning project. This new and exciting project will target undergraduate students in medicine, nursing and allied health, who are on placement in the South West Victorian Region. A coordinator has been employed for 12 months to facilitate scenarios and simulated learning opportunities to enhance students' clinical practice. Our clinical skills room is well-stocked with low fidelity manikins which will be utilised to enhance learning. Various simulated learning opportunities will be offered to fill gaps in knowledge or clinical exposure. After the 12 months, it is anticipated that the project will be self-sustaining.

Aged Care Education Program
The current Aged Care Education Program began in February 2011 and is a three year plan based on all 44 aged care standard outcomes. Each of the WDHS aged care facilities have monthly in-service education based on this plan. With the use of WebEx, each in-service program can be accessed live by staff from all facilities via computer. Staff

may now access four in-services a month where previously it was only one. The in-services are recorded and made available for staff to view at a later date and are accessible online at work or at home. This program has provided easier access for all staff to in-service education and ensures education requirements of the standards are met.

Medical Education
There have been significant changes to the weekly medical education sessions over the last year. The Director of Medical Services and the Medical Student Training Coordinator at the Hamilton Medical Group have coordinated the program since September 2011. There has been an increase in attendees with an average of 25 per session with staff from various disciplines represented including specialist medical staff, GPs, HMO's, nursing and allied health staff. The sessions have been made available to staff at Penshurst, Portland, Edenhope, Casterton and Coleraine via a webinar link. In addition, expert external speakers have been engaged to lead practical workshops for specific groups after their presentations. Weekly sessions are also held for interns on rotation from metropolitan hospitals. In addition registrars and consultants are able to access continuing education via videoconferencing.

Nursing Graduate Diplomas
WDHS supports nursing staff undertaking postgraduate studies in critical care, peri-operative nursing and midwifery. The students are enrolled in the courses through Deakin University with the practical experience gained at WDHS. Some placements are undertaken at other health services.

Critical Care – Two staff members undertook the Graduate Diploma of Nursing, specialising in critical care in 2011 with one staff member commencing in February 2012. Students are progressing well at this stage. The course involves two placements at a larger facility for further experience. The first of these placements is completed in first semester, and the other during second semester.

Peri-operative – In 2011, two students completed the Graduate Diploma of Nursing specialising in peri-operative care. In February 2012, one student commenced studies in this field and is improving her knowledge and skills in the area. A placement at a larger organisation will be completed in the second semester for this course.

Midwifery – The Graduate Diploma of Midwifery is an 18 month course. One student completed the course in June 2012. A second student commenced in February 2012 and is gaining valuable experience in the midwifery area of nursing.

→ Meghan Silke and Stephanie Trebilcock, two of this year's participants in the new extended Graduate Nurse program that has a focus on Aged Care

Orientation
All new staff members to WDHS undertake a one day orientation program to facilitate their entry into the organisation. The day covers an overview of the Health Service role and directions, human resources and payroll, mandatory competencies in emergency codes, fire training and basic life support, infection control and manual handling. The program is supplemented by two online courses in quality management and occupational health and safety. The number of participants in 2011/12 program is presented as follows;

DISCIPLINE	NO OF ATTENDEES
Corporate Services	36
Nursing Staff	37
Personal Care Staff	19
Community / Allied Health	22
Medical Staff	5
NCFH	1
Students and Trainees	4
Volunteers	32
Total	156

Occupational Health and Safety

Equipment Procurement Program
WDHS Occupational Health and Safety management equipment improvement procurement program invested almost $80,000 to make the workplace safer for staff and clients. Almost a quarter of this funding was directed to ensure the safety of bariatric clients. A bariatric chair transporter and two bariatric patient trolleys were purchased for the Emergency Department. The new Coleraine campus will have two bariatric hoists installed once the redevelopment is complete in 2012.

WDHS appreciates the support of our volunteers and Auxiliaries who raise funds to purchase equipment that allows our staff to work safely in the community. In particular, we would like to acknowledge the support of the North Hamilton Ladies' Auxiliary, which assisted District Nursing with the purchase of an Enfield floor-line bed for one of their clients in the community, improving nursing care and minimising risk of back injury.

A major OH&S strategy has focused on the purchase of lifting equipment at Penshurst, Coleraine, Birches and the Grange. All resident rooms across the Hamilton Aged Care campuses (Grange and Birches) have had ceiling hoists installed to complement our no lift program. As part of this project, three aged care rooms were fitted with bariatric ceiling hoists.

→ Deputy HR Manager, Sally Hicks advising staff, Executive Support Officer, Jenny Riddle (left) and HR Executive Support Officer on the OH&S features of equipment being installed in the Hamilton Base Hospital

Fire Safety and Emergency Procedures

Fire and emergency code training is compulsory for all staff. During 2011/2012, a new emergency warning and intercommunication (EWIS) fire system was installed at the Grange. The WDHS Bushfire Preparedness Plan was revised in December 2011, and in June 2012 the contractor induction manual was revised. Occupational Health and Safety policies are regularly reviewed to ensure compliance with best practice and legislative changes.

During the past year, there were no Chemical Biological and Radiation incidents where the exhaust mode in the emergency department needed to be activated.

Occupational Health and Safety Training

The OH&S training plan was updated in 2012 to deliver targeted training across the service to reduce the risk of injury. This training is targeted to promote a culture in which WDHS employees and contractors share commitment for OH&S excellence and take individual ownership for OH&S performance.

The following major training initiatives were undertaken in addition to regular mandated OH&S training:

» Driver training sessions under the Transport & Logistics Training Package, which were delivered by CITS to ensure staff are able to safely carry out vehicle inspections and apply safe car driving behaviours when driving

» SWTAFE delivered Construction Industry Training to 19 staff from the Facility Management department and some of our contractor staff

» Safe Work at Heights training provided to Facility Management department staff

Workcover

WDHS has continued to review and develop policies and procedures in accordance with the relevant legislative requirements and was free from serious injury or death in 20011-12. This year, WDHS recorded five claims but saw a decrease in the days lost from the previous year by approximately 50%.

There were no WorkSafe notifiable incidents in 2011/2012

2011/2012 Work Cover Premiums

» Projected premium rate for 2011/12 is 1.3794%, which is an increase of 0.1412% from the previous year

» Illustrative data for this year shows an increase in premium of approximately $49,000 however the performance rating for WDHS still remains at 9.89 %, better than the average for the industry

→ Celebrating International Nurses' Day with a cake and uniforms from years gone by is a fun calendar event for Hamilton Base Hospital Nursing staff, L-R Abby McKerlie, Kim Hearn, Brittany Raymond, Meg Ryan, Shaylee Stephens, Meaghann Silk and Zoe Price

Corporate Services – Business Systems and Sustainability

→ WDHS Linen Services staff have provided a first rate service to the sub-region for over 47 years

The Corporate Services Division comprises departments staffed by people with a wide range of skills and expertise in business analysis, budget and finance, food, environmental and linen, human resources, information communications and technology, library and supply and maintenance services. These departments support direct patient care and ensure Western District Health Service (WDHS) functions effectively and efficiently. The division employs 121 people (92.84 EFT) and has an annual budget of $11.5 million.

The Division participates in management decision-making, in particular the interpretation of government policy, the implementation of changes required for compliance with statutory obligations and the management of resources necessary for the delivery of clinical services.

Challenges

- Support clinical services development, review and restructure
- Develop, implement and monitor infrastructure and technology strategic initiatives
- Take a leadership role in alliances and peer groups to promote innovative practice within the Sub-Region
- Implement, monitor and review risk management strategies
- Ensure effective governance and management of resources
- Monitor, interpret and respond to changes in government policy and strategic directions
- Maintain timely, accurate, efficient and effective reporting on finance, service activity and compliance
- Ensure efficient and contemporary workforce management strategies to maximise organisational effectiveness

Achievements

- WDHS invited to participate in Statewide Reference Groups established by Health Department for National Activity Based Funding system and negotiation of the Nurses Enterprise Bargaining Agreement
- WDHS Sub-Regional strategic direction endorsed with the release of the Health Department Rural & Regional Health Plan in December 2011
- Service Plan and Model of Care strategy completed in July 2011
- Information and Communications Technology Strategic Plan 2011-2013 completed in August 2011
- In December 2011 WDHS agreed to establish a Sub-Regional Linen Service in conjunction with South West Healthcare the new service to be operational from 13th August 2012
- Wide Area Network (WAN) upgrade completed in September 2011 doubling capacity for all WDHS sites
- Completion of ICT Disaster Recovery system upgrade in November 2011
- Successful transfer of all local data storage to SWARH Alliance centralised storage in December 2011 enhancing security and redundancy for all WDHS data
- Establishment of SWARH Alliance Regional (ICT) Helpdesk
- Statewide Oracle FMIS Benefits Realisation Project progressing in conjunction with Health Purchasing Victoria with formal project plan completed and adopted in October 2011
- Health Department Redesigning Care project completed in March 2012 – WDHS represented on the Statewide Redesigning Hospital Care Program Lead Group
- New Human Resource Self Service (HRSS) system implemented in November 2011 enables remote access for all employees in the sub-region
- SMS messaging system for managing staff rosters implemented in September 2011

→ WDHS staff involved in renovating the new Oncology Consulting suite at Hamilton Base Hospital – L-R electrician, Bodey Moore, carpenter, Ian Phillips, painter, Doug Johnstone and plumber, Jordan Roberts

- $26.5m Coleraine Health Service Redevelopment commenced with Thomas Hodgetts Primary Care Centre to be commissioned in September 2012
- $2.85m Grange Redevelopment completed in May 2012 and $2.2m fundraising target achieved
- Stage 1 of Hamilton Medical Group Upgrade completed – $500,000 Commonwealth Government grant provided to enable completion of Stage 2 in 2012/13 – total project cost $1.22m
- Construction commenced on the $4.1m Hamilton Base Hospital GEM/Rehab Redevelopment in May 2012 to be completed in April 2013
- Consulting Suites Cancer Services development completed in June 2012
- Replacement of main switchboard and sub mains to be completed by September 2012 total project cost $1.1m
- 10 Year Capital Investment Strategy 2011-2021 completed – the strategy requires an investment of $120m over 10 Years
- $223,874 funding received from Rural Capital Support Fund to upgrade the Building Management Control System at the Hamilton Base Hospital site
- Implementation of risk management framework review
- Achieved above the mean average in all areas in food satisfaction that measured Quantity, Temperature and Quality, in the VPSM state-wide food satisfaction survey for Category B Hospitals, in 2011/2012
- 100% compliance - external food safety audit - 2012
- Annual state-wide external cleaning audit score of 96.6%

The Future

- Complete establishment of Sub-Regional Line Service
- Relaunch upgraded Internet website and internal intranet site in August 2012
- Complete upgrade of Building Management Control System
- Undertake Fire Safety Re-Audit of all facilities
- Complete Hamilton Base Hospital Sub-Acute Redevelopment
- Complete replacement of VITAL Patient Management System in November 2012
- Continue progress towards an electronic patient record with implementation of electronic alerts and allergies , replacement of PJB for community services and allied health and enhancing system access in clinical service areas
- Extend Sub-Regional corporate services model as supported by the Rural And Regional Health Plan
- Continue to expand the use of virtual services to include establishment of Medical Benefits Schedule funded virtual consultations in accordance with New Medicare arrangements introduced in July 2011
- Implement environment, waste management, food and fire safety programs
- Continue to monitor and implement changes associated with the National Health Reform – '' A National Health and Hospitals Network''
- Continue to deliver statewide system benefits through the FMIS Benefits Realisation and VMO projects

National Health Reform

The current year has been unprecedented in terms of the release of major reforms by Government at Commonwealth and State level which will have a significant impact on health services and service delivery in the next few years as the reforms are implemented within ambitious timeframes.

The National Health Reform – '' A National Health and Hospitals Network'' released by the Commonwealth Government is being progressively implemented in conjunction with the States with some key changes to apply from July 2012 including the payment for Inpatient, Outpatient and Emergency Department activity on the basis of a National Weighted Activity Unit (NWAU).

In addition to the funding system changes the Australian Commission on Safety and Quality in Health Care released new National Safety & Quality standards which are mandatory standards to be complied with as part of Health Service Accreditation from 1st January 2013.

In response to the Productivity Commission Report ''Caring for Older Australians'' released in August 2011 the Commonwealth Government released in April 2012 a 10 Year Aged Care Reform Package '' Living Longer, Living Better'' with key reforms to commence from July 2012.

In December 2011 the Victorian Government released the Victorian Health Priorities Framework 2012-2022 – Rural and Regional Health Plan and will release a final strategy – Health Capital and Resources Plan later in 2012.

The Policy Direction of the reforms at Commonwealth and State level strongly support WDHS strategies including the focus on quality local governance and leadership, development of partnerships, consumer involvement, quality services, innovation, the use of technology and the development of sustainable service delivery. Considerable work has been undertaken in reviewing and updating strategic plans during the year ensuring synergy with Commonwealth and State Health Plans – key strategic plans completed during the year include:

- WDHS Service Plan & Model of Care (July 2011)
- Information Management and Communications Strategic Plan 2011-2013 (August 2011)
- Human Resources Strategic Plan 2012-2017 (October 2011)

WDHS Corporate Services staff have been actively involved in the Department of Health

ABF Implementation Reference Group which has been established to inform the transition by Victoria to the new funding system. In addition information systems requirements have been identified and specified for inclusion in the new Patient and Client Management System (PCMS) currently being implemented and costing systems have been updated to ensure WDHS will be able to isolate and report service costs to the level of individual service activities as required by the new activity based funding system.

Sub Regional Progress, Alliances and Partnerships

Sub-Regional Linen Service

WDHS has operated an efficient high quality linen service servicing the sub-region for over 47 years since its formation in March 1965. Over the past two years, an extensive review of options for the provision of linen services was undertaken in response to the need for a significant capital investment required to upgrade equipment. South West Healthcare – the other major provider of linen services to public health services in the sub-region also required a significant capital investment to be made.

After considering all options available including outsourcing to private provider's agreement was reached with South West Healthcare in December 2011 to jointly establish sub-regional linen service to service all public health services in the region. Major processing will be centralised in Warrnambool and a distribution centre and personal laundry service will be retained in Hamilton. The new sub-regional service will commence operating in August 2012 and involves an investment of $2.6m which includes the installation of a high capacity ''Batch Washer''. The new linen service will have a production capacity of 1800 tonnes per year in a single shift significantly higher than the current 480 tonnes per year capacity of the WDHS Linen Service.

The new sub-regional service incorporates all of the design features of a modern linen service with automated processing and handling systems to reduce manual handling risks, savings in energy consumption, water usage and trade waste in the order of 50-60% from current levels. It will also facilitate significant savings in labour required to support the increased production levels. While acknowledging the outstanding performance of WDHS linen service staff in delivering a high quality and cost effective service for the region over decades, the new service offers the most cost effective, sustainable model for the public health services in the region over the next 10 years.

SWARH Alliance

As a member of the SWARH ICT Alliance WDHS staff take an active role in the governance of the joint venture and the support of all the specialist sub-committees. WDHS staff were active in many of the projects completed during the year including:

- Upgrade and Expansion of the Wide Area Network (WAN) doubling capacity of the links to major sites including all WDHS sites (September 2011)
- Implementation of a new Storage Management Solution to utilise Geelong and Warrnambool sites for enhanced Disaster Recovery (November 2011)
- Transfer of all locally stored data from Hamilton Base Hospital Computer Room to the SWARH Storage facility in Warrnambool (December 2011)
- Implementation of a new data management strategy providing effective and secure storage and archiving of user information, automated backup process and the ability for users recovery of archived data – completed in March 2012
- Consolidation of helpdesk support into a single Regional Helpdesk with extended support coverage, improved escalation and job tracking – completed in June 2012

The major priority for WDHS as a member of the SWARH Alliance has been the implementation of the new Patient & Client Management system, which will enable the Trak Clinical system to be extended to provide a single integrated system for management of clinical data and provide the foundation for significant progress towards the achievement of a patient electronic record. This complex project was due to go-live for the Patient Management System component in May 2012 with the Community Health functionality to be available from September 2012. As it involves clinical workflows and processes and the key systems providing access to and storage of patient data there is a need to ensure any go live is well tested and risks are well managed. Concern with data migration and configuration during the testing phase of the project has led to a rebasing of the project to provide sufficient time to mitigate all potential risks. The revised project plan now provides for the Patient System go live in November 2012 with Community Health to follow in early 2013.

Sub-Regional Corporate Services

The Sub-Regional Corporate Services across the Glenelg and Southern Grampians planning area has continued with a representative steering committee meeting on a bi-monthly basis identifying new opportunities for cooperative initiatives. The Sub-Regional Corporate Services initiative has developed an effective resource sharing arrangement among member agencies to provide relief for periods of leave and resources on a fee for service basis in areas of finance, human resources, payroll, supply and engineering.

The strategic direction of the Sub-Regional Corporate Services group was significantly reinforced in December 2011 with the release of the Victorian Health Priorities Framework 2012-2022 – Rural and Regional Health Plan. In relation to the priority to increase the system's financial sustainability and productivity, the plan highlighted the need for local health services to generate efficiency in clinical support and corporate services by ''combining effort with other health providers within their local area.''

Financial Management Information Systems

In June 2011, the Department of Health allocated $400,000 to WDHS as project lead over the next two years to deliver these benefits to all rural alliances. A key deliverable of the project is to develop a common catalogue, which is shared by all rural and regional health services and maintained by Health Purchasing Victoria. WDHS Corporate Services staff continue to lead this project chairing the statewide steering group and being responsible for project management. In addition to development of the common catalogue, the project scope includes the implementation of business to business eCommerce and provision of training and support to rural FMIS users.

Benefits delivered to members within the SWARH Alliance include:

- A single stock catalogue for the region – saving 1.0 EFT
- 40% of items purchased now processed electronically business to business
- Total Alliance Stock holdings reduced by 23% ($450,000)

Business Support and Innovation Projects

The Business Support and Innovation Unit (BSI)leads change management across the organisation by assisting with process improvements including planning, organising and managing resources to bring about successful completion of projects that impact across the organisation.

→ **The $26.5m Coleraine campus redevelopment project includes the Thomas Hodgetts Centre -part of the WDHS capital investment strategy being implemented over the next three years**

In 2010/11 WDHS received funding of $100,000 to enable participation in the Department of Health Redesigning Hospital Care Program. This initiative sought to develop within health agencies the ability to analyse, review and redesign of health service processes and workflows to enhance performance and patient outcomes. The BSI team worked with clinicians to redesign and improve patient flow for high volume short length of stay surgical patients. The project concluded in December 2011 with many areas for improvement identified and actioned. A reduction of 15 minutes in the average patient journey time for short stay surgical patients was achieved following completion of the redesign project

Other improvement projects completed during the year include:

- implementation of new HR Self Service system for the sub-region which enables remote access for employees, enhanced leave management and ability to update personnel details on-line
- implementation of web-based maintenance requisition and remediation status system
- completion of Radio Frequency Identification (RFID) electronic monitoring and alert system for all refrigerators at Hamilton Base Hospital site utilising the wireless network and messaging system
- implementation of SMS messaging system to manage and fill roster vacancies
- extension of e-learning system with 46 courses now available for staff to complete on line

Facilities Management

Facilities management requires ongoing maintenance of physical facilities to ensure their reliability, safety and compliance with relevant standards. The significant investment in infrastructure requires a long term planning approach, which includes major redevelopment and refurbishment, and maintenance of essential plant at all campuses. The Facilities Department also has responsibility for the procurement of capital equipment for the health service, in accordance with constantly changing product standards and government procurement policies.

