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GOULBURN VALLEY HEALTH Annual Report 2016/17

Annual Report 2016/17

REDEVELOPMENT OF GV HEALTH MARKS AN EXCITING NEW ERA

GV Health
Annual Report 2016-17

Vision

Healthy communities

Mission

Goulburn Valley Health will:

- provide the highest quality care and service in prevention, diagnosis and treatment of injury, disease and other clinical conditions;
- support integrated healthcare;
- drive innovation in healthcare provision;
- work in partnership with others to promote healthy communities;
- provide leadership in healthcare to the region;
- provide opportunities for teaching, training and research in health care;
- attract health care professionals as an employer of choice.

Values

COMPASSION

We are caring and considerate in our dealings with others.

RESPECT

We acknowledge, value, and protect the diversity of beliefs, and support the rights of others in delivering health services.

EXCELLENCE

We act with professionalism to bring the highest quality of care to meet the needs of our patients.

ACCOUNTABILITY

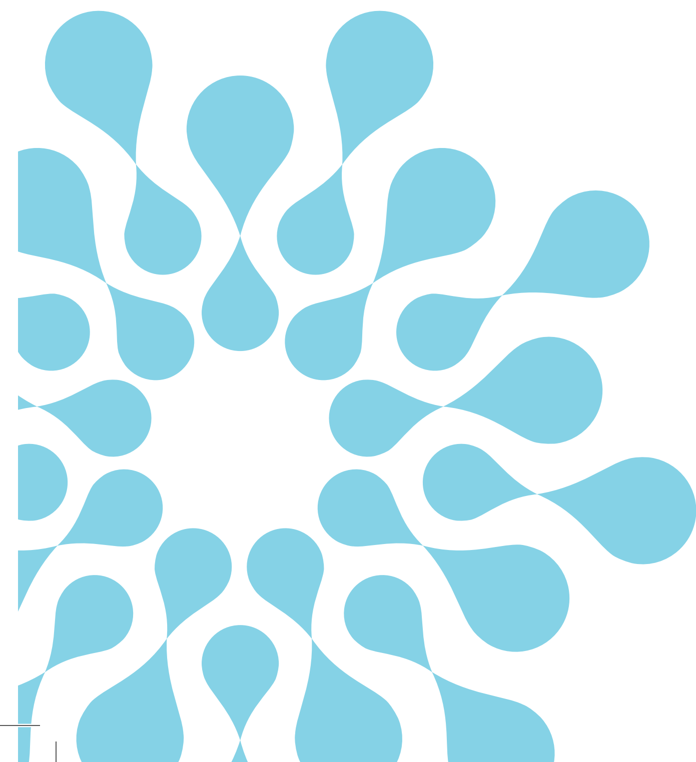
We will be responsible for the care and patient outcomes provided by GV Health, and the consequences of our actions.

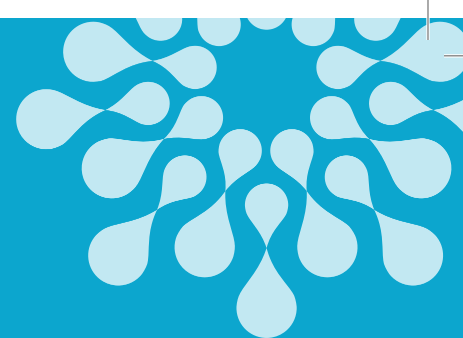
TEAMWORK

We work constructively and collaboratively within GV Health as well as with external partners to deliver integrated care to our patients.

ETHICAL BEHAVIOUR

We act with integrity, professionalism, transparency, honesty and fairness to earn the trust of those we care for.





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CEO Report

This has been an exciting year of significant achievement and change for GV Health.

Redevelopment and Capital Works

Much work has been undertaken as we prepare for the $168.5 million redevelopment of the GV Health Graham Street campus in Shepparton. The consultation and design phases are complete and three construction firms have been shortlisted to submit a final bid for the redevelopment. A decision on the final builder is expected to be made in August 2017. Construction will start in November 2017 – for completion in 2020.

The redevelopment will provide significantly increased capacity, including doubling of the Emergency Department, expansion of inpatient wards, adding new operating theatres, establishing a new onsite Women and Children's Precinct, expanding the Intensive Care / Coronary Care / High Dependency Unit, enhancing medical imaging and dialysis, and improving onsite critical infrastructure services.

Work has also progressed for the redevelopment of the Waranga Aged Care Hostel and initial images of the proposed design have been released. The successful tenderer will be appointed in August 2017 and construction is expected to begin on site in the same month – for completion in 2019.

GV Health is extremely grateful to the State Government for funding these projects, which will provide state-of-the art facilities to enable us to meet the growing healthcare needs of our community and provide services locally.

During the year, the Wanyarra inpatient adult mental health unit was redeveloped to feature gender sensitive design and to cater for the different levels/complexity of care needed. The redevelopment also provides for enhanced therapeutic care, safety, privacy and dignity of patients. A new reception and admission area was also created.

The GV Health Lactaction Day Stay unit was relocated to a new and comfortable, home-like environment for new mums. It includes couches and recliner chairs in the lounge room, a kitchen to heat up meals and a room for private consultations with lactation consultants.

Finance and Service Delivery

We are in a sound financial position and continue to perform well despite growing pressures in demand on the health system and infrastructure needs.

The Emergency Department continues to face challenges with the volume of patients that attend each day and the change in acuity. Our staff are working hard each day to improve the service and the recent additional allocation of funding to support improved patient flow will help. However, the quality of services remains high and I commend staff on their efforts.

Accreditation and Organisation Improvements

This year we successfully achieved accreditation, meeting the safety and quality standards that will ensure we continue to provide excellent services to our community.

GV Health changed its Organisation Structure, Executive Structure and Committees during the year, to improve service delivery, enhance efficiency and streamline decision-making. The new structures will be implemented in 2017/18.

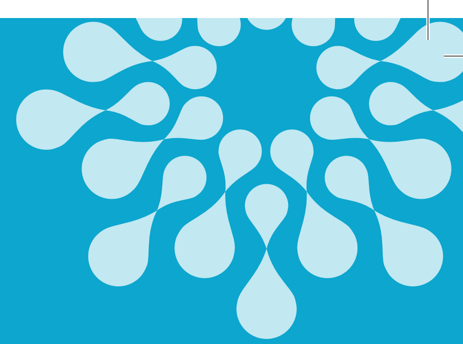
Regional Leadership

GV Health has developed and maintained strong links with partners throughout the region this year.

The regional and rural partnerships project is underway, which sees GV Health partnering with other health organisations across the region to enhance learning, share knowledge, improve service provision and patient care, and strengthen resources.

Our elective surgery waiting list has decreased this year as a result of securing partnerships with other local health services within the Hume region.

GV Health was recognised at the 2016 Victorian Premier's Health Care Awards with an award for the unique funding model that supports the role of specialist prostate cancer nurse, which is funded via a special partnership with the annual Shepparton Biggest Blokes Lunch. GV Health has



now also received funding to secure a specialist bowel cancer nurse in the GV Health oncology unit. We are truly grateful for this community support.

The GV Research Consortium was formed and facilitated the inaugural GV Health Research Fair in August 2016. This event provided the opportunity for local researchers to present their ideas, showcase local studies and clinical audits and propose research collaboration to an interested audience, highlighting regional improvements and innovations.

The GV Rural Health Careers Workshops were held in June 2017, bringing together high school students from across the region to discover the local opportunities available to study and work in the health industry.

The day is the result of a collaborative partnership between the Department of Rural Health - University of Melbourne, GV Health, City of Greater Shepparton, La Trobe University, GOTAFE, State Government, Goulburn Murray LLEN and Rumbalara.

The Goulburn Valley Alcohol and Other Drugs Services Plan 2015-2018 was launched, outlining 30 areas for action, which are being implemented by multiple agencies to prevent and reduce the adverse impact on the wellbeing of people from communities in the municipalities of Greater Shepparton, Mitchell Shire, Moira Shire, Murrindindi Shire and Strathbogie Shire. The development of the plan was led by the Goulburn Valley Alcohol and Drug Service (GVADS), a consortium led by GV Health, including Odyssey House Victoria and Salvocare.

The inaugural Healthpromoting Workplace Award was presented to Unilever at the Shepparton Chamber of Commerce Business Awards in October 2016. GV Health is proud to be sponsoring this new award category for an initial three years.

Our Staff and Volunteers

GV Health is one of the largest employers in the Goulburn Valley region with more than 2,000 staff.

We aim to maintain a healthy working environment and be an employer of choice, and to do this we conduct annual surveys of staff and patients.

GV Health staff engagement has improved significantly this year, according to the People Matter Survey, which measures the level of staff engagement and job satisfaction. The response rate to the survey has increased this year; 53% of staff completed the survey compared to 23% in 2016, providing valuable data and feedback. This information can be used to drive positive change throughout the organisation and ensure we create and maintain a model working environment.

I would like to take this opportunity to thank all staff at GV Health, who have worked hard to ensure the delivery of quality services to the community.

Our volunteer team is going from strength to strength. The number of volunteers engaged at GV Health has increased from 25 in 2015/16 to 48 in 2016/17. Volunteers are located at all the campuses and in many departments; and are now also stationed in the Emergency Department to help provide care and communication in the waiting room. We are privileged to have such dedicated volunteers who enrich the individual patient and visitor experience every day. Thank you!

Board Changes

I would like to thank the former Chair, Peter Ryan for his outstanding contribution to GV Health and the community over two terms as Chair, since 2011. Peter has been a wonderful leader and realised many achievements for GV Health during his time here.

Roslyn Knaggs has resigned from her role as GV Health Board Director. We thank Ros for her dedication and commitment to the community and the organisation in the Director role since 2010.

We also thank Bill Parsons and Stephen Merrylees for their valuable contribution to GV Health as Board Members.

We welcome Rebecca Woolstencroft as the new GV Health Board Chair. Rebecca brings extensive experience as a Chartered Accountant and CEO of a financial services business. Rebecca has a Bachelor Commerce, Accounting and Business Management and is a graduate of the Australian Institute of Company Directors.

Trevor Saunders
CEO

Chair Report

I was delighted to celebrate the 140th anniversary of GV Health providing care in our community this year and to mark the occasion of the 20th anniversary of Waranga Aged Care Hostel in February 2017.

The redevelopment is the most significant event for GV Health since it was relocated from Mooroopna all those years ago. While stage 1 is funded, a further $150m is needed for the next stages of the board's GV Health Master Plan to ensure the whole job is completed to meet the well-recognised health requirements of the Goulburn Valley community. Included in the next stages of the masterplan is the provision for a comprehensive cancer centre that includes radiotherapy capability.

The financial result for the 2016/2017 year for GV Health is quite sound with an operating surplus of $0.518m (net result before capital and specific items). It is also pleasing that revenue has grown by $17.4m for the year ended 30 June 2017 which is a 7% increase on the previous year. There is a challenge ahead to continue to grow the revenue of GV Health to enable it to match the service capability when the Stage 1 redevelopment is complete.

GV Health appointed Trevor Saunders to the CEO role in February 2017 and I am confident that he will lead the organisation successfully into its new chapter.

Triple M Shepparton continues to support our fundraising efforts by driving the annual Give Me 5 for Kids campaign, which raises much-needed funds for the Child and Adolescent Unit and Special Care Nursery to obtain equipment and resources to care for children locally.

Other local fundraising efforts have also continued to generously support the health care service this year, such as the Mad Cow Mud Run, Shepparton Biggest Blokes Lunch and the generosity of the Georgopoulos family.

More than 1,000 GV Health patients each year are now being transported in greater comfort, thanks to two new patient transport vehicles that were donated this year.

The two Renault modified buses replaced two 20 year old vehicles that had clocked up 400,000 km each. This upgrade was brought about thanks to a $20,000 donation from the GV Health Extended Care Auxiliary, a $20,000 donation from the estate of Miss Margaret Attwood and other community donations and support.