Considerable progress was made on the three year $35m building program commenced in the previous year with progress on the Coleraine Health Precinct substantially ahead of schedule, completion of the Grange Redevelopment on time and on budget and the commencement of the HBH Sub-Acute redevelopment in May 2012. Our three year program includes the following major projects:

- Coleraine Redevelopment – commenced August 2011 (cost $26.5m)
- Grange Redevelopment – completed May 2012 (cost $2.85m)
- Hamilton Medical Group Renovation – completed May 2012 (cost $760,000)
- HBH Sub-Acute Redevelopment – commenced May 2012 (cost $4.1m)
- Cancer Consulting Suites – completed in June 2012 (cost $185,000)
- Emergency Generator & Load Bank Installation completed in April 2012 (cost $260,000)
- electrical switchboard & sub-mains to be completed September 2012 (cost $840,000)

In February 2012, a 10 Year Capital Investment Strategy covering the period to 2020/21 was completed identifying capital investments of $120m required over the next 10 years. The strategy identified that, in addition to major works currently underway, the building fabric and functional layout of key service areas at HBH will require substantial investment in the next five to 10 years. The most urgent areas requiring significant investment include the catering department, theatre, emergency department and the acute ward area. Masterplans for the Hamilton Base Hospital and Penshurst campuses are due for completion in 2012 to initiate the planning and Government funding submission process to address key components of the Capital Investment Strategy.

In June 2012, WDHS received funding of $223,000 under the 2011-2012 Rural Capital Support Fund to upgrade the Building Management System at the Hamilton Base Hospital campus. This upgrade, when

completed in August 2012, will significantly enhance management of emergency power supplies, heating cooling and ventilation systems and other building controls with savings in energy consumption and system maintenance costs of $54,000 per annum.

Risk Management

In November 2011 our insurers VMIA conducted a Risk Management Framework Quality Review and assessed WDHS level of maturity as ''integrating'' and identified opportunities and improvement to move to the ''effective'' level of maturity. Following the VMIA review the a new Risk Management Framework has been completed and adopted in February, Risk Management training was undertaken in March and the Risk Register and executive reporting systems reviewed and revised.

The Audit & Compliance Committee continues to monitor organisational risks in accordance with a three year internal audit program undertaken by RSM Bird Cameron independent internal auditors contracted by the WDHS Board. Review projects were conducted during the year in accordance with priorities identified in the Organisation Wide Risk Assessment undertaken in 2011. The highest risk identified in the year was the implementation of the Patient & Client Management system with project status reports and readiness assessments presented by the internal auditors. As a consequence of identified risks the project plan was revised, additional readiness indicators and milestones developed and ''go-live'' dates amended to November 2012. In June there was a high level of confidence the revised date will be achieved with all identified risks identified and adequately managed.

Considerable progress was made during the year in the management of other Corporate Risks identified in relation to emergency power supplies, data security and Occupational Safety associated with manual handling including:

- completion of the installation of ceiling hoists in The Birches and Grange Residential Care facilities
- establishment of the Sub-Regional Linen Service which will eliminate high risk manual handling processes

Installation of New Emergency Generator and upgrade of switchboard and sub mains to provide sufficient emergency power for the entire Hamilton Base Hospital site and testing of the system on a monthly basis

Transfer of all local data files to the SWARH shared services centre with automated backup procedures operational

→ **WDHS gardener, Craig Richardson planting roses in the newly landscaped grounds surrounding the new wing of the Grange**

Completion of the upgrade of the SWARH ICT Disaster Recovery to include sites at Geelong and Warrnambool.

Hotel Services

Hotel Services includes Food Services, Environmental Services, Linen Services, Garden and Grounds, as well as contracted services for Security, Pest Control and General/Prescribed Waste. The Hotel Services team regards itself as an integral part of WDHS and in particular, has forged a desire to continually seek excellence in the delivery of quality services to its community.

In keeping with this desire, Hotel Services participates in rigorous, on-going external audit examinations, as well as benchmarking exercises to see how it rates against other, peer-group services.

Achievements in the current year include:

- achieved above the mean average in all areas in food satisfaction that measured Quantity, Temperature and Quality, in the VPSM state-wide food satisfaction survey for Category B Hospitals in 2011/2012
- 100% external food safety audit result for all sites 2012
- 96.6% score for annual state-wide external cleaning audit
- completed design and works associated with Landscaping of Grange Residential Care Project
- completion of staff accommodation strategy
- installation of new blast chillers – HBH Kitchen $80,000
- reconfiguration of catering staff to provide additional support for Birches residents during peak meal times
- Environmental Management Plan (including Water Management Plan) revised February 2012
- Waste Management Plan revised and updated in February 2012

Our Community Partnerships

→ The Hamilton & District Aged Care Trust members have raised an outstanding $335,000 for the Grange Residential Aged Care facility in 2011/12

WDHS values its partnerships with the communities of the Western District. The Health Service's Community Liaison Department has the lead in developing and fostering our community partnerships.

Community Liaison promotes new WDHS programs and services, coordinates fundraising events and initiatives, supports the many volunteers who give their valuable time, and represents WDHS at community events. The commendable image of WDHS is promoted through the media, Annual and Quality of Care (QOC) reports, brochures, biannual newsletters and the website.

The goal of the Community Liaison Department is to fully inform the community, increasing awareness of and promoting its involvement with the Health Service. Community Liaison has a commitment to community feedback, which identifies needs and facilitates community participation in the current and future activities of the Health Service.

We thank everyone in the community who has contributed to WDHS, whether financially or in-kind throughout this year.

Fundraising Strategy

WDHS' fundraising is conducted in accordance with the Fundraising Appeals Act 1994, and the Fundraising Institute of Australia Ethical Codes of Fundraising. The total fundraising strategy of the Health Service is guided by the WDHS Development Council, an eight-member committee plus Board of Directors representation.

The Community Liaison Department manages the overall fundraising strategy on behalf of WDHS. In addition to fundraising events and functions, the department submits applications to philanthropic Trusts and Foundations to support the health service's fundraising efforts. This year, a total of $1,313,789 was raised.

Key fundraising events in 2011/12 were the Grange Redevelopment Appeal, with a final total of $2,212,855, which included pledges and funds held in reserve by the Health Service, the Arctic Blast Party, which raised $45,515. The Hospital Door Knock Appeal raised $52,500, the Christmas Appeal $25,073, and the Murray to Moyne Cycle Relay raising $12,375.The Hamilton Fun Run and the Hamilton Golf Tournament raised $10,592 and $13,161 respectively for the Grange Redevelopment Appeal. WDHS received bequests totalling $61,555 and grants from Trusts and Foundations totalling $430,325 in 2011/12.

Fundraising Activities

The Grange Redevelopment Fundraising Appeal

This appeal was launched in April 2009 by campaign patron Dr Geoff Handbury AO to raise money for the final redevelopment stage at an estimated cost of $2.841m. It has provided the facility with a new wing of seven beds and a redesign of Home 3 to care for residents with more complex needs (15 beds to 13 beds), a total increase of five beds (45 to 50). A new kitchen was constructed along with increased activity space for programs and covered delivery and pick up areas. This stage was the final building block in the creation of a first class aged care facility, ensuring The Grange will retain its premier status in the Western District and continue to meet the increasing needs of the community. Construction commenced on 27 June 2011 and was completed in May 2012.

Christmas Appeal

In December, the Hospital Christmas Appeal, conducted via letters of request and newsletters sent into the community raised $25,073. The funds were directed to the purchase of a portable video intubation laryngoscope for the Operating Theatre, which assists the provision of safe airways for patients under general anaesthetic.

Hospital Door Knock Appeal

This year's Hospital Door Knock Appeal was a resounding success yet again with over 120 Volunteers door knocking from the 16th to 24th of June in the communities of Hamilton, Glenthompson, Dunkeld, Cavendish, Penshurst and Branxholme and surrounding rural districts.

The appeal tally reached $52,500 with the funds going towards the purchase of a rigid ureteroscope for urology, six capnography modules to monitor patients in theatre recovery and telemedicine equipment for the Medical Unit and ICU to facilitate bedside consultation and monitoring by external specialist consultation. Funds were also directed to Penshurst and Coleraine where requested.

Murray to Moyne

The annual Murray to Moyne Team Cycle Relay was held in April with a great team of enthusiasts participating. For Hamilton, twelve riders and a support team of four took up the challenge, had a lot of fun and managed to raise a total $12,375, which was used to purchase multiple equipment items for WDHS.

The Penshurst team of 13 riders and support crew enjoyed a very successful event riding, and managed to raise a total of $21,100 for the purchase of a range of equipment items for the Penshurst & District Health Service campus.

Support for Appeals
Many community groups and individuals have provided WDHS with considerable financial and in-kind support throughout the year, including:

$5,000	Freemasons Public Charitable Foundation
$5,000	Gwen & Edna Jones Foundation
$5,000	Mr and Mrs Row
$6,500	The James Charitable Trust
$20,000	ANZ Trustees
$55,000	Collier Charitable Fund
$120,000	Dr Geoff Handbury AO
$50,000	Grange Hamilton Farms Pty Ltd
$51,547	Estate of Dorothy Mary Mildon
$448,657	Mr Leo O'Brien

Jacinta and John Hedley of Darriwill Farm provided sponsorship of our Employee of the Month Award, James Dean Pharmacy provided gift packs for Midwifery private patients and IGA Hamilton contributes via the Community Benefit Scheme.

These generous donors and supporters are extremely important to WDHS, making it possible for us to purchase much-needed equipment and to refurbish our facilities to meet the needs of our patients and clients.

We sincerely thank all those who contributed, financially or in-kind throughout the 2011/12 year. A list of donors contributing $100 or more is shown on page 52.

Auxiliaries and Community Groups
WDHS' five auxiliaries, the Hamilton Base Hospital Opportunity Shop, the Penshurst Opportunity Shop and the Hamilton & District Aged Care Trust have again contributed a great deal to the Health Service. The North Hamilton Ladies' Auxiliary donated $4,000 towards an Enfield Floor Line Bed. The Hamilton Base Hospital Ladies' Auxiliary donated $6,500 to purchase a new Renal Dialysis chair and an Aminec Infusion blood warmer. The Hamilton & District Aged Care Trust contributed an amazing $335,000 to the Grange Appeal.

The Coleraine District Health Service Ladies' Auxiliary donated $10,151 for the Coleraine campus and is continually raising funds for equipment for the newly redeveloped Coleraine Hospital. The Coleraine Homes for the Aged Auxiliary held various fundraising activities throughout the year and raised a total of $1,271.

The Penshurst Hospital Ladies' Auxiliary donated $5,164 to purchase a new wheelchair, furniture, carpet, and blinds for a staff sleepover/family room and utensils for the kitchen and residents.

Opportunity Shop
The Hospital Opportunity Shop is open five days a week from 10:00am to 4:00pm and is staffed by two volunteers each day. For the 2011/12 year, 3000 hours were contributed by this fantastic team of 17 volunteers. The Opportunity Shop has raised a total of $426,500 since its inception in 1938.

The Hospital Opportunity Shop donated $36,000, for the purchase of a dialysis chair and two ENT rigid telescopes.

WDHS is extremely grateful for the excellent contribution put forward by the hard working auxiliaries and community groups.

Our Volunteers
WDHS has 309 registered, unpaid volunteers, excluding auxiliary members, who give of their valuable time and skills to support our patients, residents and clients across the health service. Volunteers are recruited through an interview process with the Volunteer Coordinator to determine where their skills, experience and interests will be best used. All undergo a Police Check and comprehensive orientation program before commencement of service.

The Health Service relies heavily upon the support of all its volunteers and we acknowledge and appreciate their dedication and unswerving contribution to improving the lives of people we provide services to.

Hours of Service in 2011/12
Twenty seven volunteers provided 1,198 hours of support to the Grange Residential Care Service. Nine volunteers and external work placement / work experience volunteers provided 743 hours of support at The Birches. Twenty four volunteers provided 1,510 hours of support to Penshurst campus residents through individual and group visits, activities, excursions and gardening. Sixteen volunteers provided 314 hours of support at Wannon Court and Mackie House in Coleraine. Five volunteers give their time to the PAGS group, which operates for 10 hours each week and one volunteer assists with the Hospital Nursing Home residents. Four volunteers provided 72 hours of support to the Men's Out and About program. The Merino Community Health Centre is supported by 27 volunteers.

Fourteen volunteers worked to provide a comforts trolley service to Hamilton Base Hospital inpatients, raising $606 after costs. Over 130 volunteers donated in excess of 360 hours to doorknock for the Hospital Doorknock Appeal, which raised $52,500 for Theatre, ICU and Emergency Departments. The Adult Day Activity and Support Service in Hamilton and Penshurst received 712 hours of volunteer support to assist with transport, meals, activities and a three-day trip. Students from Baimbridge College, Monivae College and The Hamilton and Alexandra College volunteered as Hospital Door Knock Appeal collectors throughout the second half of June. The Hamilton House Day Centre was supported by 517 hours of volunteer time. 400 hours were given to the Planned Activity Group (PAGS) and two volunteers provided 192 hours of administrative support to the Community Liaison Department. Other areas of volunteer support include Palliative Care, Carer Support Groups and Ward support.

Volunteer Support for Fundraising
WDHS uses registered volunteers in its fundraising program separate from the Auxiliary committees, and they include:

- The HBH comforts trolley service
- The HBH Opportunity Shop
- The Annual Door Knock Appeal
- The Grange Redevelopment Golf Day
- The Vitality Fun Run – Run the Grange for the Grange
- The Arctic Blast Party
- The Hospital Harmonies Choir

Community Transport Program
The Hamilton Community Transport Program had 47 volunteer drivers and seven escorts assisting the Health Service in 2011/12. The volunteers donated 2,958 hours and provided 1,996 trips covering a total of 156,372 kilometres.

The majority of clients are from the Hamilton and district area however the program will provide transport for clients living further afield if they are unable to access transport in their region. The program takes clients to medical appointments locally and to services in Ballarat, Warrnambool, Geelong, Horsham and Mt. Gambier. As many as four trips a week are provided to Melbourne hospitals for appointments and admission, these being The Alfred, The Austin, St. Vincent's, The Royal Melbourne, The Royal Women's, The Royal Children's, Peter McCallum, the Eye and Ear Hospitals, and orthopeadic surgeon, Mr Cunningham in Heidelberg.

Regular trips are also made to Ballarat, Geelong, Mt Gambier, Warrnambool, Portland and Horsham.

Drivers also transport clients to the Hamilton ADASS program three days a week and twice fortnightly to the Penshurst ADASS program.

Volunteer escorts accompany residents of the Grange Residential Care Service to medical and dental appointments.

→ Federal Member for Wannon, Dan Tehan with WDHS volunteers and staff who accepted the Australian Government National Volunteers Group Volunteers' Award for the Birches program – from left Diversional Therapist, Julianne Gould, volunteers, Jane Van Herpen, Kaylene Sandford, Pauline McCay, volunteer coordinator, Jeanette Ryan and Peter's Project Founder, Vicki Kellie

The Coleraine Community Transport program was supported by 30 volunteers making 1,287 trips totalling 25,321 kilometres over 1,424 hours, enabling clients to attend local activities and medical appointments.

The Palliative Care Program

Seven WDHS registered volunteers are available to participate in the Palliative Care Service. The Palliative Care service assists clients and their carers via visits that can provide moral support and friendly reliable companionship on a regular basis. They may give general assistance by helping with feeding, accompanying clients on a walk, special outing, or help them with a hobby they love. Volunteers can also, if required, accompany clients to their medical appointments. This level of support gives carers free time to run errands, attend a favourite respite activity or take some well-earned time out with peace of mind, knowing their loved one has company and is being cared for.

Palliative Care Volunteers provide support for clients and their carers in the client's home, as a visitor during acute episodes in hospital, during respite and on external appointments and excursions.

This year's Palliative Care volunteers have undertaken a Palliative Care Victoria training course, which has a primary focus on giving them the tools to work with people who have a terminal illness.

Volunteering Awards 2012

WDHS volunteers were recognised for their outstanding efforts this year via a number of significant awards:

- **2012**- Minister for Health Volunteer Awards for outstanding team achievement in a regional health service – Grange Residential Care Service Volunteers
- **2012**- Minister for Health Volunteer Awards for outstanding individual achievement in a regional health service – Ian McLean
- **2011** – Australian Government National Volunteer Awards – Wannon Ceremony for the Birches Special Extended Care Service volunteer group
- **2011** – Department of Health Certificate of Recognition and Appreciation – individual – Charlie Watt

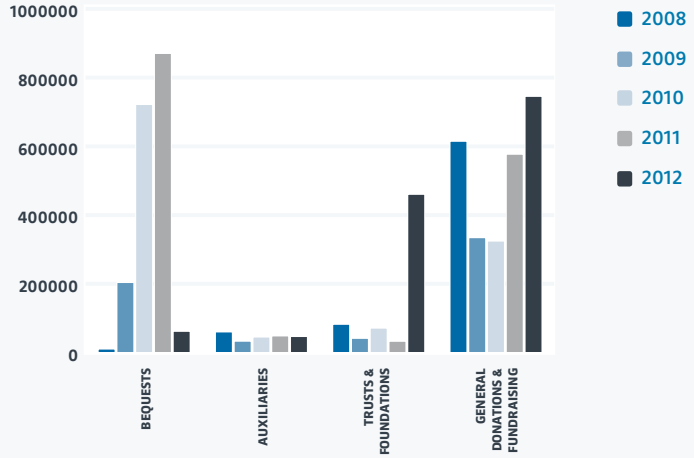
Aged Care Program

Volunteers visit residents at our Aged Care facilities to provide companionship, escort them to appointments, help with shopping and recreational activities such as cooking, gardening, playing cards, music, having manicures, hair sets, wheelchair walks and outings. They also assist diversional therapists and occupational therapists in regular activities. A total of 2,852.8 volunteer hours were provided to residents in our combined aged care facilities and programs.

Appreciation

The Community Liaison Department extends its sincere appreciation to WDHS' auxiliaries, the Op Shop, Aged Care Trust, Murray to Moyne teams, community groups, local businesses, Trusts and Foundations, WDHS staff, volunteers and many local individual donors for their outstanding support during 2011/12. Clearly, we are able to continue to provide high calibre service to our community because of your generosity and commitment and we thank you all for your ongoing contribution.

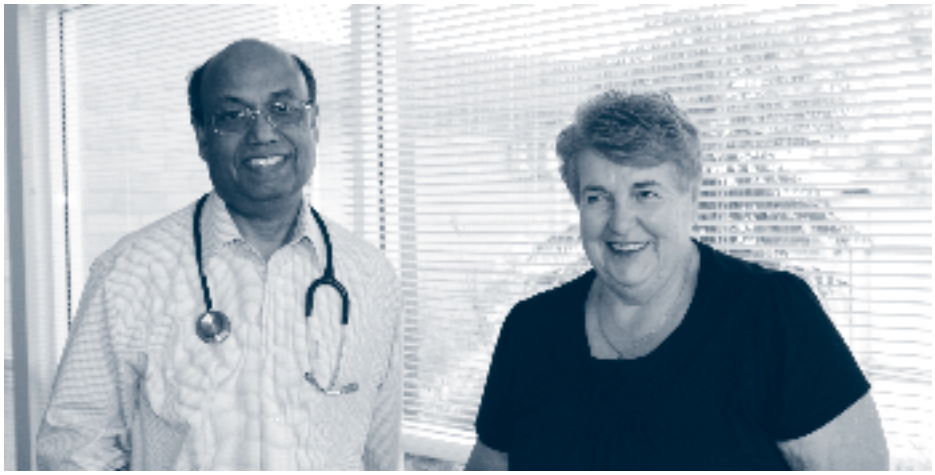
Donations and Bequests
The five year report - $6,022,233



Life Governors

Aarons B
Aarons F
Apex Club of Coleraine
Bailey M
Baudinette LE
Baudinette NR
Baxter CJ
Beggs HN
Boyle J
Brabham R
Broers M
Brumby A
Bunge B
Bunge R
Burgin E
Clifforth S
Duff S
Edmonds J
Fleming JD
Fraser M
Fraser T
Gaussen D
Gardiner PD
Gubbins J
Gumley F PSM
Gurry AJ
Handbury G AO
Heazlewood P
Hickleton E
Holmes ES
Hope M OAM
Hutton T
Kanoniuk M
Kruger N
Langley C
Lawson V
Linke N
Lyon E
McLean M
Morrison HM
Muir R
Murray EM
Nagorcka L
Northcott J
Rabone M
Robertson M
Ross J
Runciman P
Ryan D
Scaife C
Scaife S
Scullion E
Templeton H
Turner J
Walker O
Wallis V
Walter R AM
Wettenhall HM
Wettenhall M
Williams J
Wraith L

NOTE: A full list of Life governors, including those who are deceased, is available from the Community Liaison Department at the Hamilton Base Hospital campus.



→ Mrs Margaret Eales, President of the Penshurst Ladies' Auxiliary with Dr Mohammed Abdullah and a new ECG Machine recently purchased by the Auxiliary

→ The 350 participants in the 2011 Hamilton Vitality Fun Run raised almost $11,000 for Western District Health Service' Grange Redevelopment project for aged residential care services

→ It's all about apples as ADASS clients Dorothy Knights (left) and Dini Vandermost (right) celebrate Red Apple Day with Community Health Nurse, Sue Watt (front) and ADASS Activity Assistant, Michelle Maslen (back)

Our Donors

Donations over $100

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Ms Patricia Britten
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Gwen & Edna Jones Foundation
Hamilton & District Aged Care Trust
Hamilton & District Pensioners Association Inc.
Hamilton & District Stock Agents Association
Hamilton Base Hospital Ladies Auxiliary
Hamilton Church of Christ
Hamilton Farm Supplies
Hamilton Medical Group
Hamilton Produce
Hamilton Stock Agents Bulk Billing Centre
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Mr and Mrs Thelma Handreck
Mr and Mrs HN Hatherall
The Hon and Mrs David Hawker
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Mrs Anne Hindson
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Mr and Mrs Stan Hornby
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Mr and Mrs RM Hunter
Ms Sandra Hurley
Mrs Jenny Hutton
Mr Noel Hyslop
Mr and Mrs Bruce Iredell
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Mrs Joan Lewis
Mrs Glenys Leyonhjelm
Mr and Mrs P Linke
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Mr and Mrs Ian Macgugan
Mr and Mrs Rod MacGugan
Mr and Mrs Sandy MacKirdy
Mr and Mrs Neil MacLean
Mr and Mrs Edwin MacLean
Miss Olwyn MacLeod
Mr and Mrs Freddy Mailes
Ms Kerry Martin
Anne Mathews
Mr Donald McArthur
Ms Shirley McCarthy
Mr Kerry McCaskill
Ms Jillian McDonald
Mr John McIntyre
Mr Fraser McKenzie
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Merino Association
Mr Neville Mirtschin
The Estate of Adella Mitchell
Ms Rebecca Morton
National Australia Bank
Nationwide Breeders
Anne Nelson
Trevor Nelson
North Hamilton Base Hospital Ladies Auxiliary
Mr Leo O'Brien
G and N Oliver
Mr and Mrs Cornelius Onderwater
Miss Eva Palmer
Parklands Golf Club
Pauline Oliver - Snell Rentsch Clinic
Ms Joan Pearson
Penshurst & Dist Health Service Ladies Auxiliary
Penshurst Opportunity Shop
Mrs Bev Pepper
Mrs Bev Pepper
Mrs A M Philip
Ms Laurice Picken
Ms Fay Picken
Mrs Norma V Pratt
Mr John Prust
Mr and Ms Roy Rabone
Mr Max Rees
Ms Jenny Reeves
Dr David Rendell
Mr John Rentsch
Mr Andrew Rentsch
Mrs Vannis Rich
Mr Craig Richardson
Ms Leanne Rigby
Mr and Ms Jason Ritchie
Mr and Mrs Neil Ross
Mr and Mrs P H Row
Mr Frank Sanders
Dr Robert Scaife
Mr and Mrs Mervyn Schultz
Mrs Edna Scullion
Ms Leonie Sharrock
Mrs and Mrs Ruth Silcock
Mrs Lesley Slorach
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Mr and Mrs Les Smith
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Mr and Mrs Keith Stinton
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Tarrington Lutheran Women's Guild
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The Hamilton & Alexandra College Junior School
The James Charitable Trust
The William Angliss (Vic) Charitable Fund
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Mrs Carol Uebergang
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Walkenhorst Family
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Mrs Anna Walter
Mr and Mrs BJ Warburton
Dr and Mrs Tony Wark
Mrs Judith Warne
Ms Ellwyn Watt
Mr and Mrs J Watt
WDHS Social Club
Western District Pastoral Co. Pty Ltd - Yarram Park
Mr and Mrs Clive Whitehead
Mr and Mrs Simon Wilson
Mr Mark Wootton and Ms Eve Kantor
Mr and Mrs Peter Young

Arctic Blast

Air Adventure Australia
Alexandra House
Ardgartan Pastoral Company
Bendigo Radiology
Robert Brown & Associates
C.I.T.S.
Cogger Gurry
Donehue's Leisure
Farm Food Retail Services
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Grampians Tyre Services
Hamilton Farm Supplies
Hamilton Hearing Clinic Tim Rayner Audiology
Hamilton Medical Group
Hamilton Spinal Sports & Wellbeing
Harvey Norman
MC Herd
Hunts Auto Spares
Dale Hutchins - The Gas Man
Kanawalla Past Co
Kerr & Co Livestock
Landmark
LMB Linke
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Victorias Sights & Delights
Weeran Angus
WHK
Windmill Ag
Yarram Park

Fun Run

Lakesedge - VicUrban
Shire of Southern Grampians
Wannon Water

Senior Staff

Chief Executive Officer
Jim Fletcher BHA, AFCHSE, CHE, MIPAA, MAICD

Community Liaison Manager
Kerry Martin AssDipBusAdmin, Cert1V WplaceL&M

Penshurst Manager/Director of Nursing
Alastair Doull DipN, MBA

Penshurst Unit Manager
Jenny Paton RN, RM to 02 September 2011
Anne-Marie Wheaton from 17 October 2011

Coleraine Manager/Director of Nursing
Tim Pitt-Lancaster RN BN Cert Peri-Operative Nursing, GradDipNursingSci

Coleraine Unit Manager
Denise Beaton RN RM

Deputy Chief Executive Officer/Director of Corporate Services
Patrick Turnbull BBus, BHA, FCPA

Manager Finance & Budget
Nicholas Starkie BBus DipTS(Bus),GradCertBusAdmin, ASA

Business Support and Innovation Manager
Colin Barrie BE

Hotel Services Manager
Peter Davies BA

Human Resources Manager
Hilary King MBA, Grad Dip HR, Dip Physio, CAHRI

Facility Manager
Trevor Wathen Dip Frontline Mgt, MFAM

Learning and Education Manager
Deborah Smith PGradCert Ed, PGradDipEval, BAAdmin Hons), Cert IV A&WT

Librarian
Louise Milne ALIA

Nursing Services

Director of Nursing
Janet Kelsh RN, ICUCert, BAppSci(Nadmin), CertMgt(Deakin), GradDipAgedServMgt, MRCNA

Deputy Director of Nursing
Bronwyn Roberts RN, CriticalCareCert, GradCertBusAdmin, MRCNA

ADON Business Manager
Lorraine Hedley RN, BN, MRCNA

ADON Clinical Operations
Judy Esson RN,RM,BN,CertCritCare,GradDipHealthAdmin

After Hours Coordinators
Dianne Nagorcka RN, RM, Peri-opCert,BN
Dianne Raymond RN
Jennifer O'Donnell RN, RPN, AdvCertMgt, AdvCertWorkplace Practice Skills
Kathy Ross RN GradDipCriticalCare
Leanne Deutscher RN
Lesley Stewart RN, Sterilisation&InfectionControlCert, Post Grad Cert Wound Management
Linda Donaldson RN, MRCNA
Mavis Wilkinson RN, RM

NURSE MANAGERS

Aged Care Services

Unit Manager The Birches
Lee Vause RN, MBA, Manager from March 2012
Bongai Duma RN, M Clin.Science(Healthy Ageing and Aged Care), BA(nursing science) to March 2012

Unit Manager the Grange
Pam Vince RN, BaHealth Science (Nursing), Nurse Immuniser, MRCNA, AdvDip Business

District Nursing
Pat O'Beirne RN, RM

Unit Manager Medical/ICU/ED
Lisa Livingstone CCRN

Unit Manager Surgical/Obstetrics/ Paediatrics
Kate Stewart BN, Grad Cert (cancer nurse), RN Acting to August 2011
Julie Zagorski from 03 October 2011 – 01 January 2012
Monica Neeson RN Acting from February 2012

Unit Manager Theatre/CSSD
Jane Sanders RN, Dip Frontline Mgt, Cert Education

REGIONAL PROGRAMS

Infection Control
Mark Stevenson RN, PeriopCert, GradCertBusAdmin, Sterilisation&InfectionControl Cert, Accredited Nurse Immuniser
Carolyn Templeton RN, Sterilisation&InfectionControlCert, CertHIV/HEPCounselling, Accredited Nurse Immuniser

Palliative Care Service
Erika Fischer RN

Regional Wound Management
Lesley Stewart RN, Sterilisation&InfectionControlCert, Post Grad Cert Wound Management

IC4OP
Jennie O'Donnell RN,AdvCertMgt, AdvCertWorkplaceSkills

Medical Services

Director Medical Services
Dr Alastair Wilson B.Sc., MB.ChB., Dip.Obs., Dip. Indust.Health, DipH.S.M., FRNZCGP

Quality Manager
Gillian Jenkins RN Master of Education (Rsch), GradCertBusAdmin, MRCNA

Chief Pharmacist
Lynette Christie M Pharm, MPS, GradCertBusAdmin

Chief Health Information Manager
Carolyn Gellert Grad Dip HSci, BAppSci

Senior Medical Staff

Anaesthetics (Director)
James Muir MBChB, FRCA

Anaesthetists in General Practice
Craig deKievit MBBS, DRANZCOG, FACRRM
Kim Fielke MBBS, DRANZCOG, DA (UK), FRACGP
Stuart Perry MBBS

General Practitioners
Mohamed Abdullah MBBS
Victoria Blackwell MB, ChB, MRCGP, DRCOG, DFFP
Brian Coulson MBBS, FACRRM, Dip O&G
Craig deKievit MBBS, DRANZCOG, FACRRM
Dale Ford MBBS, FRACGP, FACRRM
Allan Mark Johnson MBBS
Robey Joyce MB, ChB (Pretoria)
Anita Lindell BMBS from March 2012
Andrew McAllan MBBS, MMed (Ophth)
Nazar Osman BMBS
Stuart Perry MBBS
Greta Prozesky MB, ChB, FRACGP
Shaun Renfrey MBBS
Susan Robertson MBBS, DipRACOG, FRACGP, DipPallCare
Robert Scaife MBBS, FACRRM
Jan Slabbert MB, ChB (Free State), FRACGP, RACGP
Ramin Taheri MBBS
Kim Eng Tan MBBS to December 2011
Linda Thompson BMS, FRACGP
Sharma Kaipa Tripura MD., FHM
Leesa Walker MBBS, FRACGP
Anthony Wark MBBS

Dental Officers (honorary)
David Baring BDSc
Timothy Halloran LDS,BDSc
(Steven) Jiwen Sun BDSc
Peter Tripovitch LDS, BDSc

Dermatologist
Julie Wesley RFD, MBBS, FACD

Endocrinologist
Fergus Cameron B Med Sci, MD, BS, Dip RACOG, FRACP

General Surgeons
Stephen Clifforth MBBS, FRACS
Uvarasen Kumarswami Naidoo MBcHB, FCS, FRACS
Peter Tung MBBS, FRACS, FHKAM

Neurologists
Associate Professor Peter Gates MB, BS, FRACP, Neurology RACP

Obstetrician/Gynaecologist
Christopher Beaton MB.ChB, FRANZCOG

Obstetricians in General Practice
Craig deKievit MBGBS, DRANZCOG, FACRRM
Robey Joyce MB, ChB (Pretoria)
Anita Lindell BMBS from March 2012
Jan Slabbert MB, ChB, (Free State), FRACGP, RACGP

Oncologist
David Ashley MBBS; FRACP; PHS

Ophthalmologist
Vincent Lee MBBS, MMed, FRACS, FRANZCO

Oral and Maxillofacial Surgeons
Graeme Fowler LDS, BDSc, MDSc, FDSRCPS

Orthopaedic Surgeon
Ric Cunningham MBBS, FRACS (ORTH)

Otolaryngologists
Anne Cass MBBS, FRACS

→ Registered Nurse, Fiona Cogger and After Hours Co-ordinator, Dianne Nagorcka supporting Person Centred Care in the Surgical Unit at HBH

Paediatrician
Christian Fiedler MD, (KIEL), FRACP

Pathologist
David Clift MBBS, FRCPA

Physicians
Andrew Bowman MBChB (Zimb),LRCP(Edin),LRCS(Edin),LRCP&S(Glas),FRCP(UK),CCST(UK),FRACP
Andrew Bradbeer MBBS, FRACP
Trevor Branken MB. ChB (Birm) FCP (Sth Africa) from February 2012
Geoffrey Coggins MBBS, FRACP

Radiologists
Margaret Bennett MBBS, FRANZCR
Damien Cleeve MBBS, FRACR
John Eng MBBS, FRANZCR
Robert Jarvis MBBS, FRACR
Sarah Skinner BMBS, Flinders University SA
Dr Julius Tamangani MBChB(Hons), MSc, FRCR
Dr Jill Wilkie BSc(Hons), MBBS, MRCP, FRCR

Urologists
Richard Grills MBBS, FRACS

Hospital Medical Officers (visiting on rotation)
St Vincent's Hospital-two general surgical interns, two general medicine interns
Barwon Health – one general medicine intern, one surgical registrar, one medical registrar
Austin Hospital – one surgical registrar

Hospital Medical Officers (employed by WDHS)
Rashi Anand MBBS from May 2012
Thilini Kodithuwakku MBBS
Ashwin Koshy MBBS
Linn Kyaw MBBS to April 2012
Wah Wah Lin MBBS
Shanthi Sibbaiah MBBS
Sushrut Vijay MBBS
Suhail Wani MBBS from April 2012
Dinushi Weerrsinghe MBBS

Primary & Preventative Health

Director Primary & Preventative Health
Rosie Rowe BNatRes, MBA, Honorary Fellow, University of Melbourne, AICD

Manager, Primary Care Services
Fran Patterson to March 2012
Belinda Payne, GradDipBus from May 2012

Manager, Care Coordination
Megan McLeish to November 2011
Usha Naidoo, MSc, BSocSc, RN, DipOncol, DipMgt from February 2012

Dentist
Dr Tony Buc BA DentalSci

Chief Dietitian
Jodie Nelson BHSc(Nutrition&Dietetics)

Chief Occupational Therapist
Sue Adamson to March 2012
Fran Patterson BAppSci (O.T), Dip VET from March 2012

Chief Physiotherapist
Lyn Holden BAppSc(Physio), MPhysio, MHealthAdmin, Member APA

Speech Pathologist
Sue Cameron BAppSc(SpeechPath), MSPAA

Senior Social Worker
Rinu Thomas B.Com, MSocialWrk

Senior Podiatrist
Phuong Huynh MSc, BAppSci(Pod), MAPodA, AAPSM

Primary Care Partnership

Executive Officer
Jeanette Lowe MBA, BEng

National Centre for Farmer Health

Director
Associate Clinical Professor Susan Brumby RN, RM, DipFMgt, GradDipWomen's Studies, MHMgt, CertIVWorkplaceTrainer, AFCHSE, MRCNA

Sustainable Farm Families Program Manager
Cate Mercer-Grant B.Bus, B. Bus (Property Valuations), Certificate IV (Training and assessment)

Statement of Priorities Agreement

Strategic Priorities for 2011-12

The Victorian Government's priorities and policy directions are outlined in the Victorian Health Priorities Framework 2012-2022. The seven priority areas are:

1. Developing a system that is responsive to people's needs
2. Improving every Victorian's health status and experiences
3. Expanding service, workforce and system capacity
4. Increasing the system's financial sustainability and productivity
5. Implementing continuous improvements and innovation
6. Increasing accountability and transparency
7. Utilising e-health and communications technology

In 2011-12 Western District Health Service contributed to the achievement of these priorities by:

VHPF PRIORITY	HEALTH SERVICE STRATEGY	DELIVERABLES	OUTCOMES
Developing a system that is responsive to people's needs Expanding a service, workforce and system capacity	Complete the final stage redevelopment of the Grange to expand and enhance services for our ageing population	‣ Completion of construction including redevelopment of one wing, a new 7 bed wing, a new kitchen and additional activity space ‣ Commissioning of five new beds ‣ Completion of $2.2m fundraising appeal	‣ Redevelopment completed May 2012 ‣ Five beds commissioned March 2012 ‣ Fundraising target of $2.2m achieved March 2012
Developing a system that is responsive to people's needs Improving every Victorian's health status and experiences Expanding service, workforce and system capacity	Ensure health care is provided in the most clinically and cost effective environment by improving access and functionality of sub acute services to better meet the needs of rehabilitation, Geriatric Evaluation Management and long stay older patients needs	‣ Commence construction of $3.5M Council of Australian Governments sub acute development to include expansion of bed capacity, assisted daily living skills, kitchen and gym facilities	‣ Construction commenced 21 May 2012
Developing a system that is responsive to people's needs Expanding service, workforce and system capacity	Enhance individuals and families ability to make decisions that improve their health status and reduce their risk of ill health by improving health literacy Improve service provision and linkages for indigenous health	‣ Completion of oral health research project re access for 5-12 year olds ‣ Provision of outreach Podiatry and Dietician services to Windamarra ‣ Implementation of Workplace Mentoring program for Windamarra staff	‣ Research project completed and presented to DHSV and State conferences ‣ 11 sessions provided to clients for Podiatry and 17 sessions provided to 56 clients for Dietetics ‣ Allied Health Assistant trainee position established
Improving every Victorian's health status and experiences Implementing continuous improvements and innovation	Improve care planning and coordination of care for patients with chronic and complex conditions To ensure consumer involvement and person centred care service model	‣ Further implementation of care coordination model through enhancement to care planning process ‣ Integration of Rehabilitation/Geriatric Evaluation Management, transition care and long stay older patients programs	‣ Coordinated care planning implemented in partnership with consumers ‣ Integrated service pathway developed for implementation
Developing a system that is responsive to people's needs Improving every Victorian's health status and experiences Expanding service, workforce and system capacity Implementing continuous improvements and innovation	Enhance individuals and families ability to make decisions that improve their health status and reduce their risk of ill health by improving health literacy through the implementation of National Centre for Farmer Health key objectives	‣ Roll out of 12 Flood Relief Sustainable Farm Families programs in partnership with DPI ‣ Delivery of the Agriculture Health and Medicine Unit in Victoria and Queensland ‣ Implementation of Agriculture Health and Medicine Graduate Certificate ‣ Establishment of Agri Safe Clinic ‣ Completion of Workforce Innovation project developing pathways for certificate courses in Rural Health ‣ Completion of evidence based research projects and dissemination of outcomes	‣ 10 of 12 2nd year programs completed ‣ 18 students undertaking Health and Medicine Unit in Victoria ‣ 14 medical students completed the Queensland program ‣ Agricultural Health and Medicine Graduate Certificate established. 4 students enrolled ‣ Clinic established 50 farmer attendees, eight field days and 720 health assessments ‣ Project completed – Pilot undertaken ‣ Farming Fit Project completed with projects related to hearing loss, arthritis, exposure to hazards and alcohol intervention in progress
Developing a system that is responsive to people's needs Expanding service, workforce and system capacity	Construction of the 1st stage of Coleraine redevelopment	‣ 1st stage completed with construction of new primary care building, new acute and aged care wing and rehousing of residents and demolition of sub standard buildings	‣ 1st stage with construction of new primary care building completed with new acute and aged care wing on schedule for completion ahead of target December 2012
Increasing accountability and transparency	Complete a review of the provision of a Sub Regional Linen Service	‣ Develop a business plan to establish a Sub Regional Linen Service in partnership with South West Healthcare	‣ Business Plan completed with Sub Regional Service commenced 13/8/12
Developing a system that is responsive to people's needs Improving every Victorian's health status and experiences Utilising e-health and communications technology	Ensure health care provided in the most clinically effective and cost effective environments Improve access to Cancer services	‣ Establish an outreach visiting oncology service to Hamilton through a MOU with Barwon Health	‣ Monthly visiting oncology service commenced at Western District Health Service in March 2012 ‣ New consulting and education suite established