A number of reviews were conducted at GV Health in 2016 and all confirmed that we have a sound organisation, facing difficult sector-wide issues. The outcomes of the reviews provided some helpful direction for improvement.

A review of the Child and Youth Mental Health Service in July 2016 led to the development of a new model of care. Community, stakeholder and staff consultations were held over a number of months. In November 2016, a forum was held to introduce the new model. The new model began being implemented in January 2017. A stakeholder forum was held in June 2017 to obtain feedback about the new model of care. I am pleased to advise that the response has been overwhelmingly positive.

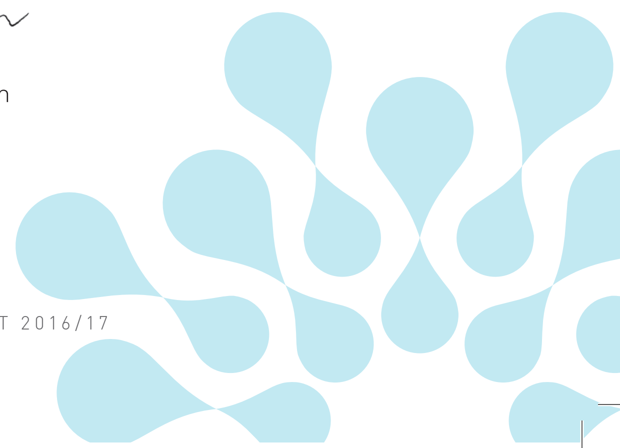
I would like to give a huge thank you to every member of the Board for working so hard together as a cohesive, effective and strategic group, guiding the organisation through a challenging period.

During the year we welcomed Dr Richard King as a new board member and Dr Michael Walsh to the Board as the Ministerial Delegate.

I very much appreciate the effort, professionalism and expertise provided throughout the year, of Ms Fiona Brew and then Dr Max Alexander, as Interim CEOs for the period 1 July 2016 until the permanent appointment of Mr Trevor Saunders as the CEO in February 2017.

As the 2016/2017 year closed the process for the full reaccreditation was very near completion. I would like to take this opportunity to thank and congratulate the management team and the entire staff of GV Health for their efforts, not only to demonstrate to the external accreditors the high quality of health services provided, but more importantly for their ongoing commitment and dedication to providing such an excellent service to our community.

Mr Peter F. Ryan
Board Chair



Introduction

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

Peter F. Ryan
Chair - Board of Directors

Relevant Ministers

The responsible Ministers during the reporting period were:

The Honourable Jill Hennessy MP, Minister for Health and Human Services, Minister for Ambulance Services.

The Honourable Martin Foley MP, Minister for Housing, Disability and Ageing, Minister for Mental Health.

Report of Operations

GV Health reports on its annual performance in two separate documents each year.

This annual report fulfils the statutory reporting requirements for government by way of an Annual Report, and the Quality of Care Report reports on quality, risk management and performance improvement matters.

Both documents are presented at the Annual General Meeting and then made available to the community.

GV Health is a designated Public Health Service under the *Health Services Act 1988* and is the main referral health service for people in the Goulburn Valley.

The purpose, functions, powers and duties of GV Health are described in the Operations Practices and By-laws of the organisation.

Nature and range of services

GV Health is a multi-campus facility, providing a broad range of hospital and community-based health care services throughout the region.

The main campus is located at Graham Street, Shepparton, providing emergency services, intensive care, outpatients, medical, surgical, paediatric, obstetric, dental, palliative, oncology, mental health, aged care, rehabilitation, medical imaging, pathology, pharmacy and related allied health and community health care services.

A community health facility in Corio Street, Shepparton provides a range of wellbeing programs aimed at preventative and community-based care.

The Tatura campus includes the Tatura Hospital and Parkvilla Aged Care residential facility.

The Rushworth campus includes Waranga Memorial Hospital, Waranga Nursing Home, Waranga Community Health and Waranga Aged Care Hostel.

Total number of beds	2014/15	2015/16	2016/17
All acute (includes Shepparton, Tatura and Waranga)	172	180	180
Acute (Shepparton campus only)	152	160	160
Aged Care Residential	77	77	77
Mental Health - Acute	20	20	20
Mental Health - Community Based Beds (PARC & SRRP)	20	20	20
Sub-acute	44	48	48

Board Directors

GV Health Board Directors

	Date of Appointment	Term Expires	Board	Quality	Finance	Audit & Risk	Workforce	Facilities, Infrastructure & ICT	Remuneration	Primary Care & Population Health	Community Advisory Committee
Mr Peter Ryan (Chair)	1/11/2014	30/6/2017	Chair								
Ms Barbara Evans	1/7/2015	30/6/2018			Chair 2016						
Ms Roslyn Knaggs	1/7/2014	30/6/2017		Chair	Part year						
Mr Stephen Merrylees	1/7/2014	30/6/2017				2016			Chair	Chair	
Mr Bill Parsons	1/7/2014	30/6/2017						Chair			
Mr Roger Coates	8/9/2015	30/6/2018					Chair				
Ms Jo Breen	26/4/2016	30/6/2018									
Ms Natalie Goodall	26/4/2016	30/6/2018			Chair 2017	2017					
A/Prof Richard King	29/11/2016	30/6/2019			Part year						
Dr Michael Walsh Ministerial Delegate	29/12/2016	28/12/2017									

Committee Membership

Board Members

Board Attendance

Board Director	26 July	30 August	12 September (Special Meeting)	27 September	25 October	29 November	20 December	January	February	March	April	May	June	TOTAL
Peter Ryan	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	92%
Barbara Evans	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	92%
Ros Knaggs	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	84%
Bill Parsons	✓	✓	A	A	✓	✓	✓	✓	A	✓	✓	✓	✓	77%
Stephen Merrylees	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100%
Roger Coates	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	92%
Jo Breen	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	A	✓	✓	84%
Natalie Goodall	A	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	84%
Dr Richard King							✓	✓	✓	✓	✓	✓	✓	100%
Dr Michael Walsh								✓	✓	✓	✓	A	✓	88%

✓- In Attendance A- Apology

Senior Officers

Trevor Saunders

Chief Executive Officer

Master Public Sector Executive Management, B.Bus, CPA, Grad Cert Public Sector Management, GAICD.

Trevor was appointed Chief Executive Officer of Goulburn Valley Health in February 2017.

Trevor has significant experience at senior executive level and has held leadership roles at a range of large organisations within the health and education government sectors across Australia.

Prior to working at GV Health, Trevor held senior positions at SA Health including: Director Medical Imaging Operations, Director of Finance and Executive Director Corporate Services. He was also employed as the Chief Finance Officer at Gold Coast Health and Northern Territory Employment, Education and Training.

Trevor's professional affiliations over recent years have included membership of the Australian Society of Certified Practicing Accountants. Trevor is a former member of the Institute of Public Administration Australia, and the Australian Institute of Company Directors.

Trevor prides himself on his work ethic, political acumen, service delivery record, management skills and strong communication – demonstrating effective leadership at both an organisational and community level.

Trevor is dedicated to providing excellent services to the community and is actively involved in the local area. He lives in Shepparton and is a member of the Shepparton Central Rotary Club.

Interim Chief Executive Officer Positions

Following the resignation of Dale Fraser in June 2016, Fiona Brew was appointed Interim CEO for the period July 2016 to September 2016 and Dr Max Alexander was appointed Interim CEO for the period October 2016 – February 2017.

Donna Sherringham

Executive Director, Clinical Operations

RN, Dip App Sci, B Nursing, MHA, FACSHM

Donna Sherringham is the Executive Director Clinical Operations. This role manages the clinical operations of GV Health, including medical, surgical, critical care, women's and children's, pathology, pharmacy and radiology at all campuses.

This role also provides strategic and operational direction and support to the clinicians to provide high quality care.

Donna Sherringham grew up in country NSW and started her career as a division 1 nurse at Westmead Hospital, Sydney. Later, she moved to nurse at various hospitals in Melbourne.

Donna earned her Bachelor of Nursing from Monash University. She also earned her Diploma of Applied Science from Mitchell College of Advanced Education – Bathurst, NSW. Donna made the transition to work in rural health at Echuca Regional Health from 2004 to 2008.

From 2008 to 2013, Donna served as Director of Nursing and Manager of Clinical Operations – Medicine and Critical Care at Bendigo Health.

Donna earned a Master of Health Services Administration at Monash University and is a Fellow of the Australian College of Health Service Executives. Donna joined the GV Health team in early 2013 as Executive Director Clinical Operations. Donna is a representative on the Health Minister's State Trauma Committee.

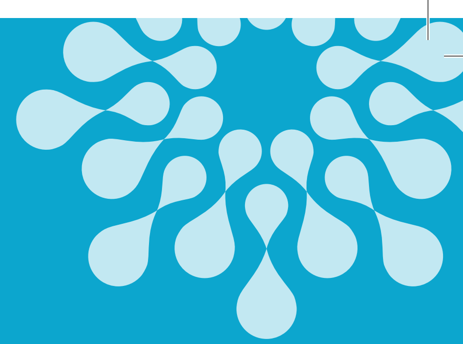
Salvatore Costanzo

Executive Director, Finance and Business Services

B.Bus (Accounting and Business Law), CPA, MBE (Masters Business Executive), Grad Dip (Business Computing), GAICD

Salvatore Costanzo commenced at Goulburn Valley Health in February 2017.

He has held a variety of roles in the public health system over 16 years. As Goulburn Valley Health's Executive Director, he oversees a number of support service areas. In his current role he is responsible for financial governance and oversight in support of the CEO and Executive team.



Prior to Goulburn Valley Health, Mr Costanzo worked at Central Queensland Hospital and Health Service, Northern Health, Western Health, TXU (formally Wester Pty Ltd), the Gas and Fuel Corporation, and Whittlesea City Council in senior finance and management roles.

The previous Executive Director, Planning and Resources during the financial year was Bill Morfis.

A/Prof Vasudha Iyengar

Chief Medical Officer (to May 2017)

MBBS, FRANZCOG, FRCOG

Vasu Iyengar is a senior consultant whose specialised area of clinical work has been complex laparoscopic gynaecological pelvic floor surgery. She has practiced in this area for more than a decade now. Her area of basic specialty training is Obstetrics and Gynaecology and she continues to maintain that profile. She trained in India, the United Kingdom and eventually pursued a busy career for 11 years in New Zealand before relocating to Australia. She spent a year in Western Australia before moving to take up the position at GV Health.

Vasu enjoys bringing in change that improves, innovates and adds value to health services for the community. She remains a passionate advocate of quality, integrated and skilled medical care delivered in a variety of ways to the local community.

Dr Nadarajah Ramesh

(Interim Chief Medical Officer May 2017 - continuing)

FRCS (Glas), FRCS (A&E) (Edn), FCEM, FRACMA, MHA (UNSW)

Dr Ramesh joined GV Health in May 2017 from Hawkesbury District Health Service in Sydney, having worked in the UK, American Hospital in the Gulf and Sydney for the past 15 years.

Dr Ramesh worked in a dual directorship as the Director of Emergency and Medical Services and has been instrumental in successfully pioneering Hawkesbury District Health Service's public-private partnership model with the New South Wales Government for the Nepean Blue Mountains Local Health District.

His previous work commitment to providing quality health care services for the local community contributed to Hawkesbury District Health Service evolving from a rural hospital to a well-respected teaching district hospital. Dr Ramesh has also: directed the transfer of myocardial infarct patients to Westmead Hospital for stenting; the introduction of the Hawkesbury After Hours GP Clinic and an @HomeGP service; the implementation of a mental health nurse consultant in the Emergency Department; and the establishment of a Model Rehabilitation Team supporting improved health outcomes for patients. In addition, he was involved in developing models of care projects for Western Australia Country Health Service.

Fiona Brew

Executive Director Innovation and Performance, Chief Nurse and Midwifery Officer

RN, Perioperative Cert., Grad Dip Acute Care, MBA, GAICD

Fiona Brew was the Executive Director Innovation and Performance, Chief Nurse and Midwifery Officer at Goulburn Valley Health, responsible for: Nursing and Midwifery; Safety, Quality, Innovation and Risk; Redesign – Hospital Improvement; Education and learning; Human Resources; Occupational Health and Safety; and Yea and District Memorial Hospital.

Fiona was Interim CEO from July to September 2016 and left the organisation in November 2016 to take up a new role with Ballarat Health.

Senior Officers continued

Kellie Thompson

Director Quality & Clinical Service Planning

Interim Executive Director Innovation & Performance/ Chief Nurse and Midwifery Officer
July 2016 – Oct 2016, Nov 2016 – Feb 2017

RN, B.HlthSc (Nursing), MACN, Grad Dip Gerontic Nursing, Dip Management, Grad Cert Health Systems Management

Kellie Thompson joined GV Health in 1999 as the Aged Care Quality Manager bringing extensive experience in quality and as a member of the Aged Care Accreditation agency. Kellie has held various senior positions across GV Health in mental health, occupational health and safety, disaster management, education and quality. Kellie has a nursing background and is a member of Australian College of Nursing.

Kellie has built on her early career in quality to become the Director of Quality and Clinical Service Planning, managing all the quality functions across the organisation. The clinical service planning function is a critical element of the redevelopment of GV Health over the next 3 years.

Kellie and her family are local members of the community and she is committed to ensuring that safe, quality care is provided to everyone who uses GV Health services.

Leigh Rhode

Executive Director of Community and Integrated Care (until June 2017)

RPN, B.HlthSc (Nursing), Dip. Business

Leigh Rhode joined GV Health's executive team in 1998 as Executive Director of Community and Integrated Care. She holds a Diploma of Business and a Bachelor of Health Sciences (Nursing) from Latrobe University. She spent her early career working in management roles in community-based organisations.

Leigh has a special interest in population health improvement and has driven a range of rural health innovations in the Goulburn Valley including expansion of the community dental program, chronic disease self-management support programs and health promotion initiatives.

Leigh provides executive support to GV Health's Primary Care and Population Health Advisory Committee and Consumer Advisory Committee.

She is a member of several professional associations, including the Australasian College of Health Service Management (ACHSM); International Society for Quality in Health Care (ISQUA), and the Australian Health Promotion Association (AHPA).

Leigh Rhode left the organisation in June 2017 to take up a position as CEO of Gateway Health.

Anne Robinson

Interim Chief Nurse and Midwifery Officer
(February to August 2017)

RN, Grad Dip Nursing Management, Grad Cert Orthopaedic Nursing

Anne has extensive experience in nursing and management both in Australia and in England and has undertaken a key leadership role at GV Health over many years.

Anne undertook the Chief Nurse and Midwifery Officer (Interim) role at GV Health from February 2017 to July 2017.

For the last four years, Anne has worked in the role of Divisional Operations Director of Medical and Critical Care and continues in this significant role. Since 2004, Anne has held a variety of nurse management roles at GV Health.

Anne lives locally, enjoys her role, has a passion for patient care, and is committed to improving patient outcomes.

Stacey Weeks

Executive Director Workforce
(Interim) from November 2016 - ongoing

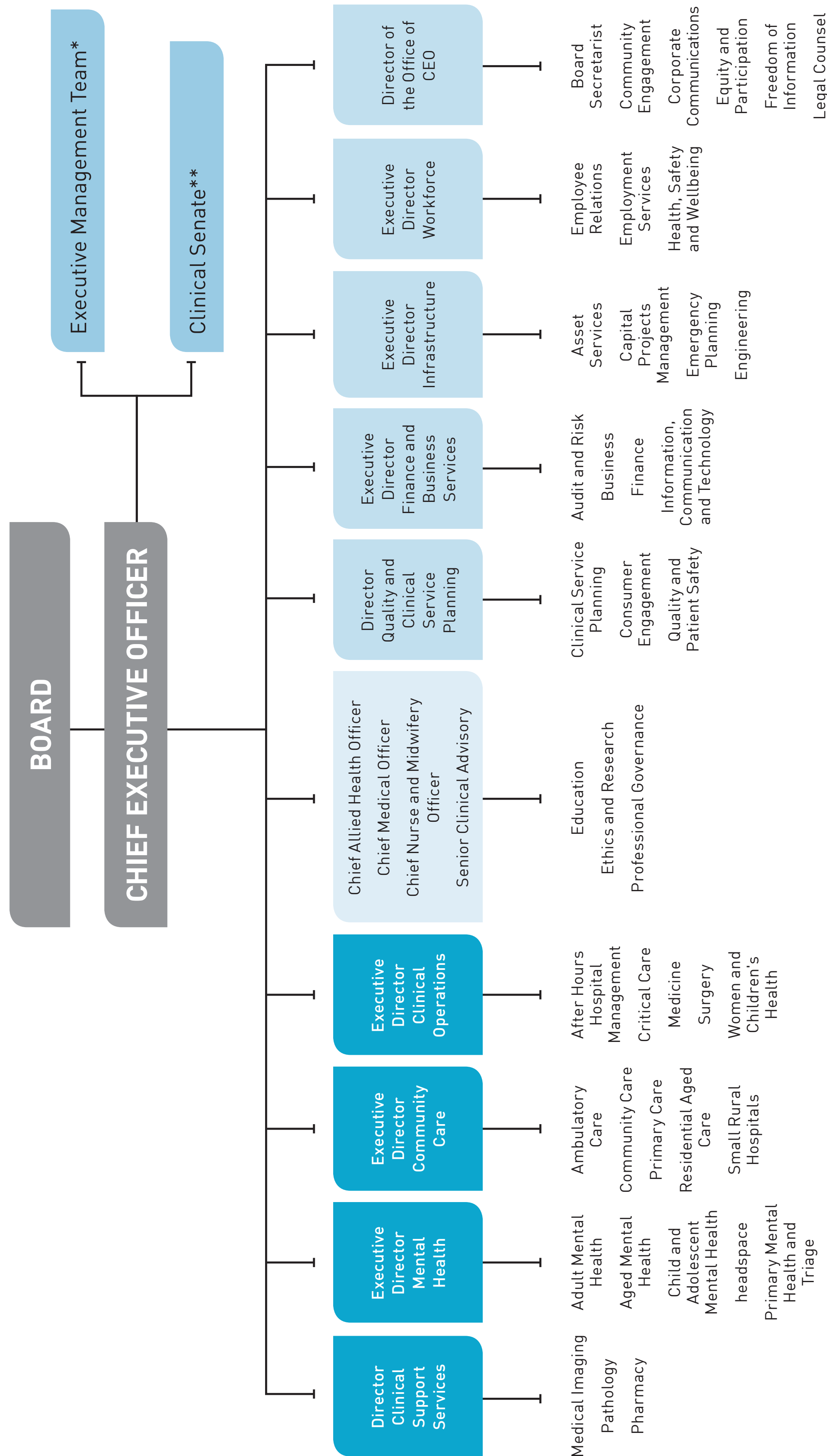
BBus, GradCert IR

Stacey commenced at GV Health in 2001 and has held various senior positions within the Human Resources function including employee/industrial relations, recruitment and management. She holds a Bachelor of Business from La Trobe University and a Graduate Certificate in Industrial Relations from Charles Sturt University.

Stacey was appointed as interim Executive Director Workforce in November 2016 and is responsible for functions ranging from employee relations, organisational development, employment services and junior medical workforce.

Stacey is passionate about attracting and retaining quality staff, ensuring GV Health is an Employer of Choice and enhancing the capability of managers and the broader workforce to assist with future growth strategic objectives.

Organisation Structure



Our Services

Admitted patients, sub acute and Emergency services

$168m

- After Hours Hospital Management
- Critical Care
- Emergency Services
- Medicine
- Non-admitted Sub Acute
- Women's and Children Services
- Sub Acute
- Oncology

Non-Admitted services

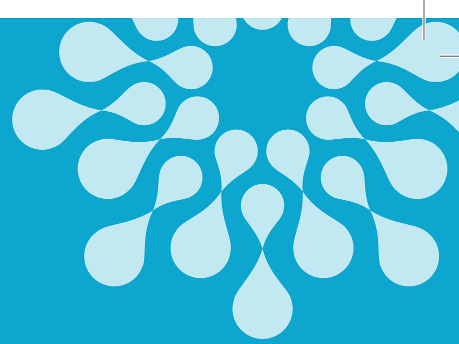
$5m

- Ante Natal Clinic
- Breast Clinic
- Home Enteral Nutrition
- Lactation Clinic
- Outpatients

Aged Care Services

$18m

- Tatura Parkvilla
- Waranga Nursing Home
- Waranga Aged Care Hostel
- Commonwealth Home Support Program
- National Disability Insurance Scheme
- Home and Community Care



- Adult
- Aged
- Child and Adolsecent
- Grutzner House
- Headspace
- Primary Mental Health Triage

- Clinical Support Services
- Diagnostic Services
- Pharmacy

- Allied Health Services
- Business Services
- Capital Programs
- Depreciation
- Engagement, Communications and Fundraising
- Engineering
- ICT
- Finance
- Quality and Clinical Service Planning
- Retail
- Specific and Restricted Purpose Funds
- Workforce

Highlights and Achievements

GV Health Redevelopment Shepparton

The $168.5 million redevelopment project is progressing well. The design phase is complete and public tender process for the construction of the project has been undertaken. The appointment of a builder is expected in August 2017 with completion due in 2020. The redevelopment will provide significantly increased capacity, including doubling of the Emergency Department, expansion of inpatient wards, adding new operating theatres, establishing a new onsite Women and Children's precinct, expanding the Intensive Care / Coronary Care / High Dependency Unit, enhancing medical imaging and dialysis, and improving onsite critical infrastructure services.

Waranga Aged Care Hostel Redevelopment

The State Government announced $10 million in funding to co-locate Waranga health and aged care services under one roof, in December 2016. The Waranga Aged Care Hostel will be redeveloped into a one-stop-shop for all of Rushworth's acute, aged care, primary care and community health services – all inside a fully-integrated, state-of-the-art facility. It will also include new office, administration, reception, storage, consulting and activity areas, four new acute beds, as well as a refurbished dining room and laundry facilities. The campus is currently split over two sites at the Waranga Aged Care Hostel and the Waranga Memorial Hospital and Nursing Home, which was built in 1961. Bringing the services together on one site will reduce duplications of health, IT, kitchen, laundry, utility and maintenance services. This will make a real difference to the lives of patients, aged care residents and staff who will benefit from more modern, safe and accessible facilities.

Child and Youth Mental Health Service

A review of the Child and Youth Mental Health Service in July 2016 led to the development of a new model of care. Community, stakeholder and staff consultations were held over a number of months. In November 2016, a forum was held to introduce the new model. The new model was implemented in January 2017. A stakeholder forum was held in June 2017 to obtain feedback about the new model of care, which has been positive.

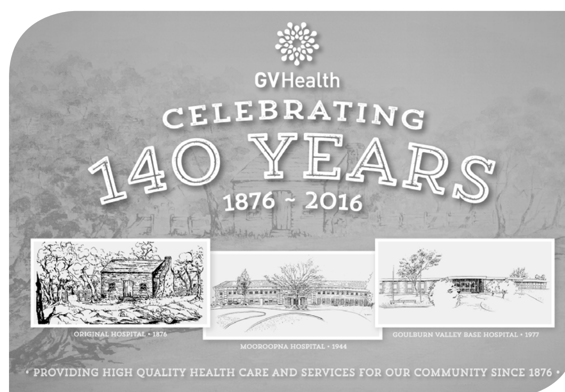
Mothers and Babies Project

GV Health engaged KPMG, through a tender process, to develop a strategic vision and service plan for a mothers and babies service (for children aged -1 to 4 years) in the Goulburn Valley region. The project is being undertaken in partnership with the GV Health Foundation. Data collection and consultation with key community representatives, health care organisations, GV Health staff and other key stakeholders took place in June 2017 and continued into July. This included interviews, workshops, surveys and research. A range of high quality services are currently operating across the region, including obstetrics, paediatrics, mental health and community-based primary care services. However, there is a significant opportunity to improve service coordination efforts between GV Health and the community, and to develop better care pathways with various specialty groups and community-based services. The project aims to explore a number of service gaps. Examples include: Support with drug and alcohol services for pregnant women, mothers and their babies; inpatient care where babies need to be kept alongside their mothers to enhance bonding; and supporting those with serious mental illness.