Service Performance

Financial Performance

KEY PERFORMANCE INDICATOR	TARGET	2011-12 ACTUALS
OPERATING RESULT		
Annual operating result ($m)	0.02	0.30
CASH MANAGEMENT		
Creditors	< 60 days	34
Debtors	< 60 days	37

Access Performance

KEY PERFORMANCE INDICATOR	TARGET	2011-12 ACTUALS
EMERGENCY CARE[1]		
Percentage of emergency patients transferred to an inpatient bed within 8 hours	80	99
Percentage of non-admitted emergency patients with a length of stay less than 4 hours	80	94
Number of patients with a length of stay in the emergency department greater than 24 hours	0	0
Percentage of Triage Category 1 emergency patients seen immediately	100	100
Percentage of Triage Category 2 emergency patients seen within 10 minutes	80	94
Percentage of Triage Category 3 emergency patients seen within 30 minutes	75	95

Service Performance

KEY PERFORMANCE INDICATOR	TARGET	2011-12 ACTUALS
WIES[2] ACTIVITY PERFORMANCE		
Percentage of WIES (public & private) performance to target	98 to 102	98.35
QUALITY AND SAFETY		
Health service accreditation	Full compliance	Full compliance
Residential aged care accreditation	Full compliance	Full compliance
Cleaning standards	Full compliance	Full compliance
Submission of data to VICNISS[3]	Full compliance	Full compliance
Hand Hygiene Program compliance rate	65	78
Victorian Patient Satisfaction Monitor: (OCI)[4]	73	83
Consumer Participation Indicator [5]	75	82
Residential Aged Care Services Organisational Readiness Tool	Full compliance	Full compliance
Maternity		
Percentage of women with prearranged postnatal home care	100	100

(1) Established benchmark targets for patient access to public health services. It is expected that health services show demonstrable improvement towards achievement of benchmark targets

(2) WIES is a Weighted Inlier Equivalent Separation

(3) VICNISS is the Victorian Hospital Acquired Infection Surveillance System

(4) The target for the Victorian Patient Satisfaction Monitor is the Overall Care Index (OCI) which comprises six categories

(5) The Consumer Participation Indicator is a category of the Victorian Patient Satisfaction Monitor

Activity Performance

FUNDING TYPE	2011-12 ACTIVITY ACHIEVED
ACUTE INPATIENT	
WIES Public	3,315
WIES Private	1,080
WIES (PUBLIC AND PRIVATE)	4,395
WIES Rural Patient Initiative	31
WIES Renal	59
WIES DVA	264
WIES TAC	20
WIES TOTAL	4,769
SUBACUTE INPATIENT	
Rehab L2 Public	1,189
GEM Public	406
GEM DVA	53
Palliative Care Public	367
Palliative Care Private	52
Palliative Care DVA	15
NHT	38
NHT DVA	290
AMBULATORY	
Emergency Services – Non Admitted	7,221
Non VACS Outpatients	54,951
Transition Care – Bed days	820
Transition Care – Home day	870
SACS	7,445
SACS DVA	344
Palliative Care – Community	3,693
AGED CARE	
Residential Aged Care	42,115
COMMUNITY HEALTH / PRIMARY CARE	
Community Health Direct Care	4,040
SMALL RURAL	
SRHS – Acute	176
SRHS – Residential Aged Care	18,685
OTHER	
Other specified funding	
TOTAL FUNDING	

Legislative Compliance

Financial Management Act 1994
In accordance with the Direction of the Minister for Finance part 9.1.3 (IV), information requirements have been prepared and are available to the relevant Minister, Members of Parliament and the public on request.

Fees
WDHS charges fees in accordance with the Commonwealth Department of Health and Aged Care, the Commonwealth Department of Family Services and the Department of Health (Vic) directives, issued under Regulation 8 of the Hospital and Charities (Fees) Regulations 1986, as amended.

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

Consultancies
In 2011-12 Western District Health Service engaged 12 consultancies where the total fees payable to the consultants were less than $10,000, with a total expenditure of $63,445 (excl.GST).

Consultancies greater than $10,000 – refer to below table

Freedom of Information (FOI)
Access to documents and records held by WDHS may be requested under the Freedom of Information Act 1982. Consumers wishing to access documents should apply in writing to the FOI Officer at WDHS. This year 74 FOI requests were received. No request was denied. There were no documents for seven requests and for all others access was granted in full.

Declarations of Pecuniary Interest
All necessary declarations have been completed. Refer to Note 24 of the Financial Statements. Building and Maintenance

All building works have been designed in accordance with DOH Capital Development Guidelines and comply with the Building Act 1993, Building Regulations 2006 and Building Code of Australia relevant at the time of the works.

Buildings Certified for Approval
A certificate of final inspection was issued on 20th October 2011 for stage 2 works at Penshurst Hospital with the kitchen and coolroom upgrade.

An occupancy permit was issued on 29th March 2012 for all associated works with the Grange Residential upgrade –a new seven bed home, new kitchen and refurbishment of existing home 3 rooms.

A certificate of final inspection was issued 19th January 2012 for the new emergency generator and acoustic canopy upgrade.

An occupancy permit was issued on 29th May 2012 for stage 1 refurbishment works at Hamilton Medical Group.

Building works 2011/2012
Penshurst & District Health Service – Stage 2 works with kitchen / coolroom upgrade was completed in October 2011.

Grange Residential –A $2.85 m upgrade that included a new seven bed home, refurbishment of home 3 rooms, new kitchen, new hairdresser room and alterations to front entrance.

New emergency generator and acoustic canopy was completed in January 2012.

Hamilton Medical Group Stage 1 works was completed in May 2012 with an internal refurbishment to reception, treatment rooms and waiting areas.

Infrastructure projects
Ceiling hoist tracks were installed into all rooms at the Birches and the Grange.

Vinyl replacement to the Theatres at Hamilton Base Hospital was completed in April 2012.

Pathology wing automatic door install and spouting replacement completed June 2012.

Electricity sub main cable upgrade to South East wing was completed in May 2012.

Extension to Birches car park completed June 2012.

Attestation on Data Integrity
I, Jim Fletcher, certify that WDHS has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. The Health Service has critically reviewed these controls and processes during the year.

Jim Fletcher

CHIEF EXECUTIVE OFFICER

9 August 2012

CONSULTANCIES > $10,000				
CONSULTANT	**PURPOSE OF CONSULTANCY**	**TOTAL APPROVED PROJECT FEE (ex. GST)**	**EXPENDITURE 2011-12 (ex. GST)**	**FUTURE EXPENDITURE (ex. GST)**
Health Science Planning	Grange Redvelopment	161,000	56,659	-
Health Science Planning	Sub Acute Project	159,600	129,129	30,471
Balcombe Griffiths	Coleraine Redevelopment	1,958,245	264,815	411,452
Aurecon Australia	Coleraine Redevelopment	484,122	95,868	189,764
Aquenta Consulting	Coleraine Redevelopment	326,603	34,020	90,154
Brian Sherwell & Associates	Coleraine Redevelopment	23,231	23,231	-
Cosgriff & Associates	Sub Acute Project	54,000	37,503	16,497
Cosgriff & Associates	Generator Upgrade	34,000	34,000	-
Newton & Kerr	Sub Acute Project	32,600	12,800	19,800
Cooper Scaife	HMG Upgrade	62,236	62,236	-
Provider Assist	ACFI Review	73,877	73,877	-
Judith Nichols	Dartmoor BNC	10,550	10,550	-
Health Science Planning	Feasibility & Masterplan Study	40,000	36,915	3,085
Total		**3,420,063**	**871,603**	**761,222**

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

We certify that the attached financial statements for Western District Health Service has been prepared in accordance with Standing Direction 4.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards, Australian Accounting 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 notes to and forming part of the financial report, presents fairly the financial transactions during the year ended 30 June 2012 and the financial position at that date of Western District Health Service as at 30 June 2012.

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

We authorise the attached financial report for issue on this day.

Mary Ann Brown
President

Hamilton
09 August 2012

Jim Fletcher
Chief Executive Officer

Hamilton
09 August 2012

Pat Turnbull
Chief Finance and Accounting Officer

Hamilton
09 August 2012

Disclosure Index

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

Note: This Disclosure Index consists of 2 pages, and is not required to be completed by denominational hospitals.

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VAGO
Victorian Auditor-General's Office

Level 24, 35 Collins Street
Melbourne VIC 3000
Telephone 61 3 8601 7000
Facsimile 61 3 8601 7010
Email comments@audit.vic.gov.au
Website www.audit.vic.gov.au

INDEPENDENT AUDITOR'S REPORT

To the Members of Western District Health Service

The Financial Report

The accompanying financial report for the year ended 30 June 2012 of the Western District Health Service which comprises the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a statement of significant accounting policies and other explanatory information, and the Board member's, accountable officer's and chief finance and accounting officer's declaration has been audited.

The Board Members' Responsibility for the Financial Report

The Board Members of the Western District Health Service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*, and for such internal control as the Board Members determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

As required by the *Audit Act 1994*, my responsibility is to express an opinion on the financial report based on the audit, which has been conducted in accordance with Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report 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 entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Board, as well as evaluating the overall presentation of the financial report.

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

Independent Auditor's Report (continued)

Independence

The Auditor-General's independence is established by the *Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, the Auditor-General, his staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of the Western District Health Service as at 30 June 2012 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

Matters Relating to the Electronic Publication of the Audited Financial Report

This auditor's report relates to the financial report of the Western District Health Service for the year ended 30 June 2012 included both in the Western District Health Service's annual report and on the website. The Board of the Western District Health Service is responsible for the integrity of the Western District Health Service's website. I have not been engaged to report on the integrity of the Western District Health Service's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in the website version of the financial report.

MELBOURNE
10 August 2012

for D D R Pearson
Auditor-General

Comprehensive Operating Statement For the Year Ended 30 June 2012

	Note	Total 2012 $'000	Total 2011 $'000
Revenue from Operating Activities	2	61,660	59,874
Revenue from Non-operating Activities	2	1,658	1,629
Employee Expenses	3	(42,786)	(41,018)
Non Salary Labour Costs	3	(3,298)	(3,311)
Supplies & Consumables	3	(5,891)	(6,163)
Other Expenses From Continuing Operations	3	(11,040)	(10,736)
Net Result Before Capital & Specific Items		**303**	**275**
Capital Purpose Income	2	14,569	8,012
Impairment of Financial Assets	3	(14)	(12)
Depreciation and Amortisation	4	(3,302)	(3,618)
Assets Received Free of Charge	2d	-	459
NET RESULT FOR THE YEAR		**11,556**	**5,116**
Other comprehensive income			
Net fair value gains/(losses) on Available for Sale Financial Investments		(78)	17
COMPREHENSIVE RESULT FOR THE YEAR		**11,478**	**5,133**

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

Balance Sheet As at 30 June 2012

	Note	Total 2012 $'000	Total 2011 $'000
Current Assets			
Cash and Cash Equivalents	5	24,504	22,917
Receivables	6	2,892	2,853
Inventories	8	369	365
Other Current Assets	9	87	18
Total Current Assets		**27,852**	**26,153**
Non-Current Assets			
Receivables	6	977	787
Investments and other Financial Assets	7	1,639	1,711
Property, Plant & Equipment	10	60,632	48,693
Intangible Assets	11	7	12
Total Non-Current Assets		**63,255**	**51,203**
TOTAL ASSETS		**91,107**	**77,356**
Current Liabilities			
Payables	12	4,095	3,669
Provisions	13	9,395	7,703
Other Liabilities	14	1,714	1,871
Total Current Liabilities		**15,204**	**13,243**
Non-Current Liabilities			
Provisions	13	1,531	1,402
Other Liabilities	14	3,675	3,492
Total Non-Current Liabilities		**5,206**	**4,894**
TOTAL LIABILITIES		**20,410**	**18,137**
NET ASSETS		**70,697**	**59,219**
EQUITY			
Property, Plant & Equipment Revaluation Surplus	15a	2,437	2,437
Financial Asset Available for Sale Revaluation Surplus	15a	(52)	26
Restricted Specific Purpose Reserve	15a	8,716	11,815
Contributed Capital	15b	49,535	49,535
Accumulated Surpluses/(Deficits)	15c	10,061	(4,594)
TOTAL EQUITY	15c	**70,697**	**59,219**
Contingent Assets and Contingent Liabilities	19		
Commitments for Expenditure	18		

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

Statement of Changes in Equity For the Year Ended 30 June 2012

	Note	Property, Plant & Equipment Revaluation Surplus	Financial Asset Available for Sale Revaluation Surplus	Restricted Specific Purpose Surplus	Contributions by Owners	Accumulated Surpluses/ (Deficits)	Total
		$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2010		**2,437**	**9**	**6,738**	**49,535**	**(4,633)**	**54,086**
Net result for the year		-	-	-	-	5,116	5,116
Other comprehensive income for the year	15a	-	17	-	-		17
Transfer to accumulated surplus	15c	-	-	5,077	-	(5,077)	-
						.	
Balance at 30 June 2011		**2,437**	**26**	**11,815**	**49,535**	**(4,594)**	**59,219**
Net result for the year		-	-	-	-	11,556	11,556
Other comprehensive income for the year	15a	-	(78)	-	-	-	(78)
Transfer to/ from accumulated surplus	15c	-	-	(3,099)	-	3,099	-
Balance at 30 June 2012		**2,437**	**(52)**	**8,716**	**49,535**	**10,061**	**70,697**

This Statement should be read in conjunction with the accompanying notes

Cash Flow Statement For the Year Ended 30 June 2012

	Note	Total 2012 $'000	Total 2011 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		42,310	41,328
Patient and Resident Fees Received		12,933	12,365
Private Practice Fees Received		95	325
GST Received from/(paid to) ATO		2,252	1,343
Interest Received		950	839
Dividend Received		29	15
Other Receipts		6,148	5,440
Employee Expenses Paid		(41,475)	(40,368)
Non Salary Labour Costs		(3,298)	(3,311)
Payments for Supplies & Consumables		(9,483)	(10,087)
Other Payments		(8,150)	(8,424)
Cash Generated from Operations		**2,311**	**(535)**
Capital Grants from Government		11,419	5,063
Capital Grants from Non-Government		18	450
Capital Donations and Bequests Received		1,314	1,987
Other Capital Receipts		1,575	1,387
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	16	**16,637**	**8,352**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Investments		77	95
Payments for Non-Financial Assets		(15,516)	(4,414)
Proceeds from sale of Non-Financial Assets		223	178
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		**(15,216)**	**(4,141)**
NET INCREASE/(DECREASE) IN CASH HELD		**1,421**	**4,211**
CASH AND CASH EQUIVALENTS AT BEGINNING OF PERIOD		**17,821**	**13,610**
CASH AND CASH EQUIVALENTS AT END OF PERIOD	5	**19,242**	**17,821**

This Statement should be read in conjunction with the accompanying notes

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Note 1: Statement of Significant Accounting Policies

(a) Statement of Compliance

These financial statements are a general purpose financial report which has been prepared in accordance with the Financial Management Act 1994, applicable Australian Accounting Standards (AASs), and Australian Accounting Interpretations and other mandatory requirements. AASs include Australian equivalents to International Financial Reporting Standards.

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 Minister for Finance.

The Health Service is a not-for profit entity and therefore applies the additional Aus paragraphs applicable to "not-for-profit" Health Services under the AAS's.

The annual financial statements were authorised for issue by the Audit & Compliance Committee of Western District Health Service on 08/08/2012.

(b) 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 2012, and the comparative information presented in these financial statements for the year ended 30 June 2012.

The going concern basis was used to prepare the financial statements.

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

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 these items, that is they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

The Financial Statements are prepared in accordance with the historical cost convention, except for the revaluation of certain non-financial assets and financial instruments, as noted. Particularly, exceptions to the historical cost convention include:

- Non-current physical assets, which subsequent to acquisition, are measured at valuation and are re-assessed with sufficient regularity to ensure that the carrying amounts do not materially differ from their fair values;
- Available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised.
- The fair value of assets other than land is generally based on their depreciated replacement value.

Historical cost is based on fair values of the consideration given in exchange for assets.

In the application of AAS's management is required to make judgments, estimates and assumptions about carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. Judgements made by management in the application of AASs that have significant effects on the financial statements and estimates, with a risk of material adjustments in the subsequent reporting period, are disclosed throughout the notes to the financial statements and estimates, with a risk of material adjustments in the subsequent reporting period, relate to:

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 1(k);
- actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 1(L).

(c) Reporting Entity

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

Its principle address is:
20 Foster Street,
Hamilton 3300

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

(d) Principles of Consolidation

Intersegment Transactions

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

Jointly Controlled Assets

Interest in jointly controlled assets are accounted for by recognising in Western District Health Service's financial statements its proportionate share of the assets, liabilities and any income and expense of such assets.

Details of jointly controlled assets are set out in Note 21.

(e) Scope & presentation of financial statements

Fund Accounting

The Health Service operates on a fund accounting basis and maintains three funds:

Operating, Specific Purpose and Capital Funds. The Health Service's Capital and Specific Purpose Funds include unspent capital donations and receipts from fund-raising activities conducted solely in respect of these funds.

Services Supported By Health Services Agreement and Services Supported by Hospital and Community Initiatives

Activities classified as Services Supported by Health Services Agreement (HSA) are substantially funded by the Department of Health and includes Residential Aged Care Services (RACS) and are also funded from other sources such as the Commonwealth, patients and residents; while Services Supported by Hospital and Community Initiatives (H&CI) are funded by the Health Service's own activities or local initiatives and/or the Commonwealth.

Residential Aged Care Service

The following Residential Aged Care Services operations are an integral part of the Health Service and share its resources.

- The Birches and Grange Residential Care Service (located in Hamilton)
- Kolor Lodge and W J Lewis Nursing Home (located in Penshurst)
- Valley View Nursing Home and Wannon Hostel (located in Coleraine)

These Residential Aged Care Services are substantially funded by Commonwealth bed day subsidies. Where services are co-located with other health service operations an apportionment of land and buildings has been made based on floor space. The results of all operations have been segregated based on actual revenue earned and expenditure incurred by each operation.

Western District Linen Service

The Western District Linen Service is a self-funding operation controlled by the Health Service Board. As the Linen Service operations are an integral part of the agency, with shared resources, its operations have been included with the Health Service for accountability.

Comprehensive operating statement

The Comprehensive operating statement includes the subtotal entitled "Net Result before Capital & Specific Items" to enhance the understanding of the financial performance of the Health Service. This subtotal reports the result excluding items such as capital grants, assets received or provided free of charge, depreciation, expenditure using capital purpose income and items of an unusual nature and amount such as specific income and expenses. The exclusion of these items is made to enhance matching of income and expenses so as to facilitate the comparability and consistency of results between years and Victorian Public Health Services. The "Net Result before Capital & Specific Items" is used by the management of the Health Service, the Department of Health and the Victorian Government to measure the ongoing result of Health Services in operating hospital services.

Capital and specific items, which are excluded from this sub-total, comprise:

- Capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer Note 1 (g)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.
- Specific income/expense, comprises the following items, where material:
  - Non-current asset revaluation increments/decrements
  - Diminution in investments
- Impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), related to non-current assets only which have been recognised in accordance with Note 1 (j) and (i)
- Depreciation and amortisation, as described in Note 1 (h)
- Assets provided or received free of charge, as described in Note 1 (g) and (h)
- Expenditure using capital purpose income, which comprises expenditure which either falls below the asset capitalization threshold (Note 1 (h)) or doesn't meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

Balance Sheet

Assets and liabilities are categorised either as current or non-current.