Staff Engagement

The People Matters Survey was completed on 19 May 2017 after a three week period for staff to respond to the survey. A response rate of 53% was achieved compared to a response rate of 23% for the prior year and a rate of 46% in the year before.

140th Anniversary and Awards



GV Health celebrated its 140th anniversary at the 2016 Annual General Meeting in December, by reflecting on the past years and looking to the future – with the redevelopment concepts. At the AGM, our Reward and Recognition program recognised the significant efforts of staff and volunteers. Awards were presented to the following recipients:

- Abby Conti, winner of the CEO Award for Living the Values.
- Dr Alexander Courtney, winner of the Board Chair Award for Excellence in Customer Service.
- Alynda Wayman and Porsha Atkinson, winners of the Award for Excellence in Consumer Participation in Quality Improvement.
- Cardiac Rehabilitation, winner of the Patient-Centred Care Award.
- Hilda Biach and John Patterson, Volunteer Recognition Award recipients.

Highlights and Achievements continued

Fundraising and Events

- The GV Health Foundation teamed up with the Friends of the Shepparton Art Museum to present a Mother's Day lunch in May at Eastbank featuring speakers from the National Gallery of Victoria talking about the Winter Masterpieces exhibition. It was a most successful occasion.
- High Teas were held throughout GV Health at all locations on 12 May 2017 to celebrate International Nurses Day and thank our nurses for all that they do to provide care and compassion for our community.
- GV Health is proud to again be a category sponsor of the 2017 Shepparton Chamber of Commerce Business Awards. Supporting the "Health-promoting Workplace" award category, GV Health is leading the way in encouraging employers and employees to work in partnership, in a supportive workplace environment, to create and sustain good health.
- The annual GV Rural Health Careers Workshops were held in June; a great collaboration with local educational and training organisations.
- The Give Me 5 for Kids campaign was held in June, raising much needed funds for the Children and Adolescent Unit.

Emergency Department Funding and Initiatives

The State Government announced an extra $2 million for GV Health's Emergency Department in December 2016 to help treat and admit patients quickly by opening more beds and hiring more clinicians, freeing up paramedics to get back on the road sooner. With this boost, a new ED assessment and streaming model was established to move patients more quickly through emergency, and increase capacity in the short stay unit. The funding also helped to purchase eight new cardiac monitors, an ECG machine and an ultrasound. GV Health's capacity to boost treatment at weekend peak times is being assisted by staffing changes to ensure a physio, nurse practitioner and radiographer are on site seven days per week.

Launch of the new Alcohol and Other Drugs Service Plan

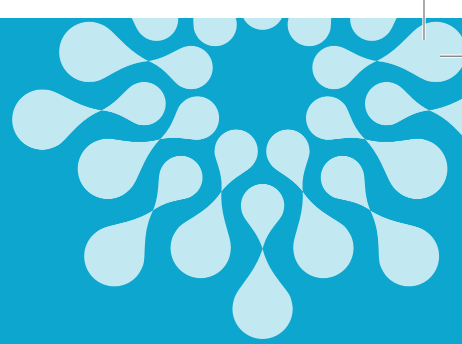
The Goulburn Valley Alcohol and Other Drugs Services Plan 2015-2018 was launched in November 2016. It outlines 30 areas for action, which will be implemented by multiple agencies to prevent and reduce the adverse impact of alcohol and other drugs on the health and wellbeing of people from communities in the municipalities of Greater Shepparton, Mitchell Shire, Moira Shire, Murrindindi Shire and Strathbogie Shire.

The development of the plan has been led by the Goulburn Valley Alcohol and Drug Service (GVADS), a consortium led by GV Health, including Odyssey House Victoria and Salvocare. The consortium is supported by an advisory network, which includes ACSO, Primary Care Connect, NEXUS Primary Health, Rumbalara Aboriginal Cooperative Ltd, the University of Melbourne Department of Rural Health, LaTrobe University Rural Health School, Murray Primary Health Network and community members.

The plan includes information about alcohol and drug use in the Goulburn Valley, the impact of alcohol and drug use and where there are service gaps and where services need to be strengthened or additional services provided in the Goulburn Valley.

Accreditation

GV Health successfully achieved accreditation, meeting the safety and quality standards that will ensure we continue to provide excellent services to our community.



Research Fair

The first annual GV Health Research Day Fair, held 20 July 2016, highlighted the outstanding work being undertaken on research studies and clinical audits, and the regional improvements and innovations being achieved in the local community. The event was a significant local learning opportunity and a great chance to celebrate important regional research work.

Patient Flow Initiative

Patient Flow is an important factor that can influence quality of care, safety, timeliness, performance and patient experience at GV Health.

A collaborative at GV Health was established to work on the various matters that affect patient flow, including clinical leadership, resourcing, access to diagnostics, bed block, transport, training, equipment etc. Patient Care initiatives included the 'Choosing Wisely' initiative, which aims to reduce unnecessary testing and improve diagnostics; a dedicated focus on reducing the elective surgery waiting list - we have developed an elective surgery partnership initiative with Shepparton private; improving patient referrals for allied health; and attracting and retaining workforce.

Lactation Day Stay Gets a New Home

GV Health's Lactation Day Stay service moved into a new home, located at 69-71 Numurkah Road, Shepparton (corner Numurkah Road and Graham Street) in December 2016. The new day stay facility is in a comfortable, home-like environment with couches and recliner chairs in the lounge room, a kitchen to heat up meals and a room for private consultation with lactation consultants. The Lactation Day Stay service provides support to help women breastfeed. On average, more than 500 women use the service each year. Having access to a more comfortable environment is settling for mums and babies. The Lactation Day Stay is a free service which is currently available on Mondays, Wednesdays and Fridays. No referral is necessary.

GV Health Disability Action Plan 2016-2019

This year marks the first year of the Disability Action Plan. Our Disability Action Plan, lodged with the Australian Human Rights Commission, highlights our commitment to improve outcomes for people with a disability. We aim to be an inclusive and accessible health service for all. The Plan will reduce discrimination, promote equality of people with a disability and help GV Health to meet its obligations under federal and state laws.

In 2016-2017 we are proud to announce the following achievements;

Outcome 1: Reducing barriers to people with a disability accessing GV Health goods, services and facilities.

Physical access improvements have been made including upgrades to lifts, pedestrian access, installation of a hearing loop and purchasing of accessible patient telephones.

Outcome 2: Reducing barriers to people with a disability obtaining and maintaining employment.

Volunteering opportunities within GV Health have increased for people with a disability.

Outcome 3: Promoting inclusion and participation of people with a disability in the GV Health community.

People with a disability are working with GV Health to improve our signage and wayfinding.

Improved access to rights and communication with Braille Health Care Rights are now available and a new complaint form is with the Disability Services Commissioner.

Outcome 4: Achieving tangible changes in attitudes and practices of GV Health staff which discriminate against people with a disability.

GV Health is now a registered NDIS provider and supports several people in the community who have an early release under this scheme.

Education and awareness raising opportunities around Disability have increased with a Grand Round on Essential Tremor and other presentations about disability services at 'Out of the Fishbowl'.

Statutory Requirements

Building Works

A variety of building works were conducted this year, with the assistance of the engineering department, including:

- Ongoing removal of asbestos flooring to improve facilities.
- Renovation of Birth Suite reception to facilitate improvements in ITC clinical services.
- Ongoing retrofitting of LED lights internally and externally to improve security and reduce energy use.
- Installation of an Emergency Warning Intercom System to strengthen evacuation processes in the case of a fire.
- Lease and refurbishment of a building to re-locate the Lactation Day Stay Unit and Infection Control team to strengthen our services to the community.
- A new office was created for Mental Health Triage team in the Emergency Department to streamline the service.
- The Wanyarra inpatient adult mental health unit has been reconfigured to feature specific gender sensitive design elements and consideration of varying acuity levels.

- **Shepparton Campus**
  The design phase of the $168.5 million redevelopment of the Graham Street campus has been completed. Construction is due to start in November 2017. The work will include:
  - 64 inpatient beds
  - Ten intensive care beds
  - Seven operating theatres
  - Kitchen
  - Morgue
  - 36 treatment spaces in the Emergency Department
  - Nine beds in the Short Stay Unit
  - 12 beds refurbished in the Maternity Department
  - Ten cots in the Special Care Nursery
  - Eight beds in the Child and Adolescent Unit
  - 16 treatment chairs in the Dialysis Department
  - Imaging expansion to include two x-rays, one CT and one ultrasound

- **Waranga Campus**
  The Waranga Campus includes the widespread refurbishment and expansion to the Hostel to incorporate acute, aged and community services all on one site. The design phase of the redevelopment of the Waranga Aged Care Hostel site has been completed. The work will build eight new aged care beds and four acute beds, new community health facilities and consulting suites. Construction is due to start in August 2017.

Compliance with Building Act

GV Health complied fully with the building and maintenance provisions of the Building Act 1993- Guidelines, issued by the Minister for Finance for publicly owned buildings.

Occupancy permits/certificates of final inspection

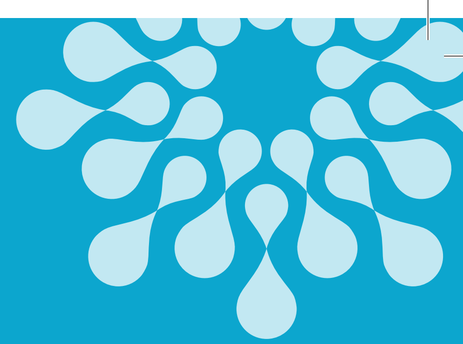
GV Health Occupancy Permits and Certificates of Final Inspection have been obtained as required.

Essential safety measures

GV Health buildings constructed after 1994 have been designed to conform to The Building Act 1993 and its regulations, as well as to meet other statutory regulations that relate to health and safety matters. All have been issued with Occupancy Permits.

Buildings constructed prior to July 1994 were not subject to issue of Occupancy Permits. However, irrespective of the age of each building, GV Health is obliged to maintain essential safety measures, so far as is practicable, in accordance with the *Building Regulations 2006*.

Compliance involves ensuring that all essential safety measures covered by the Regulations are being maintained to fulfil their purpose. It also involves keeping records of maintenance checks, completing an Annual Essential Safety Measures Report, and retaining records and reports on



the premises for inspection by the Municipal Building Surveyor or the Chief Fire Officer on request. Essential Safety Measures Reports are prepared annually for properties owned by GV Health to confirm that all of the essential safety services are operating at the required level of performance.

Fire audit compliance

All buildings are compliant with the fire safety standards.

Consultancies

In 2016/17, there were two consultancies where the total fees payable to the consultants were less than $10,000. The total expenditure incurred during 2016/17 in relation to these consultancies is $16,600 (excluding GST).

In 2016/17, there were five consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2016/17 in relation to these consultancies is $185,280 (excluding GST).

Environmental Report

GV Health monitors and reports on environmental and sustainability practices to help us better integrate and gain strategic value from existing sustainability efforts, identify gaps and opportunities in products and processes, develop communications and incorporate innovative practices.

GV Health monitors and reports on:

- energy use
- waste production
- paper use
- water consumption
- transportation fuel consumption
- greenhouse gas emissions
- sustainable procurement and associated information relevant to understanding and reducing its office-based environmental impacts

The environmental sustainability reports are available to view on the GV Health website.

We look forward to sharing future reports, as we continue to expand efforts to become a more environmentally sustainable health service.

Consultant	Purpose of Consultancy	Start Date	End Date	Total approved project (excl GST)	Expenditure (excl GST)	Future expenditure (excl GST)
Incite Information	GVH Governance Framework	Mar 17	Mar 17	$16,460	$16,460	$0
Incite Information	GVH Management Committee Structure Review	Apr 17	May 17	$56,000	$56,000	$0
Incite Information	GVH Management Committee Implementation	Jun 17	Jun 17	$32,520	$32,520	$0
CPT Global	ICT Strategy			$70,300	$70,300	$0
LaTrobe University	Proposal to evaluate Goulburn Valley Therapeutic Day Rehabilitation Program	Jan 17	Jan 17	$10,000	$10,000	$0

Statutory Requirements continued

Freedom of Information Requests

GV Health is an agency subject to the *Freedom of Information Act (Victoria) 1982.*

A total of 670 formal requests for information were received and processed under the Act in 2016/17, compared to 669 requests in 2015/16. Of that total, 335 Freedom of Information requests were processed, with a legislated application fee of $27.90 per application charged.

Total fees collected were $9,343. Charges collected were $14,152, including medico-legal reports and photocopying.

Competitive Neutrality

GV Health complied with all the government policies regarding competitive neutrality.

Victorian Industry Participation Policy Act 2003

GV Health has complied with the Victorian Industry Participation Policy Act 2003.

Car Parking Fees

GV Health complies with the Department of Health and Human Services hospital circular on car parking fees, effective 1 February 2016 and details of car parking fees and concession benefits can be viewed at www.gvhealth.org.au

Carers Recognition Act

In accordance with the Carers Recognition Act 2012, GV Health has complied with the provisions through ensuring that all staff and volunteers respect and recognise carers, support them as individuals, recognise their efforts and dedication, take into account their views and cultural identity, recognise their social wellbeing and provide due consideration of the effect of being a carer on matters of employment and education.

Safe Patient Care

Goulburn Valley Health was not required to make any disclosures in relation to nurse to patient ratios during the reporting period under the *Safe Patient Care Act 2015*

The Protected Disclosures Act 2012

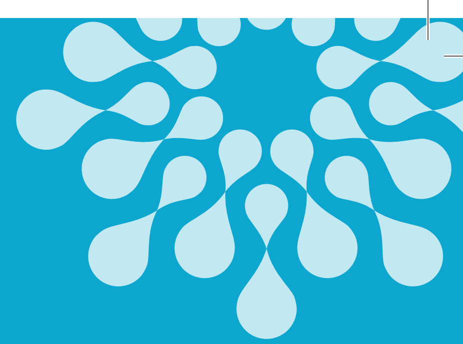
GV Health is subject to the Protected Disclosure Act 2012 that replaced the former Whistleblowers Protection Act 2001. The Act came into effect on 10 February 2013 with a purpose to facilitate disclosures of improper conduct by public officers, public bodies and to provide the appropriate level of protection for people who make disclosures without fear of reprisal.

GV Health adheres to the Protected Disclosures Act 2012 through incorporating the protected disclosure requirements of the Act into the GV Health Whistleblowers Procedure.

Information and Communication Technology expenditure

The total ICT expenditure during 2016-2017 is $1,352,542 (excluding GST) with the details shown below

Business as Usual (BAU) ICT expenditure (Total) (excluding GST)	Non-Business As Usual (non-BAU) ICT expenditure	Operational expenditure (excluding GST)	Capital expenditure (excluding GST)
$1,352,542	$0	$1,172,465	$180,077



Workforce Data

GV Health is committed to ensuring that policies and procedures are in place to promote a high standard of employment and conduct principles. GV Health upholds and adheres to the *Code of Conduct of Public Sector Employees*, issued by the Public Sector Standard Commissioner, made under the *Public Administration Act 2004*.

All employees have been correctly classified in the workforce data collections.

Labour Category	June Current Month FTE		June YTD FTE	
	2016	2017	2016	2017
Nursing	**678.63**	**661.16**	**650.12**	**657.71**
Casual	37.34	22.26	27.60	25.91
Part Time	494.44	509.13	478.33	501.14
Full Time	146.85	129.77	144.19	130.66
Administration and Medical Support	**437.92**	**459.17**	**445.31**	**445.99**
Casual	11.43	10.56	12.96	9.57
Part Time	201.24	209.86	194.74	205.78
Full Time	225.25	238.75	237.61	230.64
Hotel and Allied Services	**155.97**	**156.82**	**154.58**	**158.51**
Casual	22.94	12.18	19.29	11.40
Part Time	95.93	106.82	97.49	109.24
Full Time	37.10	37.82	37.80	37.87
Medical Staff	**174.02**	**169.68**	**165.53**	**171.82**
Casual	0.04	0.26	0.71	1.07
Part Time	14.32	14.10	12.03	16.23
Full Time	159.66	155.32	152.79	154.52
Allied Health	**102.73**	**99.29**	**98.54**	**96.38**
Casual	2.37	2.37	2.18	2.15
Part Time	48.66	48.77	47.63	50.67
Full Time	51.70	48.15	48.73	43.56
Grand Total	**1,549.27**	**1,546.12**	**1,514.08**	**1,530.41**

Statutory Requirements continued

Occupational Health and Safety

GV Health continues to adopt a proactive approach to the management of health, safety and wellbeing throughout the health service. A number of key performance indicators have been developed to monitor effectiveness of strategies that are implemented including lost time injury rates, completion of mandatory training programs, number of occupational violence incidents and number of workcover claims. Progress against the key performance indicators are regularly reported through to the GV Health Board.

Achievements

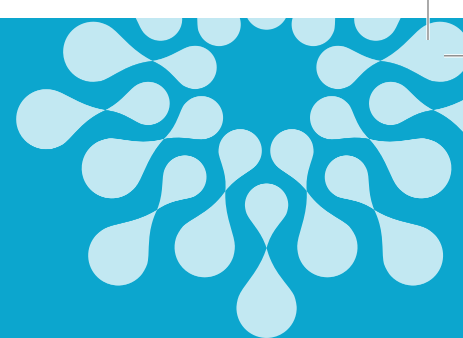
GV Health strives to improve the safety of patients, the community and its employees. Priority areas for the 2016/2017 included:

- Enhancing and extending processes to ensure organisational legislative compliance and Occupational Health and Safety performance.
- Ensuring any areas identified in the Victoria Auditor General's report in relation to process and practice improvement were reviewed and implemented.
- Developing and improving strategies for identifying and managing higher Occupational Health and Safety risks and building internal capability to address complex hazard management or incident investigation tasks.
- Building on improving the legal compliance, hazard controls and risk mitigation strategies that are applied across GV Health to improve the safety culture.

Occupational Violence Reporting Requirements

Occupational violence statistics	2016 - 2017
WorkCover accepted claims with an occupational violence cause per 100 FTE	0.13
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0.76
Number of occupational violence incidents reported	188
Number of occupational violence incidents reported per 100 FTE	12.28
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	7.98%

Financial and Service Performance Reporting



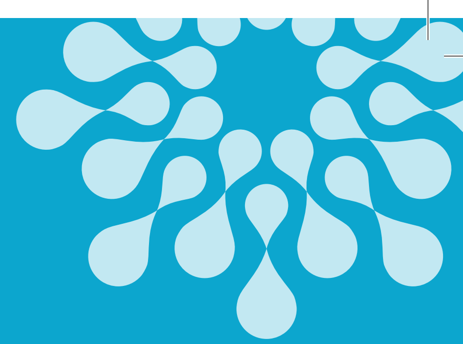
Part A: Strategic Priorities 2016/17

In 2016-17 Goulburn Valley Health will contribute to the achievement of the Government's commitments through the following:

Domain	Action	Deliverables	Outcomes
Quality and safety	Implement systems and processes to recognise and support person-centred end of life care in all settings, with a focus on providing support for people who choose to die at home.	Identify appropriate systems to support person centred end of life care in all settings, with a focus on people who chose to die at home.	Memorandum of Understanding developed and signed with GV Hospice. A GP survey was undertaken across Shepparton to establish education, care profile and service referral process. Education priorities were established. West Hume Clinical Nurse Consultant attended other services for patient referral and education of staff.
		Through West Hume Palliative Care service implement Victoria's end of Life Framework and palliative care framework. With West Hume partners develop a Palliative Care referral pathway to ensure seamless transfer of the developed care plan at all sites and services.	A referral pathway across West Hume partners (GV Hospice, Numurkah, Seymour and GV Health) was developed. Increase in palliative care type patients identified and cared for at GV Health. Pathways and end of life plan are being produced by the Department of Health and Human Services, and GV Health is looking at how we can implement this locally.
			With the new palliative care position on board we will now develop the model of care.

Financial and Service Performance Reporting continued

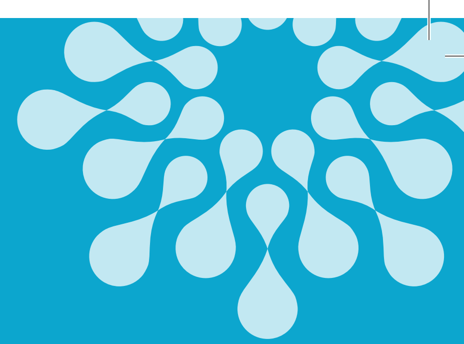
Domain	Action	Deliverables	Outcomes
		On commencement of Palliative Care physician develop and implement Care plan for dying person across West Hume and explore opportunities for clinical trial participation.	Key DHHS documents released: "Ready for Community Palliative Care" and "End of Life Improvement". We have commenced the review and application process for GV Health and West Hume. We are developing the model of care.
	Advance care planning is included as a parameter in an assessment of outcomes including: mortality and morbidity review reports, patient experience and routine data collection.	Promotion of Advance Care Planning through Consumer networks included in the Equity and Participation Plan. Undertake a Consumer Forum to support consumers with this planning.	Survey data received from all service providers is currently being analysed. All patients over 75 years of age on the elective surgery list are being encouraged to complete an Advanced Care Plan. Murray PHN will assist with promotion of Advance Care Planning with GPs. Focus is on frequent presentations to the Emergency Department. The avoidable admissions project is underway in the Community and Integrated Care area.
		Implement Advanced Care Planning parameter in Mortality and Morbidity review reports and patient experience.	Limited Care, Advanced Care and Restricted treatment PPG's have been produced. Increased focus on advanced care planning should be included within the first 48-72 hours of admission. Education and training of clinical staff is underway.



Domain	Action	Deliverables	Outcomes
	Progress implementation of a whole-of-hospital model for responding to family violence.	Goulburn Valley Health has participated in the Stage 2 roll-out of Strengthening Hospital Responses to Family Violence (SHRFV) toolkit developed by Royal Women's and Bendigo Health and will continue to progressively implement this model across the organisation.	Funding is confirmed for participation in the Stage 3 roll out. Work-plans have been submitted to Royal Women's for GV Health SHRFV roll-out and support for regional health services. Family Violence Identification and Response CPG has been drafted. Information sessions have been completed by the Manager, Trauma Informed Services for senior staff at all health services in the Goulburn Ovens-Murray region. An Education Officer was recruited to enable commencement of the next stage of staff training in sensitive inquiry and response. The Health service will continue this work into the new year, implementing the model at GV Health and regionally.
	Develop a regional leadership culture that fosters multidisciplinary and multi-organisational collaboration to promote learning and the provision of safe, quality care across rural and regional Victoria.	Regional leadership for multi-organisational credentialing programs for medical, nursing, midwifery and allied health science, therapy and medical credentialing.	A GV Health draft Nursing, Midwifery and Allied health (Science and Therapy) credentialing framework has been developed in consultation with Victoria's CNO, ACN and state-wide peers. We gained commitment from Hume Region Directors of Nursing via the regional DONs committee. The Framework and Regional Credentialing Committee Terms of Reference were approved. The Chief Nurse and Midwifery Officer was recruited. The Next step is to implement the credentialing committee.
		Leadership function in the regional perinatal morbidity and mortality meetings.	Two regional perinatal mortality and morbidity meetings commenced. Work is ongoing through the women's and children clinical services.