Statement of changes in equity

The statement of changes in equity presents reconciliations of each non-owner and owner equity opening balance at the beginning of the reporting period to the closing balance at the end of the reporting period. It also shows separately changes due to amounts recognised in the comprehensive result and amounts recognised in other comprehensive income related to other non-owner changes in equity.

Cash Flow Statement

Cash flows are classified according to whether or not they arise from operating activities, investing activities, or financing activities. This classification is consistent with requirements under AASB 107 Statement of Cash Flows.

For the cash flow statement presentation purposes, cash and cash equivalents include bank overdrafts, which are included as current borrowings in the balance sheet.

Comparative Information

Where necessary the previous year's figures have been reclassified to facilitate comparisons.

(g) Income Recognition

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

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

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

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

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

Indirect Contributions from the Department of Health

- Insurance is recognised as revenue following advice from the Department of Health.
- Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 14/2009.

Patient and Resident Fees

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

Private Practice Fees

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

Donations and Other Bequests

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

Dividend Revenue

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

Interest Revenue

Interest revenue is recognised on a time proportionate basis that takes into account the effective yield of the financial asset.

Sale of Investments

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

Resources Provided and 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 value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

(h) Expense Recognition

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

Cost of Goods Sold

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

Employee Expenses

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

Defined contribution superannuation plans

In relation to defined contribution (i.e. accumulation) superannuation plans, the associated expense is simply 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 expenses when incurred.

Defined benefit superannuation plans

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

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

The name and details of the major employee superannuation funds and contributions made by the Health Service are as follows:

Fund	Contributions Paid or Payable for the Year	
	2012 $'000	2011 $'000
Defined Benefit plans		
Health Super	251	264
Defined Contribution plans		
Health Super	2,598	2,614
HESTA	344	309
Other	120	130
TOTAL	**3,313**	**3,317**

Depreciation

Assets with a cost in excess of $1,000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives. Depreciation is generally calculated on a straight-line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health.

Depreciation is provided on property, plant and equipment, including freehold buildings, but excluding land and investment properties. Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

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

	2012	2011
Buildings	2 to 40 Years	2 to 40 Years
Plant & Equipment	8 to 10 Years	8 to 10 Years
Medical Equipment	8 to 10 Years	8 to 10 Years
Computers and Communication	1 to 5 Years	1 to 5 years
Furniture and Fittings	8 to 10 Years	8 to 10 Years
Motor Vehicles	1 to 5 years	1 to 5 Years
Intangible Assets	1 to 5 years	1 to 5 Years

As part of the Building valuation, building values were componentised and each component assessed for its useful life which is represented above.

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 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 assets concerned are tested as to whether their carrying value exceeds their recoverable amount.

Intangible assets with indefinite useful lives are not amortised, but are tested for impairment annually or whenever there is an indication that the asset may be impaired. The useful lives of intangible assets that are not being amortised are reviewed each period to determine whether events and circumstances continue to support an indefinite useful life assessment for that asset. In addition, the entity tests all intangible assets with indefinite useful lives for impairment by comparing the recoverable amount for each asset with its carrying amount:

- annually, and
- whenever there is an indication that the intangible asset may be impaired.

Any excess of the carrying amount over the recoverable amount is recognised as an impairment loss.

Intangible assets with finite useful lives are amortised over a 10-15 year period. (2011 10-15 years)

Resources Provided and Received Free of Charge or for Nominal Consideration

Resources provided or 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 value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the services would have been purchased if not donated.

(i) 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 the Western District Health Service's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

Where relevant, for note disclosure purposes, a distinction is made between those financial assets and financial liabilities that meet the definition of financial instruments in accordance with AASB 132 and those that do not.

The following refers to financial instruments unless otherwise stated.

Categories of non-derivative financial instruments

Financial assets and liabilities at fair value through profit or loss

Financial assets are categorised as fair value through profit or loss at trade date if they are classified as held for trading or designated as such upon initial recognition. Financial instrument assets are designated at fair value through profit or loss on the basis that the financial assets form part of a group of financial assets that are managed by the entity concerned based on their fair values, and have their performance evaluated in accordance with documented risk management and investment strategies.

Financial instruments at fair value through profit or loss are initially measured at fair value and attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net result.

Financial assets held for trading purposes are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in the net result. The net gain or loss recognised in net result incorporates any dividend or interest earned on the financial asset. Fair value is determined in the manner described in Note 17.

(If a Health Service has reclassified any financial assets from this category into loans and receivables category in accordance with AASB 2008-10, that fact may be disclosed in this section of the policy note. Health Services should discuss any proposed reclassifications with their VAGO representative at an early stage as any change is dependent upon satisfying certain restrictive conditions in the accounting standard)

Loans and receivables

Loans and receivables are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets are initially recognised at fair value plus any directly attributable transaction costs. Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method, less any impairment.

Loans and receivables category includes cash and deposits (refer to Note 1(j)), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

The effective interest method is a method of calculating the amortised cost of a financial asset 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 asset, or, where appropriate, a shorter period.

Held-to-maturity investments

If the Health Service has the positive intent and ability to hold nominated investments to maturity, then such financial assets may be classified as held-to-maturity. Held-to-maturity financial assets are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition held-to-maturity financial assets are measured at amortised cost using the effective interest method, less any impairment losses.

The Health Service makes limited use of this classification because any sale or reclassification of more than an insignificant amount of held-to-maturity investments not close to their maturity, would result in the whole category being reclassified as available-for-sale. The Health Service would also be prevented from classifying investment securities as held-to-maturity for the current and the following two financial years.

The held-to-maturity category includes certain term deposits and debt securities for which the entity concerned intends to hold to maturity.

Available-for-sale financial assets

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Gains and losses arising from changes in fair value are recognised directly in equity until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in net result for the period. Fair value is determined in the manner described in Note 17.

Financial liabilities at amortised cost

Financial instrument liabilities are initially recognised on the date they are originated. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these financial instruments are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in profit and loss over the period of the interest-bearing liability, using the effective interest rate method.

Financial instrument liabilities measured at amortised cost include all of the Health Service's contractual payables, deposits held and advances received, and interest-bearing arrangements other than those designated at fair value through profit or loss.

(j) Financial Assets

Cash and Cash Equivalents

Cash and cash equivalents comprise cash on hand and cash at bank, deposits at call and highly liquid investments with an original maturity of 3 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 current interest bearing liabilities in the balance sheet

Receivables

Receivables consist of;

» Statutory receivables, which includes predominantly amounts owing from the Victorian Government and GST input tax credits recoverable; and

» Contractual receivables, which includes mainly debtors in relation to goods and services, loans to third parties, accrued investment income and finance lease receivables.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition. Collectability of debts is reviewed on an ongoing basis, and debts which are known to be uncollectible are written off. A provision for doubtful debts is recognised where there is objective evidence that the debts may not be collected and bad debts are written off when identified.

Receivables that are contractual are classified as financial instruments and categorised as loans and receivables (except for impairment), but are not classified as financial instruments because they do not arise from a contract.

Receivables are recognised initially at fair value and subsequently measured at amortised cost, using the effective interest rate method, less any accumulated impairment.

Investments and Other Financial Assets

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

Investments are classified in the following categories;

» Financial assets at fair value through profit & loss;

» Loans and receivables; and

» Available-for-sale financial assets.

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

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

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

Loans and receivables

Trade receivables, loans and other receivables are recorded at amortised cost, using the effective interest method, less impairment. Term deposits with maturity greater than three months are also measured at amortised cost, using the effective interest method, less impairment.

The effective interest method is a method of calculating the amortised cost of a financial asset 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 asset, or, where appropriate a shorter period.

Held to maturity investments

Where the Health Service has the positive intent and ability to hold investments to maturity, they are measured at amortised cost less impairment losses.

Available-for-sale financial assets

Other financial assets held by the Health Service are classified as being available-for-sale and are stated at fair value. Gains and losses arising from changes in fair value are recognised directly in equity until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in profit or loss for the period. Fair value is determined in the manner described in Note 17.

Impairment of Financial Assets

At the end of each reporting period the Health Service assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, default payments, debts which are more than 60 days overdue, and changes in debtor credit rating. All financial instruments assets, except those measured at fair value through profit and loss, are subject to annual review of impairment.

Bad and doubtful debts for financial assets are assessed on a regular basis. Those bad debts considered as written off and allowance for doubtful receivables are recognised as expenses in the net result.

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

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

In order to determine an appropriate fair value as at 30th June 2012 for its portfolio of financial assets, the Health Service obtained a valuation based on the best available advice using an valuation method through a reputable financial institution. This value was compared against valuation methodologies provided by the issuer as at 30th June 2012. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

Net Gain/(Loss) on Financial Instruments

Net gain/loss on financial instruments includes;

» realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through held-for-trading;

» impairment and reversal of impairment for financial instruments at amortised cost; and

» disposals of financial assets.

Revaluation of Financial Instruments at Fair Value

The revaluation gain/loss on financial instruments at fair value excludes dividends or interest earned on financial assets.

(k) Non-Financial Assets

Inventories

Inventories include goods and other property held either for sale or for distribution at no or nominal cost in the ordinary course of business operations. It includes land held for sale and excludes depreciable assets.

Inventories held for distribution are measured at cost, adjusted for any loss of service potential. All other inventories, including land held for sale, are measured at the lower of cost and net realisable value.

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

Cost is assigned to land for sale (undeveloped, under development and developed) and to other high value, low volume inventory items on a specific identification of cost basis.

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

Inventories acquired for no cost or nominal considerations are measured at current replacement cost at the date of acquisition. Inventories acquired at no cost or for nominal consideration are measured at current replacement cost at the date of acquisition.

Property, Plant and Equipment

All non current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition.

The initial cost for non-financial physical assets under finance lease (Refer to Note 1(m)) is measured at amounts equal to the fair value of the leased asset or, if lower,

the present value of the minimum lease payments, each determined at the inception of the lease.

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 constructive 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.

Land and Buildings are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and impairment.

Plant, Equipment and Vehicles are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and impairment. Depreciated historical cost is generally a reasonable proxy for fair value because of the short lives of the assets concerned.

Revaluations of Non-current Physical Assets

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

Revaluation increments 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 at an expense in net result, the increment is recognised as revenue in the net result.

Revaluation decrements are recognised immediately as expenses in the net result, except that, to the extent that a credit balance exists in the asset revaluation reserve in respect of the same class of assets, they are debited directly to the asset revaluation surplus.

Revaluation surplus are normally not transferred to accumulated funds on derecognition of the relevant asset.

In accordance with FRD 103D the Health Service's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Intangible Assets

Intangible assets represent identifiable non-monetary assets without physical substance such as computer software.

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 the Health Service.

Other non-financial assets

Prepayments

Other non-financial assets include prepayments which represents payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period.

Disposal of Non-Financial Assets

Any gain or loss on the sale of non-financial assets is recognised at the date that control of the asset is passed to the buyer and is determined after deducting from the proceeds the carrying value of the asset at the time.

Impairment of Non-Financial Assets

Apart from intangible assets with indefinite useful lives, all other assets are assessed annually for indications of impairment

- inventories; and
- financial assets;

If there is an indication of impairment, the assets concerned are tested as to whether their carrying value exceeds their recoverable amount. Where an asset's carrying value exceeds its recoverable amount, the difference is written-off as an expense to the extent that the write-down can be debited to an asset revaluation surplus amount applicable to that same class of asset.

If there is an indication that there has been a change in the estimate of an asset's recoverable amount since the last impairment loss was recognised, the carrying amount shall be increased to its recoverable amount. This reversal of the impairment loss occurs only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

It is deemed that, in the event of the loss or destruction of an asset, the future economic benefits arising from the use of the asset will be replaced unless a specific decision to the contrary has been made. The recoverable amount for most assets is measured at the higher of depreciated replacement cost and fair value less costs to sell. Recoverable amount for assets held primarily to generate net cash flows is measured at the higher of the present value of the future cash flows expected to be obtained from the asset and fair value less costs to sell.

(l) Liabilities

Payables

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the health service prior to the end of the financial year that are unpaid, and arise when the health service becomes obliged to make future payments in respect of the purchase of those goods and services.

  The normal credit terms for accounts payable are usually Nett 30 days.
- statutory payables, such as goods and services tax and fringe benefits tax payables.

Contractual payables are initially recognised at fair value, and then subsequently carried at amortised cost. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from a contract.

Provisions

Provisions are recognised when the Health Service 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 provision 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 time value of money and risks specific to the provision.

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

Employee Benefits

Wages and Salaries, Annual Leave, Sick Leave and Accrued Days Off

Liabilities for wages and salaries, including non-monetary benefits, annual leave accumulating sick leave and accrued days off expected to be settled within 12 months of the reporting date are recognised in the provision for employee benefits in respect of employee's services up to the reporting date, and are classified as current liabilities and measured at their nominal value.

Those liabilities that the Health Service does not expect to settle within 12 months are recognized in the provision for employee benefits as current liabilities, measured at present value of the amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

Long Service Leave

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

Current Liability – unconditional LSL (representing 10 or more years of continuous service) is disclosed in the notes to the financial statements as a current liability even where the Health Service does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months.

The components of this current LSL liability are measured at:

- present value – component that the Health Service does not expect to settle within 12 months; and
- nominal value – component that the Health Service expects to settle within 12 months.

Non Current Liability – conditional LSL (represents less than 10 years of continuous service) 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. Conditional LSL is required to be measured at present value.

Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using interest rates of Commonwealth Government guaranteed securities in Australia.

Termination Benefits

Termination benefits are payable when employment is terminated before the normal retirement date or when an employee accepts voluntary redundancy in exchange for these benefits.

Liabilities for termination benefits are recognised when a detailed plan for termination has been developed and a valid expectation has been raised with those employees affected that the terminations will be carried out. The liabilities for termination benefits are recognised in other creditors unless the amount or timing of the payments is uncertain, in which case they are recognised as a provision.

On-Costs

Employee benefit on-costs are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities.

Superannuation liabilities

The Health Service does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the Health Service 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 administers and discloses the State's defined benefit liabilities in its financial statements

(m) Leases

Leases are classified at their inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee. All other leases are classified as operating leases.

Operating Leases

Rental income from operating lease is recognised on a straight-line basis over the term of the relevant lease.

Operating lease payments, including any contingent rentals, are recognised as an expense in the operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased assets.

(n) Equity

Contributed Capital

Consistent with Australian Accounting Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public Sector Entities and FRD 119 Contributions by Owners, appropriations for additions to the net asset base have been designated as contributed capital. Other transfers that are in the nature of contributions or distributions have also been designated as contributed capital is also treated as contributed capital.

Property, Plant & Equipment Revaluation Surplus

The asset revaluation surplus is used to record increments and decrements on the revaluation of non-current physical assets.

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 reserve 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 reserve which relates to that financial asset is recognized in the Comprehensive Operating Statement

Specific Restricted Purpose Reserve

A specific restricted purpose reserve is established where the Health Service has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

(o) Commitments

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer to note 18) at their nominal value and are inclusive of the goods and services tax ("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.

(p) Contingent assets and contingent liabilities

Contingent assets and contingent liabilities are not recognised in the Balance Sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively

(q) Goods and Services Tax

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case it is recognized as part of the cost of acquisition of the asset or 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 taxation authority 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 taxation authority, are presented as operating cash flow.

Commitments for expenditure and contingent assets and liabilities are presented on a gross basis

(r) Rounding of Amounts

All amounts shown in the financial statements are expressed to the nearest $1,000 unless otherwise stated.

Minor discrepancies in tables between total and the sum of components are due to rounding.

(s) New Accounting Standards and Interpretations

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2012 reporting period.

As at 30 June 2012, 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.

The Health Service has not and does not intend to adopt these standards early.

Note 1: (s) New Accounting Standards and Interpretations (Continued)

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 9 Financial instruments	This standard simplifies requirements for the classification and measurement of financial assets resulting from Phase 1 of the IASB's project to replace IAS 39 Financial Instruments: Recognition and Measurement (AASB 139 Financial Instruments: Recognition and Measurement).	1 Jan 2013	Detail of impact is still being assessed.
AASB 11 Joint Arrangements	This Standard requires entities that have an interest in arrangements that are controlled jointly to assess whether the arrangement is a joint operation or joint venture. AASB 11 shall be applied for an arrangement that is a joint operation. It also replaces parts of requirements in AASB 131 Interests in Joint Ventures.	1 Jan 2013	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 11 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 12 Disclosure of Interests in Other Entities	This Standard requires disclosure of information that enables users of financial statements to evaluate the nature of, and risks associated with, interests in other entities and the effects of those interests on the financial statements. This Standard replaces the disclosure requirements in AASB 127 and AASB 131.	1 Jan 2013	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 12 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 13 Fair Value Measurement	This Standard outlines the requirements for measuring the fair value of assets and liabilities and replaces the existing fair value definition and guidance in other AASs. AASB 13 includes a 'fair value hierarchy' which ranks the valuation technique inputs into three levels using unadjusted quoted prices in active markets for identical assets or liabilities; other observable inputs; and unobservable inputs.	1 Jan 2013	Disclosure for fair value measurements using unobservable inputs are relatively onerous compared to disclosure for fair value measurements using observable inputs. Consequently, the Standard may increase the disclosures for public sector entities that have assets measured using depreciated replacement cost.
AASB 119 Employee Benefits	In this revised Standard for defined benefit superannuation plans, there is a change to the methodology in the calculation of superannuation expenses, in particular there is now a change in the split between superannuation interest expense (classified as transactions) and actuarial gains and losses (classified as 'Other economic flows – other movements in equity') reported on the comprehensive operating statement.	1 Jan 2013	NNot-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. While the total superannuation expense is unchanged, the revised methodology is expected to have a negative impact on the net result from transactions of the general government sector and for those few Victorian public sector entities that report superannuation defined benefit plans.
AASB 127 Separate Financial Statements	This revised Standard prescribes the accounting and disclosure requirements for investments in subsidiaries, joint ventures and associates when an entity prepares separate financial statements.	1 Jan 2013	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 127 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 128 Investments in Associates and Joint Ventures	This revised Standard sets out the requirements for the application of the equity method when accounting for investments in associates and joint ventures.	1 Jan 2013	Not-for-profit entities are not permitted to apply this Standard prior to the mandatory application date. The AASB is assessing the applicability of principles in AASB 128 in a not-for-profit context. As such, impact will be assessed after the AASB's deliberation.
AASB 1053 Application of Tiers of Australian Accounting Standards	This Standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for preparing general purpose financial statements.	1 July 2013	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) for certain public sector entities and has not decided if RDRs will be implemented in the Victorian public sector.
AASB 2009-11 Amendments to Australian Accounting Standards arising from AASB 9 [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 121, 127, 128, 131, 132, 136, 139, 1023 and 1038 and Interpretations 10 and 12]	This Standard gives effect to consequential changes arising from the issuance of AASB 9.	1 Jan 2013	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2010-2 Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements	This Standard makes amendments to many Australian Accounting Standards, including Interpretations, to introduce reduced disclosure requirements to the pronouncements for application by certain types of entities.	1 July 2013	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) for certain public sector entities and has not decided if RDRs will be implemented in the Victorian public sector.
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127]	These consequential amendments are in relation to the introduction of AASB 9.	1 Jan 2013	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2010-8 Amendments to Australian Accounting Standards – Deferred Tax: Recovery of Underlying Assets [AASB 112]	This amendment provides a practical approach for measuring deferred tax assets and deferred tax liabilities when measuring investment property by using the fair value model in AASB 140 Investment Property.	Beginning 1 Jan 2012	This amendment provides additional clarification through practical guidance.
AASB 2010-10 Further Amendments to Australian Accounting Standards – Removal of Fixed Dates for First-time Adopters [AASB 2009-11 & AASB 2010-7]	The amendments ultimately affect AASB 1 First-time Adoption of Australian Accounting Standards and provide relief for first-time adopters of Australian Accounting Standards from having to reconstruct transactions that occurred before their date of transition to Australian Accounting Standards.	1 Jan 2013	No significant impact is expected on entity reporting.