Financial and Service Performance Reporting continued

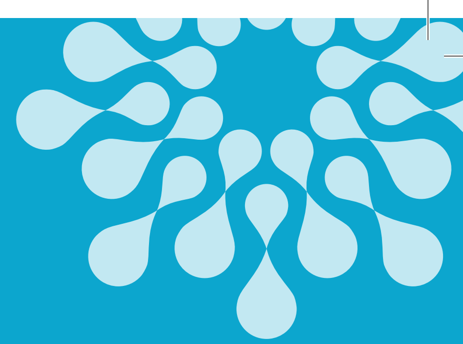
Domain	Action	Deliverables	Outcomes
		Provision of education and support in the review of clinical incidents/events in partnership small rural health services.	Regional Support was provided to Cobram Health Service following a sentinel event. GV Health led a review of the case. This was communicated with Cobram/Numurkah and Nathalia. A Plan was devised. Numurkah and Nathalia education was provided and GV Health education activity shared. Education was provided to Tatura and Waranga pertaining to Recognising and Responding to the Deteriorating Patient. We assisted Seymour and district Hospital with legal and ethics education. Education was provided to Cobram regarding Emergency Birthing and APLS in November 2016.
		Leadership of Primary Care Partnerships.	GV Health was represented on the Goulburn Valley Primary Care Partnerships Executive and statewide Executive Group. Consultation was provided to the statewide Executive group on future directions.
		Continue to develop governance oversight with partners hosting outsourced services.	Regional leadership with CG is in progress with other regional centres.
			We are in the process of developing a clinical governance framework with outreach services.
		Mid-year review for Mortality and Morbidity leadership and external participation and support of recommendations.	Organisation-wide Mortality and Morbidity was reviewed. External involvement is the next stage with peer reviews.



Domain	Action	Deliverables	Outcomes
	Establish a foetal surveillance competency policy and associated procedures for all staff providing maternity care that includes the minimum training requirements, safe staffing arrangements and ongoing compliance monitoring arrangements.	Develop a framework for the delivery of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists Foetal Surveillance Education Program for all staff providing maternity care to include minimum mandatory training requirements [such as the Foetal Surveillance Education Program (FSEP) level attainment], safe staffing arrangements and ongoing compliance monitoring arrangements. Includes a regional leadership model for rural partners in education.	We Increased FSEP & MSEP education both at GV Health and in the Hume Region – with shared funding to optimise activity through a CNME Grant.
			FSEP is in place. Regional and local PNMM is in place. PROMPT VMIA ongoing.
	Use patient feedback, including the Victorian Healthcare Experience Survey (VHES) to drive improved health outcomes and experiences through a strong focus on person and family centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	Implement an annual Patient Centred Care Campaign in partnership with the Consumer Advisory Committee, using selected and aligned Victorian Healthcare Experience Survey measures as Key Performance Indicators.	A suite of VHES measures were identified for consumer analysis and improvement planning. A Patient Centred Care Campaign for 2017 was drafted. Recruitment of an Equity and Participation Manager was undertaken.
			A report on the VHES transition index is now routinely provided to the Community Advisory Committee for advice and feedback. The Equity and Participation Manager is reviewing attendance at the Consumer Advisory Committee meetings.
	Develop a whole of hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	Conduct a whole of health service review of use of restrictive practices to reduce the use of restrictive practices and develop a framework which includes reduction of the use of seclusion and restraints, including staff education.	Mental Health reviewed the use of least restrictive practice in seclusion and is compliant with guidelines by Office of Chief Psychiatrist. Emergency Department behavioural assessment room was included in the review. Audit of Medical records commenced.

Financial and Service Performance Reporting continued

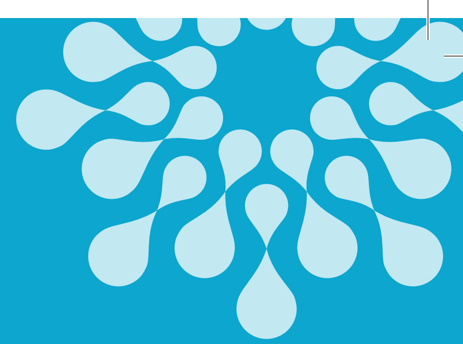
Domain	Action	Deliverables	Outcomes
		Perform analysis of Emergency Department presentation data on methamphetamine to inform education and strategy, including alignment of patients affected by drugs or alcohol who are taken into the justice system and referred to the Emergency Department.	Continuation of Drug and Alcohol Clinical Liaison funding was confirmed and a Liaison Officer was recruited. A project with Murray Primary Health Network commenced aimed at strengthening education for GPs in management of Drug and Alcohol presentations.
Access and timeliness	Ensure the development and implementation of a plan in specialist clinics to: (1) optimise referral management processes and improve patient flow through to ensure patients are seen in turn and within time; and (2) ensure Victorian Integrated Non-admitted Health data accurately reflects the status of waiting patients.	Continue the development of regional referral pathways to all referral services at Goulburn Valley Health.	Auditing of referrals to Specialist Clinics commenced.GP Liaison work commenced.
			A review of the triage process in Specialist Consulting Suite was completed. There was increased involvement of surgeons in appointment time decisions. Appointment of Divisional Clinical Director Surgery and review of processes in both Specialist Consulting Suite and Elective Admissions commenced. A key focus is in Orthopaedics, General Surgery and ENT. A Review has been underway in orthopaedics. The audit continues with a working party to be established to roll out in other areas. A Patient Flow Project is underway.
		In partnership with Murray Primary Health Network and the General Practitioners, develop suite of health pathways to streamline access to clinics by reducing waiting time by standardising referral information required resulting in a reduction of duplication ordering of diagnostics.	Pathways were developed and launched in Orthopaedics, Chronic Renal Disease and Diabetes. This is complete.



Domain	Action	Deliverables	Outcomes
		Audit of clinic referrals and access timeframes for all craft groups to ensure timely access and accurate data capture in VINAH.	Auditing of referrals to Specialist Clinics commenced. Review of the triage process in Specialist Consulting Suite was completed.
			Appointment of Divisional Clinical Director Surgery and review of processes in both Specialist Consulting Suite and Elective Admissions commenced. The key focus is in Orthopaedics, General Surgery and ENT. A review is underway in orthopaedics. The audit continues with a working party to be established to roll out in other areas. A Patient Flow Project is underway.
	Ensure the implementation of a range of strategies (including processes and service models) to improve patient flow, transfer times and efficiency in the emergency department, with particular focus on patients who did not wait for treatment and/or patients that re-presented within 48 hours.	Audit the Did Not Wait and re-presentations to gauge times, days, that are higher in rate to alter service delivery in Emergency Department by the following: 1. Implement a rapid assessment model of triage.	The Audit has been completed with days, times identified. Funding was received for staffing and equipment to implement the RAT model, which was developed. Performance target improvement was 9% overall. Recruitment of FACEMs continued with the Director expected to commence in July 2017. Infrastructure works were completed for the RAT. We are working on patient flow from the Emergency Department to medical ward.
		2. Introduce a non-urgent model of care which will include collaboration with allied health and diagnostics by developing new pathway for follow up of results of investigations and patients being sent back to Emergency Department.	A Fast Track model is under review.
			ED Director to commence in July 2017.

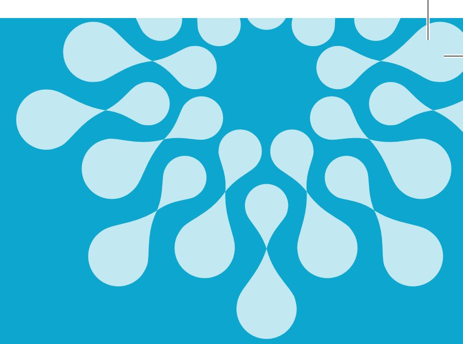
Financial and Service Performance Reporting continued

Domain	Action	Deliverables	Outcomes
		3. Develop and implement a surgical 23 hours unit.	The model was developed with focus on identifying patient at elective admissions. An audit was undertaken, which highlighted patient identification issues in recovery. We are now relaunching our processes, implementing and monitoring.
	Identify opportunities and implement pathways to aid prevention and increase care outside hospital walls by optimising appropriate use of existing programs (i.e. the Health Independence Program or telemedicine).	Appointment of a Health Independence Programs (HIP) Manager to lead this work at Goulburn Valley Health to review the decline in Health Independence rates.	The Health Independence Program Manager was appointed. Review of KPIs for HIP programs commenced. The Project commenced with Murray Primary Health Network to review COPD avoidable hospital admissions and pathways. The HIP position is well embedded and the project is underway and continues with focus on Emergency Department and patient flow.
		Remote patient monitoring link to telemedicine - Diabetes Service.	This is now underway with Melbourne Health, with particular focus on the high risk foot service.
	Increase the proportion of patients (locally and across the state) who receive treatment within the clinically recommended time for surgery and implement ongoing processes to ensure patients are treated in turn and within clinically recommended timeframes.	Work with our regional partners to increase our elective low complexity surgery opportunities with surrounding rural hospitals.	General Surgery commenced at Numurkah DHS in line with capability framework. General surgery numbers increased at Numurkah. We currently have surgery at Benalla, Seymour and Cobram. Shepparton Private commenced in April 2017. Kyabram commenced in June 2017. We treated 1462 patients this year off site. This has increased from 962 the previous year.



Domain	Action	Deliverables	Outcomes
		Review of current process at Goulburn Valley Health to meet treat in turn and clinically recommended timeframes.	Operating session review was undertaken to ensure equity of access and sessions allocated. Focus on expanding elective surgery after hours and emergency list access was included. Appointment of the Divisional Clinical Director Surgery with review of process in both Specialist Consulting Suite and Elective Admissions commenced. The key focus is in Orthopaedics, General Surgery and ENT. There was a marked improvement in performance data for ESIS. The auditing process was embedded to ensure treatment time occurs.
	Develop and implement a strategy to ensure the preparedness of the organisation for the National Disability and Insurance Scheme and Home and Community Care program transition and reform, with particular consideration to service access, service expectations, workforce and financial management.	Implement Goulburn Valley Health's Home and Community Care and the National Disability and Insurance Scheme transition plans, including a community and staff communications strategy.	Transfer of Aged Care Packages to Community Interlink from Murrindindi Shire and North East Health was completed August 2016. Employee Impact Statements were issued to initiate changes to required staffing structure for the new regional model for Aged Care Packages. A new staffing model was established for the regional aged care packages model. GV Health registered as a provider with NDIS and several early release clients were transferred to Community Interlink. Exploration of GV Health's involvement in the NDIS roll-out regionally is underway.

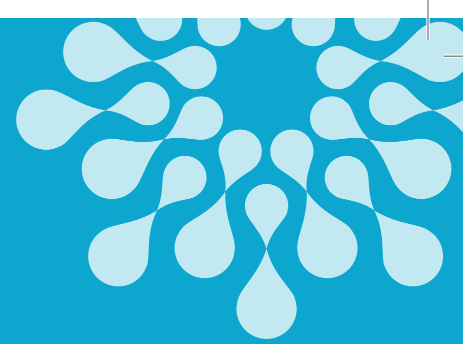
Domain	Action	Deliverables	Outcomes
		Patient self-monitoring and managing with support of Goulburn Valley Health teams.	Case by case transition of vulnerable clients to NDIS undertaken in consultation with DHHS. Data was submitted to DHHS to identify eligible clients for transition from HACC to NDIS. Five early release NDIS clients were transferred to Community Interlink. Further exploration of GV Health involvement in the NDIS roll-out regionally is underway.
		Increase the utilisation of telemedicine in Specialist Out-patient clinics with partner service, St Vincent's Hospital.	This was completed. GV Health explored telemedicine with St Vincent's and this has commenced with Haematology.
	Develop and implement strategies within their organisation to ensure identification of potential organ and tissue donors and partner with DonateLife Victoria to ensure that all possible donations are achieved.	Review current processes at Goulburn Valley Health in Organ Donation to ensure all patients captured and implement Organ and Tissue Authority Clinical Practice Improvement Program. Maintain reporting requirements.	Reporting was maintained while the project officer was seconded to Cobram. A new position for organ donation was recruited – appointed late June 2017.
		Promote Organ Donation on our website and increase community engagement via a communication strategy.	Organ Donation education continued alongside the Annual Calendar to staff. The new position for organ donation was recruited – appointed late June 2017.
Supporting healthy populations	Support shared population health and wellbeing planning at a local level - aligning with the Local Government Municipal Public Health and Wellbeing plan and working with other local agencies and Primary Health Networks.	Goulburn Valley Health will partner with Goulburn Valley Primary Care Partnership (PCP), Deakin University, City of Greater Shepparton and other local agencies to undertake stage 1 baseline data collection for the RESPOND Childhood Obesity Prevention Initiative.	A progress report on the RESPOND initiative was regularly provided to the GV Health Primary Care and Population Health Advisory Committee. The baseline data collection and report was completed and provided Goulburn Valley PCP. The process for analysis and use of results is being discussed with key stakeholders (e.g. DEET). Group modelling sessions with community leaders are being planned and coordinated by GV PCP. Group programs for community leaders were scheduled for August 2017.



Domain	Action	Deliverables	Outcomes
		Goulburn Valley Health's Primary Care and Population Health Advisory Committee in partnership with Goulburn Valley Primary Care Partnership will host discussion with Local Government Area Municipal Public Health and Wellbeing Planning representatives to identify priorities for shared action.	Consultation with Strathbogie Shire representatives was undertaken. Consultations were completed with Moira and Greater Shepparton. A summary report was provided to PC&PHA. GV PCP representatives are now part of the regional Municipal Public Health Plan network. A briefing session for PC&PHA on Liveability Index is proposed.
	Focus on primary prevention, including suicide prevention activities, and aim to impact on large numbers of people in the places where they spend their time adopting a place based, whole of population approach to tackle the multiple risk factors of poor health.	Implementation of the Healthy Together Victoria Workplace Achievement Program across Goulburn Valley Health campuses, and supporting local businesses to adopt the program.	GV Health sponsored a new Healthy Workplace Award category as part of the Chamber of Commerce Business Achievement Awards Program. A Certificate of registration of GV Health's Workplace Achievement Plan and Progress Report; work on Healthy Eating and Mental Health benchmarks continues.
	Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.	Implement Goulburn Valley Health's *One community one plan* - Equity and Participation Plan.	The GV Health Equity and Participation Plan was endorsed by the Board. The Disability Action Plan was endorsed by the Board. The New Equity and Participation Manager was appointed to lead this work. Implementation is underway.
	Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights.	A cycle of consultation will be maintained with the informal network of elders to provide Elders Council consultation on key service development topics and Improving Care for Aboriginal People priorities.	An Artist in Residence program was undertaken in partnership with Kaiela Gallery. The Improving Care for Aboriginal Patients CQI plan 2015/16 was reviewed and 2016/17 plan submitted to DHHS. Consultation was undertaken following the Koolin Balit audit, ongoing contacts were maintained via NAIDOC week activities and development of a Koolin Balit Action Plan.

Financial and Service Performance Reporting continued

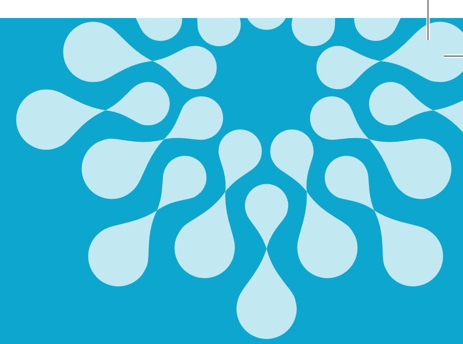
Domain	Action	Deliverables	Outcomes
	Drive improvements to Victoria's mental health system through focus and engagement in activity delivering on the 10 Year Plan for Mental Health and active input into consultations on the Design, Service and infrastructure Plan for Victoria's Clinical mental health system.	Active contribution to consultations regarding the Design, Service and Infrastructure Plan. Engage staff and draft a Goulburn Valley Health Mental Health Plan which aligns with the outcomes and actions required for the delivery of the 10 year Plan for Mental Health.	The Mental Health Operational plan was developed with staff and endorsed at Mental Governance and Strengthening Services Committee Meetings. Adult and Triage service design was reviewed.
	Using the Government's Rainbow eQuality Guide, identify and adopt 'actions for inclusive practices' and be more responsive to the health and wellbeing of lesbian, gay, bisexual, transgender and intersex individuals and communities.	Establish the role of Equity and Participation Co-ordinator to lead this work. The inclusion of recognising and responding to diversity in the Goulburn Valley Health redevelopment as a principle of schematic design.	The new Equity and Participation Manager commenced in April 2017, The Rainbow eQuality guide was distributed for consultation. Contact was made with Victorian Commissioner for Gender & Sexuality and local LGBTIQ group. We are investigating attaining the Rainbow Tick accreditation.
	Further engagement with relevant academic institutions and other partners to increase participation in clinical trials.	Further the expansion of the Regional Research Consortium development. Research Memorandum of Understandings signed with University of Melbourne, Deakin and La Trobe University.	Completed.



Domain	Action	Deliverables	Outcomes
Governance and leadership	Demonstrate implementation of the Victorian Clinical Governance Policy Framework: Governance for the provision of safe, quality healthcare at each level of the organisation, with clearly documented and understood roles and responsibilities. Ensure effective integrated systems, processes and leadership are in place to support the provision of safe, quality, accountable and person centred healthcare. It is an expectation that health services implement to best meet their employees' and community's needs, and that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	Annual review of the 2016 Goulburn Valley Health Clinical Governance Framework that reflects the soon to be released Ducket review and includes a review of the performance indicators presented to the Board.	The Board indicators have been extensively reviewed and a new indicator report has been developed. A data dictionary to support this suite is under development. The Framework (approved in April 2016) has commenced review with the release of the Duckett review in October 2016. Board indicators have been further reviewed and refined to a dashboard model and now includes a supporting data dictionary. BQC has further supported transition arrangements for review by March 2017. Review of the governance model commenced including organisation structure and committee structure. Clinical governance framework was reviewed. Implementation of organisation structure and committee structure is in place. Executive team has been revised and appointments made. Completed.
		Implementation of the revised policy and controlled documents framework, morbidity and mortality framework, and other frameworks that support the clinical governance framework to ensure that practices are contemporary and that the organisation has access to best practice information for decision making.	Implementation of the revised policy and controlled documents includes the "Reduce the Red Tape Campaign' to reduce the number of policy documents from 187 to 15. This is nearing completion. The new framework also reduces the administrative burden of document development, review and approval and improves efficiency. Implemented the M&M and Clinical Senate structure and Mortality Review e-database. All frameworks have been developed and /or reviewed and implemented on the PROMPT system. Frameworks were revised as part of continuous improvement (incident, risk, clinical governance, quality). Complete.

Financial and Service Performance Reporting continued

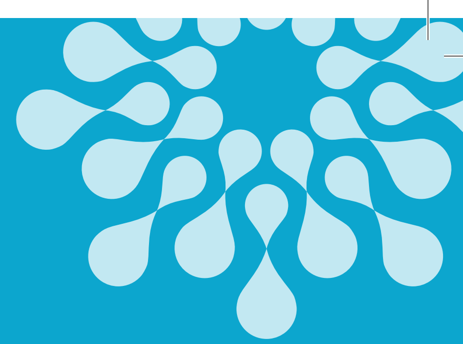
Domain	Action	Deliverables	Outcomes
		Further development of the credentialing framework that includes a nursing, midwifery and allied health science and therapy credentialing committee.	A GV Health draft Nursing, Midwifery and Allied health (Science and Therapy) credentialing framework was developed in consultation with Victoria's CNO, ACN and state-wide peers. This gained commitment from Hume Region DONs via the regional DONs committee. Review of medical credentialing processes is done.
			The Framework and Regional Credentialing Committee Terms of Reference were approved at BPC and Health Services Executive. We implemented a revised system in e-credentialing. The new CNMO will implement credentialing committee. The Medical Credentialling and appointments process was reviewed by Interim CEO, with new terms of reference to the Board. The new process was operationalized. In line with the Incite review, nursing and allied health credentialing has been included with Medical – one committee.
		Review and strengthen the medical credentialing system to provide regional leadership by including regional partners	This was reviewed – strengthening is in progress.
	Lead the development and implementation of Local Region Action Plans under the series of statewide design, service and infrastructure plans being progressively released from 2016 17. Development of Local Region Action Plans will require partnerships and active collaboration across regions to ensure plans meet both regional and local service needs, as articulated in the statewide design, service and infrastructure plans.	Goulburn Valley Health will continue to provide leadership in the provision of clinical and corporate support services across a number of Health Service in the Hume Region including Moira health services.	GVH is the lead with implementing the Oracle Financial System upgrade and is facilitating the project in consultation with DHHS and HRHA. GVH is supporting the PAS implementation for the Hume Region in terms of technical and clinical expertise. GVH is also participating in a regional approach to develop and implement a regional salary sacrificing package. GVH participated in the Hume Region tender for salary packaging services. GVH continues to support Nathalia and Yea District Hospitals by providing corporate support services.



Domain	Action	Deliverables	Outcomes
	Ensure that an anti-bullying and harassment policy exists and includes the identification of appropriate behaviour, internal and external support mechanisms for staff and a clear process for reporting, investigation, feedback, consequence and appeal and the policy specifies a regular review schedule.	Review of Goulburn Valley Health Anti-bullying and Harassment Policy to ensure it complies with the requirements stated.	The procedure has been updated as a result of feedback received from WorkSafe and as a result of the VAGO report. The organisational approach to bullying and harassment was reviewed. Work continues. We received a high level Executive Summary with recommendations from the Zietz review. An action plan is to be developed.
		Goulburn Valley Health will continue to implement the anti-bullying and harassment strategy that is consistent with the recommendations from the Victorian Auditor General's Report and reports through to the Board Workforce sub-committee.	A number of actions in the strategy have been completed. Actions around early intervention and management prior to escalation to a formal complaint. Strategy is reviewed monthly and reported to the Workforce Board Sub Committee bi-monthly. The organisational policy and procedures in respect of bullying and harassment were reviewed. Work continues. We received a high level Executive Summary with recommendations from the Zietz review. An action plan is to be developed.

Financial and Service Performance Reporting continued

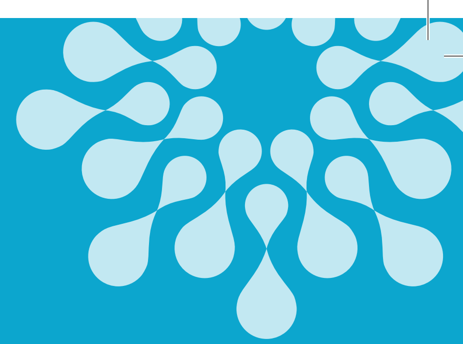
Domain	Action	Deliverables	Outcomes
	Board and senior management ensure that an organisational wide occupational health and safety risk management approach is in place which includes: (1) A focus on prevention and the strategies used to manage risks, including the regular review of these controls; (2) Strategies to improve reporting of occupational health and safety incidents, risks and controls, with a particular focus on prevention of occupational violence and bullying and harassment, throughout all levels of the organisation, including to the board; and (3) Mechanisms for consulting with, debriefing and communicating with all staff regarding outcomes of investigations and controls following occupational violence and bullying and harassment incidents.	Compliance with the Occupational Health Safety and Wellbeing strategic plan including Staff Meetings, Monthly Reports and Safety Walk-around.	Occupational Health Safety and Wellbeing strategic plan is reviewed bi-monthly. Safety walk arounds are conducted with the Executive team, Hotel services and Engineering Managers.
		Occupational Health and Safety safety initiatives will continue to be developed for all staff training including a review of the blended training model.	Occupational Health and Safety training is available to all new employees with more in-depth sessions for managers. Introduction of face to face Orientation will enable staff to ask questions and understand how important safety is. Face to face orientation commenced 30 January 2017, and will be provided monthly to ensure adequate training and induction is provided to all new employees. Blended training model continues to be utilised for mandatory training requirements. Staff training is ongoing, with blended learning.