Note 1: (s) New Accounting Standards and Statutory and Interpretations (continued)

AASB 2011-2 Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements [AASB 101 & AASB 1054]	The objective of this amendment is to include some additional disclosure from the Trans-Tasman Convergence Project and to reduce disclosure requirements for entities preparing general purpose financial statements under Australian Accounting Standards – Reduced Disclosure Requirements.	1 July 2013	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) and has not decided if RDRs will be implemented in the Victorian public sector.
AASB 2011-3 Amendments to Australian Accounting Standards – Orderly Adoption of Changes to the ABS GFS Manual and Related Amendments [AASB 1049]	This amends AASB 1049 to clarify the definition of the ABS GFS Manual, and to facilitate the adoption of changes to the ABS GFS Manual and related disclosures.	1 July 2012	This amendment provides clarification to users preparing the whole of government and general govovernment sector financial reports on the version of the GFS Manual to be used and what to disclose if the latest GFS Manual is not used. No impact on departmental or entity reporting.
AASB 2011-4 Amendments to Australian Accounting Standards to Remove Individual Key Management Personnel Disclosure Requirements [AASB 124]	This Standard amends AASB 124 Related Party Disclosures by removing the disclosure requirements in AASB 124 in relation to individual key management personnel (KMP).	1 July 2013	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2011-6 Amendments to Australian Accounting Standards – Extending Relief from Consolidation, the Equity Method and Proportionate Consolidation – Reduced Disclosure Requirements [AASB 127, AASB 128 & AASB 131]	The objective of this Standard is to make amendments to AASB 127 Consolidated and Separate Financial Statements, AASB 128 Investments in Associates and AASB 131 Interests in Joint Ventures to extend the circumstances in which an entity can obtain relief from consolidation, the equity method or proportionate consolidation.	1 July 2013	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) and has not decided if RDRs will be implemented in the Victorian public sector.
AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 9, 2009-11, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1038 and Interpretations 5, 9, 16 & 17]	This Standard outlines consequential changes arising from the issuance of the five 'new Standards' to other Standards. For example, references to AASB 127 Consolidated and Separate Financial Statements are amended to AASB 10 Consolidated Financial Statements or AASB 127 Separate Financial Statements, and references to AASB 131 Interests in Joint Ventures are deleted as that Standard has been superseded by AASB 11 and AASB 128 (August 2011).	1 Jan 2013	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 9, 2009-11, 2010-7, 101, 102, 108, 110, 116, 117, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 & 1038 and Interpretations 2, 4, 12, 13, 14, 17, 19, 131 & 132]	This amending Standard makes consequentical changes to a range of Standards and Interpretations arising from the issuance of AASB 13. In particular, this Standard replaces the existing definition and guidance of fair value measurements in other Australian Accounting Standards and Interpretations.	1 Jan 2013	Disclosures for fair value measurements using unobservable inputs is potentially onerous, and may increase disclosures for assets measured using depreciated replacement cost.
AASB 2011-9 Amendments to Australian Accounting Standards – Presentation of Items of Other Comprehensive Income [AASB 1, 5, 7, 101, 112, 120, 121, 132, 133, 134, 1039 & 1049]	The main change resulting from this Standard is a requirement for entities to group items presented in other comprehensive income (OCI) on the basis of whether they are potentially reclassifiable to profit or loss subsequently (reclassification adjustments). These amendments do not remove the option to present profit or loss and other comprehensive income in two statements, nor change the option to present items of OCI either before tax or net of tax.	1 July 2012	This amending Standard could change the current presentation of 'Other economic flows- other movements in equity' that will be grouped on the basis of whether they are potentially reclassifiable to profit or loss subsequently. No other significant impact will be expected.
AASB 2011-10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, AASB 8, AASB 101, AASB 124, AASB 134, AASB 1049 & AASB 2011-8 and Interpretation 14]	This Standard makes consequential changes to a range of other Australian Accounting Standards and Interpretaion arising from the issuance of AASB 119 Employee Benefits.	1 Jan 2013	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2011-11 Amendments to AASB 119 (September 2011) arising from Reduced Disclosure Requirements	This Standard makes amendments to AASB 119 Employee Benefits (September 2011), to incorporate reduced disclosure requirements into the Standard for entities applying Tier 2 requirements in preparing general purpose financial statements.	1 July 2013	The Victorian Government is currently considering the impacts of Reduced Disclosure Requirements (RDRs) and has not decided if RDRs will be implemented in the Victorian public sector.
AASB 2011-12 Amendments to Australian Accounting Standards arising from Interpretation 20 [AASB 1]	This Standard makes amendments to AASB 1 First-time Adoption of Australian Accounting Standards, as a consequence of the issuance of IFRIC Interpretation 20 Stripping Costs in the Production Phase of a Surface Mine. This Standard allows the first-time adopters to apply the transitional provisions contained in Interpretation 20.	1 Jan 2013	There may be an impact for new agencies that adopt Australian Accounting Standards for the first time. No implication is expected for existing entities in the Victorian public sector.
2011-13 Amendments to Australian Accounting Standard – Improvements to AASB 1049	This Standard aims to improve the AASB 1049 Whole of Government and General Government Sector Financial Reporting at the operational level. The main amendments clarify a number of requirements in AASB 1049, including the amendment to allow disclosure of other measures of key fiscal aggregates as long as they are clearly distinguished from the key fiscal aggregates and do not detract from the the information required by AASB 1049. Furthermore, this Standard provides additional guidance and examples on the classification between 'transactions' and 'other economic flows' for GAAP items without GFS equivalents.	1 July 2012	No significant impact is expected from these consequential amendments on entity reporting.
2012-1 Amendments to Australian Accounting Standards - Fair Value Measurement - Reduced Disclosure Requirements [AASB 3, AASB 7, AASB 13, AASB 140 & AASB 141]	This amending Standard prescribes the reduced disclosure requirements in a number of Australian Accounting Standards as a consequence of the issuance of AASB 13 Fair Value Measurement.	1 July 2013	As the Victorian whole of government and the general government (GG) sector are subject to Tier 1 reporting requirements (refer to AASB 1053 Application of Tiers of Australian Accounting Standards), the reduced disclosure requirements included in AASB 2012-1 will not affect the financial reporting for Victorian whole of government and GG sector.
AASB Interpretation 20 Stripping Costs in the Production Phase of a Surface Mine	This Interpretation clarifies when production stripping costs should lead to the recognition of an asset and how that asset should be initially and subsequently measured.	1 Jan 2013	No significant impact is expected on entity reporting.

(t) Category Groups

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

Acute Health (Admitted Patients) comprises all recurrent health revenue/ expenditure on admitted patient services, where services are delivered in public hospitals, or free standing day hospital facilities, or palliative care facilities, or rehabilitation facilities, or alcohol and drug treatment units or hospitals specialising in dental services, hearing and ophthalmic aids.

Aged Care comprises revenue/expenditure form Home and Community Care (HACC) programs, allied Health, Aged Care Assessment and support services.

Primary Health comprises revenue/ expenditure for Community Health Services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy.

Residential Aged Care including Mental Health (RAC incl. Mental Health) referred to in the past as psycho geriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from DH under the mental health program. It excludes all other residential services funded under the mental health program, such as mental health-funded community care units (CCUs) and secure extended care units (SECs).

Other Services excluded from Australian Health Care Agreement (AHCA) (Other) comprises revenue/expenditure for services not separately classified above, including: Public health services including Laboratory testing, Blood Borne Viruses / Sexually Transmitted Infections clinical services, Kooris liaison officers, immunisation and screening services, Drugs services including drug withdrawal, counselling and the needle and syringe program, Dental Health services including general and specialist dental care, school dental services and clinical education, Disability services including aids and equipment and flexible support packages to people with a disability, Community Care programs including sexual assault support, early parenting services, parenting assessment and skills development, and various support services. Health and Community Initiatives also falls in this category group.

Note 2: Revenue

	HSA 2012 $'000	HSA 2011 $'000	H&CI 2012 $'000	H&CI 2011 $'000	Total 2012 $'000	Total 2011 $'000
Revenue from Operating Activities						
Government Grants						
- Department of Health	41,816	39,716	-	-	41,816	39,716
- Commonwealth Government						
- Residential Aged Care Subsidy	7,316	6,573	-	-	7,316	6,573
- Other	898	634	-	-	898	634
Total Government Grants	**50,030**	**46,923**	**-**	**-**	**50,030**	**46,923**
Indirect Contributions by Department of Health						
- Insurance	142	1,494	-	-	142	1,494
Total Indirect Contributions by Department of Health	**142**	**1,494**	**-**	**-**	**142**	**1,494**
Patient and Resident Fees						
- Patient and Resident Fees (refer note 2b)	2,463	2,619	-	-	2,463	2,619
- Residential Aged Care (refer note 2b)	2,895	2,795	-	-	2,895	2,795
Total Patient & Resident Fees	**5,358**	**5,414**	**-**	**-**	**5,358**	**5,414**
Commercial Activities & Specific Purpose Funds						
- Private Practice and Other Patient Activities Fees	-	-	95	325	95	325
- Catering	-	-	318	326	318	326
- Laundry	-	-	311	341	311	341
- Cafeteria	-	-	324	277	324	277
- Other (include any unit or fund not stated above)	-	-	5,082	4,774	5,082	4,774
Total Business Units & Specific Purpose Funds	**-**	**-**	**6,130**	**6,043**	**6,130**	**6,043**
Sub-Total Revenue from Operating Activities	**55,530**	**53,831**	**6,130**	**6,043**	**61,660**	**59,874**
Revenue from Non-Operating Activities						
Interest & Dividends	-	-	950	957	950	957
Other Revenue from Non-Operating Activities	-	-	708	672	708	672
Sub-Total Revenue from Non-Operating Activities	**-**	**-**	**1,658**	**1,629**	**1,658**	**1,629**
Revenue from Capital Purpose Income						
State Government Capital Grants						
- Targeted Capital Works and Equipment	11,437	5,513	-	-	11,437	5,513
Residential Accommodation Payments (refer note 2b)	1,575	1,387	-	-	1,575	1,387
Assets Received Free of Charge (refer note 2d)	-	459	-	-	-	459
Net Gain/(Loss) on Disposal of Non-Financial Assets (refer note 2c)	-	-	86	(413)	86	(413)
Net Gain/(Loss) on Disposal of Financial Assets	-	-	(52)	(3)	(52)	(3)
Capital Interest	-	-	209	-	209	-
Donations & Bequests	-	-	1,314	1,528	1,314	1,528
Sub-Total Revenue from Capital Purpose Income	**13,012**	**7,359**	**1,557**	**1,112**	**14,569**	**8,471**
Total Revenue (refer to note 2a)	**68,542**	**61,190**	**9,345**	**8,784**	**77,887**	**69,974**

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

This note relates to revenues above the net result line only, and does not reconcile to comprehensive income

Note 2a: Analysis of Revenue by Source

	Admitted Patients 2012 $'000	RAC incl. Mental Health 2012 $'000	Aged Care 2012 $'000	Primary Health 2012 $'000	Other 2012 $'000	Total 2012 $'000
Revenue from Services Supported by Health Services Agreement						
Government Grants	32,668	10,176	6,007	1,179	-	50,030
Indirect contributions by Department of Health	79	53	7	3	-	142
Patient & Resident Fees (refer note 2b)	2,015	2,895	448	-	-	5,358
Capital Purpose Income (refer note 2)	-	1,513	-	-	62	1,575
Sub-Total Revenue from Services Supported by Health Services Agreement	**34,762**	**14,637**	**6,462**	**1,182**	**62**	**57,105**
Revenue from Services Supported by Hospital and Community Initiatives						
Commercial Activities and Specific Purpose Funds	-	-	-	-	6,130	6,130
Other	-	-	-	-	1,658	1,658
Capital Purpose Income (refer note 2)	-	-	-	-	12,994	12,994
Sub-Total Revenue from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**20,782**	**20,782**
Total Revenue	**34,762**	**14,637**	**6,462**	**1,182**	**20,844**	**77,887**

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2a: Analysis of Revenue by Source

	Admitted Patients 2011 $'000	RAC incl. Mental Health 2011 $'000	Aged Care 2011 $'000	Primary Health 2011 $'000	Other 2011 $'000	Total 2011 $'000
Revenue from Services Supported by Health Services Agreement						
Government Grants	30,749	9,385	5,132	1,657	-	46,923
Indirect contributions by Department of Health	1,210	104	125	55	-	1,494
Patient & Resident Fees (refer note 2b)	2,155	2,795	464	-	-	5,414
Capital Purpose Income (refer note 2)	5,972	1,319	-	-	68	7,359
Sub-Total Revenue from Services Supported by Health Services Agreement	**40,086**	**13,603**	**5,721**	**1,712**	**68**	**61,190**
Revenue from Services Supported by Hospital and Community Initiatives						
Commercial Activities & Specific Purpose Funds	-	-	-	-	6,043	6,043
Other	-	-	-	-	1,629	1,629
Capital Purpose Income (refer note 2)	-	-	-	-	1,112	1,112
Sub-Total Revenue from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**8,784**	**8,784**
Total Revenue	**40,086**	**13,603**	**5,721**	**1,712**	**8,852**	**69,974**

Indirect contributions by Department of Health: Department of Health makes certain payments on behalf of the Health Service. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Note 2b: Patient and Resident Fees

	Total 2012 $'000	Total 2011 $'000
Patient and Resident Fees Raised		
Recurrent:		
Acute		
– Inpatients	2,015	2,155
– Outpatients	448	464
Residential Aged Care		
– Generic	2,895	2,795
Total Recurrent	**5,358**	**5,414**
Capital Purpose:		
Residential Accommodation Payments	1,575	1,387
Total Capital	**1,575**	**1,387**

Note 2d: Assets Received Free of Charge

	Total 2012 $'000	Total 2011 $'000
During the reporting period, the fair value of assets received free of charge, was as follows:		
Land	-	114
Buildings	-	345
Total	**-**	**459**

Note 2c: Net Gain/(Loss) on Disposal of Non-Financial Assets

	Total 2012 $'000	Total 2011 $'000
Proceeds from Disposals of Non-Financial Assets		
Plant and Equipment	17	-
Medical Equipment	83	12
Motor Vehicles	123	156
Buildings	-	10
Total Proceeds from Disposal of Non-Financial Assets	**223**	**178**
Less: Written Down Value of Non-Financial Assets Sold		
Plant and Equipment	5	-
Medical Equipment	73	51
Motor Vehicles	57	151
Computers & Communications	2	-
Buildings	-	312
Land	-	77
Total Written Down Value of Non-Financial Assets Sold	**137**	**591**
Net gains/(losses) on Disposal of Non-Financial Assets	**86**	**(413)**

Note 3: Expenses

	HSA 2012 $'000	HSA 2011 $'000	H&CI 2012 $'000	H&CI 2011 $'000	Total 2012 $'000	Total 2011 $'000
Employee Expenses						
Salaries & Wages	36,924	35,016	1,039	1,245	37,963	36,261
WorkCover Premium	400	418	23	24	423	442
Departure Packages	2	22	-	-	2	22
Long Service Leave	1,085	972	-	4	1,085	976
Superannuation	3,209	3,190	104	127	3,313	3,317
Total Employee Expenses	**41,620**	**39,618**	**1,166**	**1,400**	**42,786**	**41,018**
Non Salary Labour Costs						
Fees for Visiting Medical Officers	3,298	3,311	-	-	3,298	3,311
Total Non Salary Labour Costs	**3,298**	**3,311**	**-**	**-**	**3,298**	**3,311**
Supplies & Consumables						
Drug Supplies	1,285	1,060	-	1	1,285	1,061
S100 Drugs	105	217	-	-	105	217
Medical, Surgical Supplies and Prosthesis	2,982	3,165	14	12	2,996	3,177
Pathology Supplies	274	304	-	-	274	304
Food Supplies	1,094	1,262	136	142	1,230	1,404
Total Supplies & Consumables	**5,740**	**6,008**	**150**	**155**	**5,890**	**6,163**
Other Expenses from Continuing Operations						
Domestic Services & Supplies	299	346	95	134	394	480
Fuel, Light, Power and Water	1,081	1,038	53	44	1,134	1,082
Insurance costs funded by the Department of Health	588	1,494	-	-	588	1,494
Motor Vehicle Expenses	-	290	-	-	-	290
Repairs & Maintenance	861	816	82	48	943	864
Maintenance Contracts	277	327	-	1	277	328
Patient Transport	755	534	-	-	755	534
Bad & Doubtful Debts	75	43	-	1	75	44
Lease Expenses	559	403	-	-	559	403
Other Administrative Expenses	6,112	4,995	95	146	6,207	5,141
Audit Fees						
- VAGO - Audit of Financial Statements	35	33	-	-	35	33
- Other	73	43	-	-	73	43
Total Other Expenses from Continuing Operations	**10,715**	**10,362**	**325**	**374**	**11,040**	**10,736**
Avaliable-for-Sale Financial Assets	14	12	-	-	14	12
Depreciation & Amortisation (refer note 4)	3,302	3,618		-	3,302	3,618
Total	**3,316**	**3,630**	**-**	**-**	**3,316**	**3,630**
Total Expenses	**64,689**	**62,929**	**1,641**	**1,929**	**66,330**	**64,858**

Note 3a: Analysis of Expenses by Source

	Admitted Patients 2012 $'000	RAC incl. Mental Health 2012 $'000	Aged Care 2012 $'000	Primary Health 2012 $'000	Other 2012 $'000	Total 2012 $'000
Services Supported by Health Services Agreement						
Employee Expenses	23,111	11,198	3,698	2,465	1,148	41,620
Non Salary Labour Costs	3,267	-	-	31	-	3,298
Supplies & Consumables	4,161	995	282	222	80	5,740
Other Expenses from Continuing Operations	7,322	1,794	840	336	423	10,715
Sub-Total Expenses from Services Supported by Health Services Agreement	**37,861**	**13,987**	**4,820**	**3,054**	**1,651**	**61,373**
Services Supported by Hospital and Community Initiatives						
Employee Expenses	-	-	-	-	1,166	1,166
Supplies & Consumables	-	-	-	-	150	150
Other Expenses from Continuing Operations	-	-	-	-	325	325
Sub-Total Expense from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**1,641**	**1,641**
Impairment of Financial Assets (refer note 3)	14	-	-	-	-	14
Depreciation & Amortisation (refer note 4)	2,346	508	119	204	125	3,302
Sub-total Expenditure from Services supported by Health Services Agreement and by Hospital and Community Initiatives	**2,360**	**508**	**119**	**204**	**125**	**3,316**
Total Expenses	**40,221**	**14,495**	**4,939**	**3,258**	**3,417**	**66,330**

Note 3a: Analysis of Expenses by Source

	Admitted Patients 2011 $'000	RAC incl. Mental Health 2011 $'000	Aged Care 2011 $'000	Primary Health 2011 $'000	Other 2011 $'000	Total 2011 $'000
Services Supported by Health Services Agreement						
Employee Expenses	22,355	9,844	3,691	2,461	1,267	39,618
Non Salary Labour Costs	3,284	-	-	27	-	3,311
Supplies & Consumables	4,149	968	438	292	161	6,008
Other Expenses from Continuing Operations	5,943	2,162	878	556	823	10,362
Sub-Total Expenses from Services Supported by Health Services Agreement	**35,731**	**12,974**	**5,007**	**3,336**	**2,251**	**59,299**
Services Supported by Hospital and Community Initiatives						
Employee Expenses	-	-	-	-	1,400	1,400
Supplies & Consumables	-	-	-	-	155	155
Other Expenses from Continuing Operations	-	-	-	-	374	374
Sub-Total Expense from Services Supported by Hospital and Community Initiatives	**-**	**-**	**-**	**-**	**1,929**	**1,929**
Impairment of Financial Assets (refer note 3)	12	-	-	-	-	12
Depreciation & Amortisation (refer note 4)	2,604	543	126	214	131	3,618
Sub-total Expenditure from Services supported by Health Services Agreement and by Hospital and Community Initiatives	**2,616**	**543**	**126**	**214**	**131**	**3,630**
Total Expenses	**38,347**	**13,517**	**5,133**	**3,550**	**4,311**	**64,858**

Note 3b: Analysis of Expenses by Internal and Restricted Specific Purpose Funds for Services Supported by Hospital and Community Initiatives

	Total 2012 $'000	Total 2011 $'000
Private Practice and Other Patient Activities	252	650
Catering	342	357
Laundry	808	742
Cafeteria	87	75
Property Expenses	152	105
TOTAL	**1,641**	**1,929**

Note 4: Depreciation and Amortisation

	Total 2012 $'000	Total 2011 $'000
Depreciation		
Buildings	2,073	2,428
Plant & Equipment	178	181
Medical Equipment	608	572
Computers and Communication	67	72
Furniture and Fittings	65	50
Motor Vehicles	306	310
Total Depreciation	**3,297**	**3,613**
Amortisation		
Intangible Assets	5	5
Total Amortisation	**5**	**5**
Total Depreciation & Amortisation	**3,302**	**3,618**

Note 5: Cash and Cash Equivalents

For the purposes of the cash flow statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

	Total 2012 $'000	Total 2011 $'000
Cash on Hand	9	9
Cash at Bank	13,296	12,391
Deposits at Call	11,199	10,517
TOTAL	**24,504**	**22,917**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	19,242	17,821
Cash for Monies Held in Trust		
- Cash at Bank	5,262	5,096
TOTAL	**24,504**	**22,917**

Note 6: Receivables

	Total 2012 $'000	Total 2011 $'000
CURRENT		
Contractual		
Trade Debtors	1,126	1,467
Patient Fees	910	814
Accrued Investment Income	130	41
Accrued Revenue - Other	131	133
Accommodation Bonds Owing	126	267
Less Allowance for Doubtful Debts		
Trade Debtors	(33)	(13)
Patient Fees	(56)	(48)
	2,334	**2,661**
Statutory		
GST Receivable	558	192
	558	**192**
TOTAL CURRENT RECEIVABLES	**2,892**	**2,853**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health	977	787
TOTAL NON-CURRENT RECEIVABLES	**977**	**787**
TOTAL RECEIVABLES	**3,869**	**3,640**

(a) Movement in the Allowance for doubtful contractual receivables

	Total 2012 $'000	Total 2011 $'000
Balance at beginning of year	61	87
Amounts written off during the year	(28)	(55)
Amounts recovered during the year	(19)	(15)
Increase/(decrease) in allowance recognised in net result	75	44
Balance at end of year	**89**	**61**

(b) Ageing analysis of receivables

Please refer to note 17(b) for the ageing analysis of contractual receivables

(c) Nature and extent of risk arising from receivables

Please refer to note 17(b) for the nature and extent of credit risk arising from contractual receivables

Note 7: Investments and other Financial Assets

	Specific Purpose Fund		Capital Fund		Total	
	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000
NON CURRENT						
Term Deposit						
Aust. Dollar Term Deposits > 12 months	-	-	245	229	245	229
Shares	1,394	1,482	-	-	1,394	1,482
Total Non Current	**1,394**	**1,482**	**245**	**229**	**1,639**	**1,711**
TOTAL	**1,394**	**1,482**	**245**	**229**	**1,639**	**1,711**
Represented by:						
Health Service Investments	1,394	1,482	245	229	1,639	1,711
TOTAL	**1,394**	**1,482**	**245**	**229**	**1,639**	**1,711**

(a) Ageing analysis of other financial assets

Please refer to note 17(b) for the ageing analysis of investments and other financial assets

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

Please refer to note 17(b) for the nature and extent of credit risk arising from investments and other financial assets

Note 8: Inventories

	Total 2012 $'000	Total 2011 $'000
Pharmaceuticals		
At cost	152	137
Catering Supplies		
At cost	11	10
Housekeeping Supplies		
At cost	20	19
Medical and Surgical Lines		
At cost	46	43
Engineering Stores		
At Cost	1	1
Administration Stores		
At Cost	22	21
Other		
Circulating Linen-At Net Relisable Value	117	134
TOTAL INVENTORIES	**369**	**365**

Note 9: Other Current Assets

	Total 2012 $'000	Total 2011 $'000
Prepayments	87	18
CURRENT	**87**	**18**
TOTAL	**87**	**18**

Note 10: Property, Plant & Equipment

	Total 2012 $'000	Total 2011 $'000
Land		
Land at Fair Value	3,573	3,573
Land at Cost	114	114
Total Land	**3,687**	**3,687**
Buildings		
Buildings Under Construction at cost	13,033	2,281
Buildings at Fair Value	38,734	38,734
Less Acc'd Depreciation	6,939	4,984
Buildings at cost	5,570	2,913
Less Acc'd Depreciation	154	36
Total Buildings	**50,244**	**38,908**
Plant and Equipment		
Plant and Equipment at Fair Value	3,759	3,276
Less Acc'd Depreciation	2,211	2,164
Total Plant and Equipment	**1,548**	**1,112**
Medical Equipment		
Medical Equipment at Fair Value	7,257	6,684
Less Acc'd Depreciation	3,743	3,220
Total Medical Equipment	**3,514**	**3,464**
Computers and Communication		
Computers and Communication at Fair Value	704	694
Less Acc'd Depreciation	473	433
Total Computers and Communication	**231**	**261**
Furniture and Fittings		
Furniture and Fittings at Fair Value	935	790
Less Acc'd Depreciation	492	430
Total Furniture and Fittings	**443**	**360**
Motor Vehicles		
Motor Vehicles at Fair Value	1,951	1,875
Less Acc'd Depreciation	986	974
Total Motor Vehicles	**965**	**901**
TOTAL	**60,632**	**48,693**

Note 10: Property, Plant & Equipment (Continued)

	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Computers & Communications $'000	Furniture & Fittings $'000	Motor Vehicles $'000	SWARH Joint Venture $000	Total $'000
Balance at 1 July 2010	**3,650**	**38,585**	**1,154**	**3,369**	**264**	**280**	**1,014**	-	**48,316**
Additions	-	2,718	118	718	64	130	348	26	4,122
Assets transferred as Capital Contributions	114	345	-	-	-	-	-	-	459
Disposals	(77)	(312)	-	(51)	-	-	(151)	-	(591)
Depreciation and Amortisation (note 4)	-	(2,428)	(181)	(572)	(67)	(50)	(310)	(5)	(3,613)
Balance at 1 July 2011	**3,687**	**38,908**	**1,091**	**3,464**	**261**	**360**	**901**	**21**	**48,693**
Additions	-	13,409	640	726	17	148	427	-	15,367
Disposals	-	-	(5)	(68)	(2)	-	(57)	-	(132)
Depreciation and Amortisation (note 4)	-	(2,073)	(178)	(608)	(62)	(65)	(306)	(4)	(3,296)
Balance at 30 June 2012	**3,687**	**50,244**	**1,548**	**3,514**	**214**	**443**	**965**	**17**	**60,632**

Land and buildings carried at valuation

An independent valuation of the Health Service's land and buildings was performed by the Valuer-General Victoria to determine the fair value of the land and buildings. The valuation, which conforms to Australian 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 valuation was based on independent assessments.

The effective date of the valuation is 30 June 2009

Note 11: Intangible Assets

	Total 2012 $'000	Total 2011 $'000
Computer Software	46	46
Less Acc'd Amortisation	39	34
Total Written Down Value	**7**	**12**

Reconciliation of the carrying amounts of intangible assets at the beginning and end of the previous and current financial year:

	Computer Software $'000	Total $'000
Balance at 1 July 2010	**7**	**7**
Additions	10	10
Amortisation (note 4)	(5)	(5)
Balance at 1 July 2011	**12**	**12**
Amortisation (note 4)	(5)	(5)
Balance at 30 June 2012	**7**	**7**

Note 12: Payables

	Total 2012 $'000	Total 2011 $'000
CURRENT		
Contractual		
Trade Creditors	1,412	1,033
Accrued Expenses	482	620
Other	1,349	825
	3,243	**2,478**
Statutory		
GST Payable	47	67
Department of Health	805	1,124
	852	**1,191**
TOTAL CURRENT	**4,095**	**3,669**

(a) Maturity analysis of payables
Please refer to Note 17(c) for the ageing analysis of contractual payables

(b) Nature and extent of risk arising from payables
Please refer to note 17(c) for the nature and extent of risks arising from contractual payables

Note 13: Provisions

	Total 2012 $'000	Total 2011 $'000
Current Provisions		
Employee Benefits		
- Unconditional and expected to be settled within 12 months (nominal value)	5,123	4,089
- Unconditional and expected to be settled after 12 months (present value)	4,272	3,614
Total Current Provisions	**9,395**	**7,703**
Non-Current Provisions		
Employee Benefits	1,531	1,402
Total Non-Current Provisions	**1,531**	**1,402**
Total Provisions	**10,926**	**9,105**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Unconditional LSL Entitlement	4,069	3,755
Annual Leave Entitlements	2,884	2,794
Accrued Wages and Salaries	2,374	1,091
Accrued Days Off	68	63
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements	1,531	1,402
Total Employee Benefits and Related On-Costs	**10,926**	**9,105**
(b) Movements in provisions		
Movement in Long Service Leave:		
Balance at start of year	5,157	4,683
Provision made during the year		
- Expense recognising Employee Service	1,101	1,193
Settlement made during the year	(658)	(719)
Balance at end of year	**5,600**	**5,157**

Note 14: Other Liabilities

	Total 2012 $'000	Total 2011 $'000
CURRENT		
Monies Held in Trust		
- Patient Monies Held in Trust	315	391
- Accommodation Bonds (Refundable Entrance Fees)	1,399	1,480
Total Current	**1,714**	**1,871**
NON CURRENT		
Monies Held in Trust		
- Accommodation Bonds (Refundable Entrance Fees)	3,675	3,492
Total Non-Current	**3,675**	**3,492**
Total Other Liabilities	**5,389**	**5,363**
Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (refer to Note 5)	5,262	5,096
Receivables (refer to Note 6)	127	267
TOTAL	**5,389**	**5,363**

Note 15: Equity

	Total 2012 $'000	Total 2011 $'000
(a) Reserves		
Property, Plant & Equipment Revaluation Surplus		
Balance at the beginning of the reporting period	2,437	2,437
Revaluation Increment/(Decrements)		
- Plant and Equipment	-	-
Balance at the end of the reporting period	**2,437**	**2,437**
* Represented by:		
- Land	2,061	2,061
- Plant and Equipment	376	376
	2,437	**2,437**
Financial Assets Available-for-Sale Revaluation Surplus		
Balance at the beginning of the reporting period	26	9
Valuation gain/(loss) recognised	(74)	14
Cumulative (gain)/loss transferred to Operating Statement on Sale of Financial Assets	(18)	(9)
Cumulative (gain)/loss transferred to Operating Statement on Impairment of Financial Assets	14	12
Balance at end of the reporting period	**(52)**	**26**

Note 15: Equity (Continued)

	Total 2012 $'000	Total 2011 $'000
Restricted Specific Purpose Reserve		
Balance at the beginning of the reporting period	11,815	6,738
Transfer to Asset Replacement Reserve for Aged Care Capital Income	1,485	1,387
Transfer from Asset Replacement Reserve	(2,862)	(1,113)
Transfer Specific Donations/Bequests from Accumulated Surpluses	(1,722)	1,303
Transfer Capital Grant from Accumulated Surpluses	-	3,500
Balance at the end of the reporting period	**8,716**	**11,815**
Total Reserves	**11,101**	**14,278**
(b) Contributed Capital		
Balance at the beginning of the reporting period	49,535	49,535
Balance at the end of the reporting period	**49,535**	**49,535**
(c) Accumulated Surpluses/(Deficits)		
Balance at the beginning of the reporting period	(4,594)	(4,633)
Net Result for the Year	11,556	5,116
Comprehensive Income from Associates and Joint Ventures	-	-
Transfers to and from Reserve		
- Asset replacement reserve for Aged Care Capital Income	(1,485)	(1,387)
- Specific Donations/Bequests from Accumulated Services	1,722	(1,303)
- Asset Replacement Reserve	2,862	1,113
- Capital Works		(3,500)
Balance at the end of the reporting period	**10,061**	**(4,594)**
Total Equity at end of financial year	**70,697**	**59,219**

Note 16: Reconciliation of Net Result for the Year to Net Cash Inflow/ (Outflow) from Operating Activities

	Total 2012 $'000	Total 2011 $'000
Net Result for the Year	11,556	5,116
Depreciation & Amortisation	3,302	3,618
Impairment of Non Current Assets	14	12
Net (Gain)/Loss from Non-Financial Assets	(86)	413
Net (Gain)/Loss from Financial Assets	52	3
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	(129)	(712)
(Increase)/Decrease in Other Assets	(242)	(215)
(Increase)/Decrease in Prepayments	(77)	19
Increase/(Decrease) in Payables	360	(484)
Increase/(Decrease) in Provisions	1,821	653
Increase/(Decrease) in Other Liabilities	66	(71)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**16,637**	**8,352**

Note 17: Financial Instruments

(a) Financial Risk Management Objectives and Policies

Western District Health Service's principal financial instruments comprise of:

- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Investment in Equities
- Payables (excluding statutory payables)
- Accommodation Bonds

Details of the significant accounting policies and methods adopted, including the criteria for recognition, the basis of measurement and the basis on which income and expenses are recognised, with respect to each class of financial asset, financial liability and equity instrument are disclosed in note 1 to the financial statements.

The main purpose in holding financial instruments is to prudentially manage Western District Health Service financial risks within the government policy parameters.

	Carrying Amount 2012 $'000	Carrying Amount 2011 $'000
Financial Assets		
Cash and cash equivalents	24,504	22,917
Loans and Receivables	2,423	2,722
Available for Sale	1,639	1,711
Total Financial Assets [(i)]	**28,566**	**27,350**
Financial Liabilities		
At Amortised Cost	9,437	8,965
Total Financial Liabilities [(ii)]	**9,437**	**8,965**

(i) The total amount of financial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable)

(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payable)

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

	Carrying Amount 2012 $'000	Carrying Amount 2011 $'000
Financial Assets		
Available for Sale [(i)]	950	957
Total Financial Assets	**950**	**957**

(i) For cash and cash equivalents, loans or receivables and available-for-sale financial assets, the net gain or loss is calculated by taking the movement in the fair value of the asset, interest revenue, or losses arising from revaluation of the financial assets, and minus any impairment recognised in the net result;

Note 17: Financial Instruments (continued)

(b) Credit Risk

Credit risk arises from the contractual financial assets of the Health Service, which comprise cash and deposits, non-statutory receivables and available for sale contractual financial assets. The Health Service's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to the Health Service.

Credit risk is measured at fair value and is monitored on a regular basis. Credit risk associated with the Health Service's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is the Health Service's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

In addition, the Health Service does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash assets, which are mainly cash at bank. As with the policy for debtors, the Health Service's policy is to only deal with banks with high credit ratings.

Provision of impairment for contractual financial assets is recognised when there is objective evidence that the Health Service will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, debts which are more than 60 days overdue, and changes in debtor credit ratings

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Western District Health Service maximum exposure to credit risk without taking account of the value of any collateral obtained.

Credit quality of contractual financial assets that are neither past due nor impaired

2012	Financial institutions (AAA credit rating) $'000	Government agencies (AAA credit rating) $'000	Government agencies (BBB credit rating) $'000	Other (min BBB credit rating) $'000	Total $'000
Financial Assets					
Cash and Cash Equivalents	24,504	-	-	-	24,504
Receivables					
- Trade Debtors	-	-	-	1,126	1,126
- Other Receivables	-	-	-	1,297	1,297
Other Financial Assets					
- Term Deposit	245	-	-	-	245
- Shares in Other Entities	1,394	-	-	-	1,394
Total Financial Assets	**26,143**	**-**	**-**	**2,423**	**28,566**
2011					
Financial Assets					
Cash and Cash Equivalents	22,917	-	-	-	22,917
Receivables					
- Trade Debtors	-	-	-	1,467	1,467
- Other Receivables	-	-	-	1,255	1,255
Other Financial Assets					
- Term Deposit	229	-	-	-	229
- Shares in Other Entities	1,482	-	-	-	1,482
Total Financial Assets	**24,628**	**-**	**-**	**2,722**	**27,350**

(b) Credit Risk (continued)

Ageing Analysis of Financial Asset as at 30 June

2012	Total Carrying Amount $'000	Not Past Due and Not Impaired $'000	Past Due But Not Impaired				Impaired Financial Assets $'000
			Less than 1 Month $'000	1-3 Months $'000	3 months - 1 Year $'000	1-5 Years $'000	
Financial Assets							
Cash and Cash Equivalents	24,504	24,504	-	-	-	-	-
Receivables							
- Trade Debtors	1,126	741	300	85	-	-	-
- Other Receivables	1,297	-	1,006	51	240	-	-
Other Financial Assets							
- Term Deposit	245	245	-	-	-	-	-
- Shares in Other Entities	1,394	1,394	-	-	-	-	-
Total Financial Assets	**28,566**	**26,884**	**1,306**	**136**	**240**	**-**	**-**
2011							
Financial Assets							
Cash and Cash Equivalents	22,917	22,917	-	-	-	-	-
Receivables							
- Trade Debtors	1,285	602	683	-	-	-	-
- Other Receivables	1,255	-	741	376	138	-	-
Other Financial Assets							
- Term Deposit	229	229	-	-	-	-	-
- Shares in Other Entities	1,482	1,482	-	-	-	-	-
Total Financial Assets	**27,168**	**25,230**	**1,424**	**376**	**138**	**-**	**-**

There are no material financial assets which are individually determined to be impaired. Currently Western District Health Service does not hold any collateral as security nor credit enhancements relating to any of its financial assets.

There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired, and they are stated at the carrying amounts as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired

Note 17: Financial Instruments (continued)

(c) Liquidity Risk

Liquidity risk is the risk that the Health Service would be unable to meet its financial obligations as and when they fall due.

The Health Service's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet. The Health Service manages its liquidity risk as follows:

Term deposits, investments and cash held at financial institutions are managed with variable maturity dates and take into consideration cashflow requirements of the health service from month to month.

Trade creditors are paid in accordance with their trading terms; and accommodation bonds are refunded when the resident departs the aged care facility.

The following table discloses the contractual maturity analysis for Western District Health Service financial liabilities. For interest rates applicable to each class of liability refer to individual notes to the financial statements.

Maturity analysis of Financial Liabilities as at 30 June

2012	Carrying Amount $'000	Contractual Cash Flows $'000	Maturity Dates: Less than 1 Month $'000	1-3 Months $'000	3 months - 1 Year $'000	1-5 Years $'000
Financial Liabilities						
Payables	3,243	3,243	2,717	526	-	-
Other Financial Liabilities						
- Accommodation Bonds	5,074	-	-	-	1,399	3,675
- Other	315	-	-	247	68	-
Total Financial Liabilities	**8,632**	**3,243**	**2,717**	**773**	**1,467**	**3,675**
2011						
Financial Liabilities						
Payables	2,478	2,478	2,107	371	-	-
Other Financial Liabilities						
- Accommodation Bonds	4,972	-	-	-	1,479	3,493
- Other	391	-	391	-	-	-
Total Financial Liabilities	**7,841**	**2,478**	**2,498**	**371**	**1,479**	**3,493**

Note 17: Financial Instruments (continued)

(d) Market Risk

Western District Health Service's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraph below.

Currency Risk
Western District Health Service is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitment and settlement.

Interest Rate Risk
Exposure to interest rate risk is insignificant. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial assets, the health service mainly holds financial assets with relatively even maturity profiles.

Other Price Risk
Western District Health Service is exposed to normal price fluctulations from time to time through market forces. Where adequate notice is provided by suppliers, additional purchases are made for long term goods.

Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

2012	Weighted Average Effective Interest Rate (%)	Carrying Amount	Interest Rate Exposure: Fixed Interest Rate $'000	Variable Interest Rate $'000	Non-Interest Bearing $'000
Financial Assets					
Cash and Cash Equivalents	5.25	24,504	-	24,504	-
Receivables					
- Trade Debtors		1,126	-	-	1,126
- Other Receivables		1,297	-	-	1,297
Other Financial Assets					
- Term Deposit	5.6	245	-	245	-
- Shares in Other Entities		1,394	-	.	1,394
		28,566	**-**	**24,749**	**3,817**
Financial Liabilities					
Payables(		3,243	-	-	3,243
Other Financial Liabilities					
- Accommodation Bonds	5.6	5,074	-	5,074	-
- Other		315	-	-	315
		8,632	**-**	**5,074**	**3,558**
2011					
Financial Assets					
Cash and Cash Equivalents	5.45	22,917	-	22,917	-
Receivables					
- Trade Debtors		1,467	-	-	1,467
- Other Receivables		1,255	-	-	1,255
Other Financial Assets					
- Term Deposit	5.7	229	-	229	-
- Shares in Other Entities		1,482	-	-	1,482
		27,350	**-**	**23,146**	**4,204**
Financial Liabilities					
Payables		2,478	-	-	2,478
Other Financial Liabilities					
- Accommodation Bonds	5.90	4,972	-	4,972	-
- Other		391	-	-	391
		7,841	**-**	**4,972**	**2,869**

Note 17: Financial Instruments (continued)
(d) Market Risk (continued)

Sensitivity Disclosure Analysis
Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, the Health Service believes the following movements are 'reasonably possible' over the next 12 months (Base rates are sourced from the Reserve Bank of Australia)

- A shift of +1% and -1% in market interest rates (AUD) from year-end rates of 6%;
- A parallel shift of +1% and -1% in inflation rate from year-end rates of 2%

The following table discloses the impact on net operating result and equity for each category of financial instrument held by Health Service at year end as presented to key management personnel, if changes in the relevant risk occur.

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-Y%		+X%		-Z%		+Z%	
		Profit	Equity	Profit	Equity	Profit	Equity	Profit	Equity
2012		$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial Assets									
Cash and Cash Equivalents	24,504	(245)	(245)	245	245	-	-	-	-
Receivables									
- Trade Debtors	1,126	-	-	-	-	-	-	-	-
- Other Receivables	1,297	-	-	-	-	-	-	-	-
Other Financial Assets									
- Term Deposit	245	(2)	(2)	2	2	-	-	-	-
- Shares in Other Entities	1,394	-	-	-	-	-	-	-	-
Financial Liabilities									
Payables	3,243	-	-	-	-	-	-	-	-
Other Financial Liabilities	-	-	-	-	-	-	-	-	-
- Accommodation Bonds	5,074	-	-	-	-	-	-	-	-
- Other	315	-	-	-	-	-	-	-	-
		(247)	**(247)**	**247**	**247**	**-**	**-**	**-**	**-**
2011									
Financial Assets									
Cash and Cash Equivalents	22,917	(229)	(229)	229	229	-	-	-	-
Receivables									
- Trade Debtors	1,467	-	-	-	-	-	-	-	-
- Other Receivables	1,255	-	-	-	-	-	-	-	-
Other Financial Assets									
- Term Deposit	229	(2)	(2)	2	2	-	-	-	-
- Shares in Other Entities	1,482	-	-	-	-	-	-	-	-
Financial Liabilities									
Payables	2,478	-	-	-	-	-	-	-	-
Other Financial Liabilities									
- Accommodation Bonds	4,972	-	-	-	-	-	-	-	-
- Other	391	-	-	-	-	-	-	-	-
		(231)	**(231)**	**231**	**231**	**-**	**-**	**-**	**-**

(e) Fair Value

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

- Level 1 - the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices;
- Level 2 - the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly; and
- Level 3 - the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

The Health Services considers that the carrying amount of financial instrument assets and liabilities recorded in the financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows that the fair values of most of the contractual financial

assets and liabilities are the same as the carrying amounts.

Financial assets measured at fair value

	Carrying Amount as at 30 June	Fair value measurement at end of reporting period using:		
2012	$'000	Level 1* $'000	Level 2* $'000	Level 3 $'000
Financial assets at fair value through profit & loss				
Available for sale financial assets				
- Equities and managed funds	1,394	1,394	-	-
Total Financial Assets	**1,394**	**1,394**	**-**	**-**
2011				
Financial assets at fair value through profit & loss				
Available for sale financial assets				
- Equities and managed funds	1,482	1,482	-	-
Total Financial Assets	**1,482**	**1,482**	**-**	**-**

*There is no significant transfer between level 1 and level 2

Note 17: Financial Instruments (continued)
(e) Fair Value

Comparison between carrying amount and fair value

	Consol'd Carrying Amount 2012 $'000	Fair value 2012 $'000	Consol'd Carrying Amount 2011 $'000	Fair value 2011 $'000
Financial Assets				
Cash and Cash Equivalents	24,504	24,504	22,917	22,917
Receivables				
- Trade Debtors	1,126	1,126	1,467	1,467
- Other Receivables	1,297	1,297	1,255	1,255
Other Financial Assets				
- Term Deposit	245	245	229	229
- Shares in Other Entities	1,394	1,395	1,482	1,482
Total Financial Assets	**28,566**	**28,567**	**27,350**	**27,350**
Financial Liabilities				
Payables	3,243	3,243	2,478	2,478
Other Financial Liabilities(i)				
- Accommodation Bonds	5,074	5,074	4,972	4,972
- Other	315	315	391	391
Total Financial Liabilities	**8,632**	**8,632**	**7,841**	**7,841**

Note 18: Commitments for Expenditure

	Total 2012 $'000	Total 2011 $'000
Capital expenditure commitments		
Payable:		
Land and Buildings	18,877	26,617
Total capital expenditure commitments	**18,877**	**26,617**
Land and Buildings		
Not later than one year	11,723	10,781
Later than 1 year and not later than 5 years	7,154	15,836
Total	**18,877**	**26,617**
Other expenditure commitments		
Payable:		
IT Support Maintenance	1,709	-
Total Other Commitments	**1,709**	**-**
Not later than one year	674	-
Later than 1 year and not later than 5 years	699	-
Later than 5 years	336	-
TOTAL	**1,709**	**-**
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	1,554	609
Total lease commitments	**1,554**	**609**
Non-cancellable		
Not later than one year	493	21
Later than 1 year and not later than 5 years	1,008	588
Later than 5 years	53	-
Sub Total	**1,554**	**609**
TOTAL	**1,554**	**609**
Total Commitments for Expenditure (exclusive of GST)	**22,140**	**27,226**

All amounts shown in the commitments note are nominal amounts inclusive of GST.

Note 19: Contingent Assets and Contingent Liabilities

As at balance date, the Board of Directors is unaware of the existenace of any financial obligation that may have a material effect on the Balance Sheet as a result of any future event which may or may not happen. (2011 Nil).

Note 20: Operating Segments

	Hospital		RAC		Linen Service		Primary Care		Eliminations		Total	
	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
REVENUE												
External Segment Revenue	60,794	53,353	14,637	13,603	324	349	1,182	1,712	-	-	76,937	69,017
Intersegment Revenue	873	714	-	-	559	531		-	(1,432)	(1,245)	-	-
Total Revenue	**61,667**	**54,067**	**14,637**	**13,603**	**883**	**880**	**1,182**	**1,712**	**(1,432)**	**(1,245)**	**76,937**	**69,017**
EXPENSES												
External Segment Expenses	(48,307)	(48,045)	(14,495)	(12,974)	(271)	(289)	(3,258)	(3,550)	-	-	(66,331)	(64,858)
Intersegment Expenses	(873)	(714)	-	-	(559)	(531)	-	-	1,432	1,245	-	-
Unallocated Expense	744	1,088	(603)	(958)	(131)	(130)	-	-	-	-	10	-
Total Expenses	**(48,436)**	**(47,671)**	**(15,098)**	**(13,932)**	**(961)**	**(950)**	**(3,258)**	**(3,550)**	**1,432**	**1,245**	**(66,321)**	**(64,858)**
Net Result from ordinary activities	**13,231**	**6,396**	**(461)**	**(329)**	**(78)**	**(70)**	**(2,076)**	**(1,838)**	**-**	**-**	**10,616**	**4,159**
Interest Income	950	957	-	-		-	-	-	-	-	950	957
Net Result for Year	**14,181**	**7,353**	**(461)**	**(329)**	**(78)**	**(70)**	**(2,076)**	**(1,838)**	**-**	**-**	**11,566**	**5,116**
OTHER INFORMATION												
Unallocated Assets	64,386	56,357	22,649	17,440	657	539	3,415	3,020	-	-	91,107	77,356
Total Assets	**64,386**	**56,357**	**22,649**	**17,440**	**657**	**539**	**3,415**	**3,020**	**-**	**-**	**91,107**	**77,356**
Unallocated Liabilities	12,865	10,037	7,060	7,668	236	154	249	278			20,410	18,137
Total Liabilities	**12,865**	**10,037**	**7,060**	**7,668**	**236**	**154**	**249**	**278**	**-**	**-**	**20,410**	**18,137**
Acquisition of Property, Plant and Equipment and Intangible Assets	**15,367**	**4,581**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**15,367**	**4,581**
Depreciation & Amortisation Expense	**2,519**	**2,783**	**508**	**543**	**71**	**78**	**204**	**214**	**-**	**-**	**3,302**	**3,618**
Non Cash Expenses other than Depreciation	**79**	**1,351**	**53**	**96**	**-**	**-**	**10**	**47**	**-**	**-**	**142**	**1,494**

Note 20: Operating Segments (continued)

The major products/services from which the above segments derive revenue are:

BUSINESS SEGMENTS	SERVICES
Hospitals	Acute bed based services, accident and emergency, diagnostic, outpatient services.
Residential Aged Care Services (RACS)	Aged Care Residential Services
Linen Service	Linen Services
Primary Care Service	Primary Care and Community-based services.

The basis of inter-segment pricing is at cost

GEOGRAPHICAL SEGMENT

Western District Health Service operates predominantly in Western Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets related to operations in Western Victoria.

Note 21: Jointly Controlled Operations and Assets

Name of Entity	Principal Activity	Ownership Interest	
		2012	2011
		%	%
South West Alliance of Rural Health	Information Technology	12.95	12.97
Southern Grampians/Glenelg Shire PCP	Primary Health	45.00	45.00

Western District Health Service interest in assets employed in the above jointly controlled operations and assets is detailed below. The amounts are included in the financial statements and consolidated financial statements under their respective asset categories.

	2012 $'000	2011 $'000
South West Alliance of Rural Health		
Current Assets		
Cash and Cash Equivalents	216	(45)
Receivables	249	468
Inventories	-	21
Other Current Assets	21	62
Total Current Assets	**486**	**506**
Non Current Assets		
Property, Plant & Equipment	17	21
Total Non Current Assets	17	21
Total Assets	**503**	**527**

Western District Health Service interest in revenue and expenses resulting from jointly controlled operations and assets is detailed below:

	2012 $'000	2011 $'000
South West Alliance of Rural Health		
Revenue		
Other Revenue	3,582	2,289
Total Revenue	**3,582**	**2,289**
Expenses		
Employee Expenses	709	607
Maitenance Contracts	999	203
Leases Expense	195	190
Other	1,680	1,366
Total Expenses	**3,583**	**2,366**
Net Result Before Capital & Specific Items	**(1)**	**(77)**
Depreciation	4	5
Net Result	**(5)**	**(82)**

	2012 $'000	2011 $'000
Southern Grampians/Glenelg Shire PCP		
Current Assets		
Cash and Cash Equivalents	286	248
Total Assets	**286**	**248**

Western District Health Service interest in revenue and expenses resulting from jointly controlled operations and assets is detailed below:

	2012 $'000	2011 $'000
Southern Grampians/Glenelg Shire PCP		
Revenue		
Grants	136	177
Other Revenue	114	102
Total Revenue	**250**	**279**
Expenses		
Employee Expenses	156	120
Other	149	154
Total Expenses	**305**	**274**
Net Result	**(55)**	5

Note 22a: Responsible Persons Disclosures

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

	Period
Responsible Ministers:	
The Honourable David Davis, MLA, Minister for Health and Ageing	1/07/2011- 30/06/2012
The Honourable Mary Wooldridge, MLA, Minister for Mental Health	1/07/2011- 30/06/2012
Governing Boards	
Ms M Brown	1/07/2011- 30/06/2012
Ms J Huton	1/07/2011- 30/06/2012
Mr H Macdonald	1/07/2011- 30/06/2012
Mr M McGinnity	1/07/2011- 30/06/2012
Ms L Robertson	1/07/2011- 30/06/2012
Mr M Stratmann	1/07/2011- 30/06/2012
Mr I Whting	1/07/2011- 30/06/2012
Accountable Officers	
Mr J Fletcher	1/07/2011- 30/06/2012

Remuneration of Responsible Persons

The number of Responsible Persons are shown in their relevant income bands;

	Parent	
	2012	2011
Income Band	No.	No.
$0 - $9,999	7	**7**
$280,000 - $289,999	-	1
$290,000 - $299,999	1	-
Total Numbers	8	8
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**$294,757**	**$284,770**
Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet	-	-
Other Transactions of Responsible Persons and their Related Parties.	-	-

Note 22b: Executive Officer Disclosures

Executive Officers' Remuneration

The numbers of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the first two columns in the table below in their relevant income bands.

The base remuneration of executive officers is shown in the third and fourth columns. Base remuneration is exclusive of bonus payments, long-service leave payments, redundancy payments and retirement benefits.

	Total Remuneration		Base Remuneration	
	2012	2011	2012	2011
	No.	No.	No.	No.
$110,000 - $119,999	-	1	-	1
$120,000 - $129,999	1	1	1	1
$130,000 - $139,999	1	-	1	
$150,000 – $159,999	1	1	1	1
$160,000 – $169,999	-	2	-	2
$170,000 – $179,999	1	-	1	
$210,000 – $219,999	1	-	1	
Total	**5**	**5**	**5**	**5**
Total Remuneration	**$801,973**	**$732,101**	**$801,973**	**$732,101**

Note 23: Events Occurring after the Balance Sheet Date

There were no events occuring after reporting date, which require additionl information to be disclosed.

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Glossary of Terms

ACHS
Australian Council on Healthcare Standards

ACHSE
Australian College of Health Service Executives

ADASS
Adult Day Activity and Support Service

AFPHM
Australasian Faculty of Public Health Medicine

ARA
Australasian Reporting Awards

Best practice
The way leading edge organisations deliver world class performance

BOD
Board of Directors

BSI
Business Support and Innovation

BSWRICS
Barwon South West Regional Integrated Cancer Services

CACPS
Community Aged Care Packages

CDHS
Coleraine District Health Service

CEO
Chief Executive Officer

COAG
Council of Australian Governments

CSSD
Central Sterile Supply Department

DoH
Department of Health

DON
Director of Nursing

DRG
Diagnostic Related Grouper; a means by which hospitals define and measure case mix

DVA
Department of Veterans Affairs

EBA
Enterprise Bargaining Agreement

ECG
Electrocardiograph

ECIICN
Emergency Care Improvement and Innovation Clinical Network

ED
Emergency Department

EN
Enrolled Nurse

ENT
Ear, Nose and Throat

FHCC
Frances Hewett Community Centre

FIMS
Financial Information Management System

FOI
Freedom of Information

FRD
Financial Reporting Directions

GCAHM
Graduate Certificate of Agricultural Health and Medicine

GEM
Geriatric Evaluation Management

GP
General Practitioner

GS
Glenelg Shire

HACC
Home and Community Care

HARP
Hospital Admission Risk Program

HBH
Hamilton Base Hospital

HITH
Hospital in the Home

HMG
Hamilton Medical Group

HMMC
Hamilton Midwifery Model of Care

HMO
Hospital Medical Officer

HR
Human Resources

ICT
Information, Communication and Technology

ICU
Intensive Care Unit

IC4OP
Improving Care for Older People

IMG
International Medical Graduates

IT
Information Technology

KPI
Key Performance Indicator

NCFH
National Centre for Farmer Health

OH&S
Occupational Health and Safety

OT
Occupational Therapy

PCMS
Patient and Client Management System

PCP
Primary Care Partnerships

PDHS
Penshurst & District Health Service

P&PH
Primary & Preventative Health

QI
Quality Improvement

QOC
Quality of Care Report

RFID
Radio Frequency Identification

RIST
Rural Industries Skills Training

RMIT
Royal Melbourne Institute of Technology (university with a site in Hamilton)

RN
Registered Nurse

Separation
Process by which a patient is discharged from care

SFF
Sustainable Farm Families

SGGPCP
Southern Grampians and Glenelg Primary Care Partnership

SGS
Southern Grampians Shire

Standard
A statement of a level of performance to be achieved

SWAMI
South West Area Maternity Initiative

SWARH
South West Alliance of Rural Hospitals

TIA
Transient Ischaemic Attack

TRAK
Hospital patient-based information system

VET
Vocational Education and Training

VHA
Victorian Healthcare Association Ltd

VICNISS
Healthcare Associated Infection Surveillance System

VMIA
Victorian Managed Insurance Authority

VMO
Visiting Medical Officer

VPSM
Victorian Patient Satisfaction Monitor

VTE
Venous Thromboembolism

WAN
Wide Area Network

WDHS
Western District Health Service

WIES
Weighted Inlier Equivalent Separations; allocated resource weight for a patient's episode of care. A formula is applied to the resource weight to determine the WIES for recovery of funding.

Images clockwise from top left:

- Theatre Assistant, Darren Mulley, one of many staff benefiting from improved OH&S management through an ongoing equipment procurement program.
- Grange residents, Sue Wythe, Elaine Hawker and Nellie Porter busy making the greeting cards they sell to family members visiting their loved ones in care
- WDHS Dentist, Tony Buc and Dental Assistant, Karel Walkenhorst – the wait time for dental services has been dramatically reduced over the past twelve months
- WDHS Registered Nurse, Jo Richards with Clinical Support Nurse, Judy Mibus discussing patient progress
- Hotel Services staff, Emma Nicholas and Debra McAllum, members of the team that provides thousands of meals each year at Hamilton Base Hospital
- Physiotherapist, Tatum Pretorius taking client, Aileen Corbett through rehabilitation exercises

WESTERN DISTRICT HEALTH SERVICE

Incorporates:

Hamilton Base Hospital
20 Foster Street
Hamilton 3300
T + 61 3 5551 8222

Coleraine District Health Service
119 McKebery Street
Coleraine 3315
T + 61 3 5553 2000

Penshurst & District Health Service
Cobb Street
Penshurst 3289
T + 61 3 5552 3000

Merino Community Health Centre
19 – 21 High Street
Merino 3310
T + 61 3 5579 1303

Frances Hewett Community Centre
2 Roberts Street
Hamilton 3300
T + 61 3 5551 8450

youth4youth
2 Roberts Street
Hamilton 3300
T + 61 3 5551 8450

Grange Residential Care Service
17-19 Gray Street
Hamilton 3300
T + 61 3 5551 8257

National Centre for Farmer Health
20 Foster Street
Hamilton 3300
T + 61 3 5551 8533

All correspondence to:

Chief Executive Officer
Western District Health Service
PO Box 283
Hamilton Vic 3300
T + 61 3 5551 8222
F + 61 3 5571 9584
E: ceo@wdhs.net

wdhs
Western District Health Service

www.wdhs.net