Domain	Action	Deliverables	Outcomes
		The Goulburn Valley Health Occupational Violence Working Party will continue to drive initiatives and will oversee the development of occupational violence prevention and management strategy that includes all staff groups that also supports the family violence strategy. This will include the development of a framework to manage consumers who display violence towards staff and other consumers and visitors	The Occupational Violence working party is currently developing a framework to manage consumers who may display unacceptable behaviours. The Alfred Health OHS Framework is being adopted at GV Health to cover OHS and Occupational Violence. This will be tabled at the next OHS meeting. The Occupational Violence working party is reviewing procedures. Training for staff in managing aggression is ongoing.
	Implement and monitor workforce plans that: improve industrial relations; promote a learning culture; align with the Best Practice Clinical Learning Environment Framework; promote effective succession planning; increase employment opportunities for Aboriginal and Torres Strait Islander people; ensure the workforce is appropriately qualified and skilled; and support the delivery of high-quality and safe person centred care.	Goulburn Valley Health will continue to develop and refine the planning framework for the future workforce needs and development of our staffing resources and organisational culture to become an employer of choice. This will include ongoing refinement of the Workforce Plan and implementation and monitoring of the Plan.	Review of workforce data and skill capability was undertaken and the education plan was developed to provide training and education pathways for nursing and midwifery. Review of undergraduate numbers and clinical placement was undertaken for future workforce building with Midwifery a priority to increase students to enhance workforce replacement/ development. A succession plan framework was developed. We met with University of Melbourne to evolve the Mentor program with Academic merit. A review of the workforce plan will be undertaken in line with the redevelopment to ensure adequate staffing needs are identified. The Aboriginal Employment Plan implementation is underway. A mental health recruitment and retention strategy was developed by GV Health. Implementation continues. The strategy will be mirrored across the organisation.

Financial and Service Performance Reporting continued

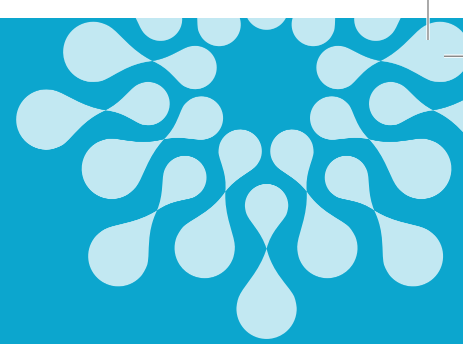
Domain	Action	Deliverables	Outcomes
		Participation and review of People Matter Surveys with initiatives implemented.	Survey results for 2016 were reviewed and analysis was undertaken with the 2014 data. The leadership day was held in December 2016. A number of actions were discussed. Initiatives include using patient experience stories as a learning tool to improve staff awareness and patient experiences. We have received the results from the People Matter Survey. 53% responded. We will now develop an action plan for implementation in 2017/18.
		The Aboriginal employment plan to be adopted and socialised.	The Aboriginal Employment Plan Implementation is underway. The Algabonya Agreement has been incorporated into the plan.
	Create a workforce culture that: (1) includes staff in decision making; (2) promotes and supports open communication, raising concerns and respectful behaviour across all levels of the organisation; and (3) includes consumers and the community.	Goulburn Valley Health will continue to implement the CREATE Our Future (Studer Program) including values recognition and acceptable behaviours program to promote a values driven organisational culture and support team performance.	The reward and recognition program was implemented in January 2016 and includes the provision of bi-monthly awards relating to the GV Health values. Further review of the program is to be undertaken to determine how to further embed the program throughout the organisation.
			A review of the Studer Program is being undertaken. Managers have been surveyed to gain an understanding of the utilisation and benefits of the program. Studer has been re-engaged to continue the roll-out of the program across the organisation.
		A Staff Survey will be conducted with a focus on the culture in the service.	The People Matter Survey was conducted in June 2016 and was undertaken again in May 2017 with 53% staff participating.



Domain	Action	Deliverables	Outcomes
	Ensure that the Victorian Child Safe Standards are embedded in everyday thinking and practice to better protect children from abuse, which includes the implementation of: strategies to embed an organisational culture of child safety; a child safe policy or statement of commitment to child safety; a code of conduct that establishes clear expectations for appropriate behaviour with children; screening, supervision, training and other human resources practices that reduce the risk of child abuse; processes for responding to and reporting suspected abuse of children; strategies to identify and reduce or remove the risk of abuse and strategies to promote the participation and empowerment of children.	Victorian ChildSafe Standards implemented across all campuses and programs.	Development of the Framework was completed with the reporting process established through VINAH. Roll-out is expected in February 2017. The Education program was rolled out to staff and is continuing.
		Establishment of the Trauma Informed Services Educator Advocate position to coordinate training and communication to support this work.	The Work-plan was developed for Stage 3 roll out of Strengthening Hospital Responses to Family Violence. Recruitment has commenced for the Education Co-ordinator.
			The GV Health Draft Child Safe Plan was completed. A training plan is to be developed for staff at community sites. This work is ongoing.
		Goulburn Valley Health participation in the Taskforce 1000 local advisory committee and work plan.	GV Health representatives are participating in Goulburn Taskforce 1000 workgroup meetings and provide consultation on developed trauma informed counselling service capability and capacity. Work is ongoing.
	Implement policies and procedures to ensure patient facing staff have access to vaccination programs and are appropriately vaccinated and/or immunised to protect staff and prevent the transmission of infection to susceptible patients or people in their care.	Improve levels of compliance with the Staff Influenza Vaccination Program. Review of current procedures to improve accessibility of vaccination programs to clinical staff.	A total of 76% of eligible staff were immunised in 2016. Immunisation is underway for 2017.
		Implement education on transmission of infections to susceptible patients or people in clinical staff care to minimise harm.	Ongoing. Orientation was re-established, with inclusion of an Infection Control presentation. The organ donation position was recruited and appointed late June 2017.

Financial and Service Performance Reporting continued

Domain	Action	Deliverables	Outcomes
Financial sustainability	Enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	Improved operational and capital budgeting processes and controls will continue to be implemented.	A business improvement planning process has been developed to improve operational and capital development process and controls and to achieve financial sustainability. We formally launched the business improvement program (BIP) and the BIP project manager commenced.
	Actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measureable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	The Environmental Management Plan will continue to be developed and refined with annual monitoring requirements.	In progress. Regular reviews are undertaken and the results are reported on the Environmental Data Management System.
			A food service delivery model has been endorsed which will assist in the reduction of plate wastage by serving food individually ordered, in a room service model.



Part B: Performance Priorities 2016/17

Quality and safety

Key performance indicator	Target	2016/17 Actual
Accreditation		
Compliance with NSQHS Standards accreditation	Full compliance	Full compliance
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Full compliance

Infection prevention and control

Key performance indicator	Target	2016/17 Actual
Compliance with cleaning standards	Full compliance	Full compliance
Compliance with the Hand Hygiene Australia program	80%	86.82%
Percentage of healthcare workers immunised for influenza	75%	77%

Patient experience

Key performance indicator	Target	2016/17 Actual
Victorian Healthcare Experience Survey - data submission	Full compliance	Full compliance
Victorian Healthcare Experience Survey — patient experience	95% positive experience	87%
Victorian Healthcare Experience Survey — discharge care	75% very positive	72%

Healthcare associated infections

Key performance indicator	Target	2016/17 Actual
Number of patients with surgical site infection	No outliers	0
ICU central line-associated blood stream infection	No outliers	No outliers
SAB rate per occupied bed days	<2/10,000	1/10,000

Maternity and newborn*

Key performance indicator	Target	2016/17 Actual
Percentage of women with prearranged postnatal home care	100%	100%
Rate of singleton term infants without birth anomalies with APGAR score <7 to 5 minutes	<=1.6%	1.64%
Rate of severe foetal growth restriction in singleton pregnancy undelivered by 40 weeks	<= 28.60%	1.13%

**Perinatal Service Performance Indicator (PSPI) reports should be consulted for a description on the utility and business rules for these indicators. Note that data for 2016 and 2017 is provisional.*

Financial and Service Performance Reporting continued

Mental health

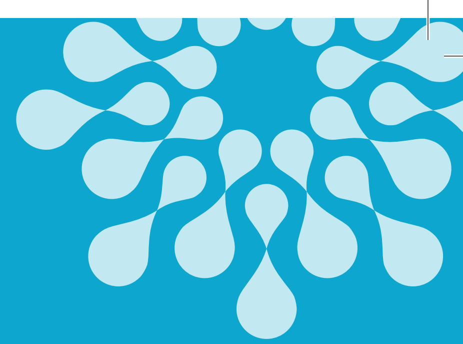
Key performance indicator	Target	2016/17 Actual
Percentage of adult inpatients who are readmitted within 28 days of discharge	14%	9%
Rate of seclusion events relating to an acute admission - composite seclusion rate	<=15/1,000	11.05
Rate of seclusion events relating to a child and adolescent acute admission	<=15/1,000	N/A for GV Health
Rate of seclusion events relating to an adult acute admission	<=15/1,000	11.7
Rate of seclusion events relating to an aged acute admission	<=15/1,000	0
Percentage of child and adolescent patients who have post-discharge follow-up within seven days	75%	54%
Percentage of adult patients who have post-discharge follow-up within seven days	75%	58%
Percentage of aged patients who have post-discharge follow-up within seven days	75%	82%

Continuing care

Key performance indicator	Target	2016/17 Actual
Functional independence gain from admission to discharge, relative to length of stay	>=0.39 (GEM) and >=0.645 (Rehab)	0.89 1.03

Emergency care

Key performance indicator	Target	2016/17 Actual
Percentage of ambulance patients transferred within 40 minutes	90%	78%
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	64%
Percentage of emergency patients with a length of stay less than four hours	81%	61%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	2



Elective surgery

Key performance indicator	Target	2016/17 Actual
Percentage of urgency category 1 elective patients admitted within 30 days	100%	100%
Percentage of urgency category 1, 2 and 3 elective patients admitted within clinically recommended timeframes	94%	86.68%
20% longest waiting Category 2 and 3 removals from the elective surgery waiting list	100%	100%
Number of patients on the elective surgery waiting list	584	606
Number of hospital initiated postponements per 100 scheduled admissions	<=8/100	6.69
Number of patients admitted from the elective surgery waiting list - annual total	3369	3580

Specialist clinics

Key performance indicator	Target	2016/17 Actual
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	73%
Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%	100%

Financial sustainability

Key performance indicator	Target	2016/17 Actual
Operating result ($m)	0.06	0.52
Trade creditor days	60	46
Patient fee debtor days	60	52
Public and private WIES %	100%	100%
Adjusted current asset ratio	0.7	0.5
Number of days with available cash	14	16

Asset Management

Key performance indicator	Target	2016/17 Actual
Basic asset management plan	Full compliance	Full compliance

Governance, leadership and cultural performance

Key performance indicator	Target	2016/17 Actual
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	67%

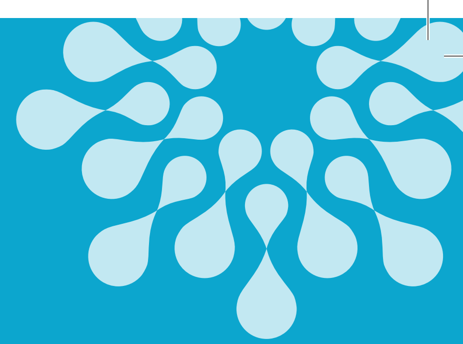
Financial and Service Performance Reporting continued

Part C: Activity and Funding 2016/17

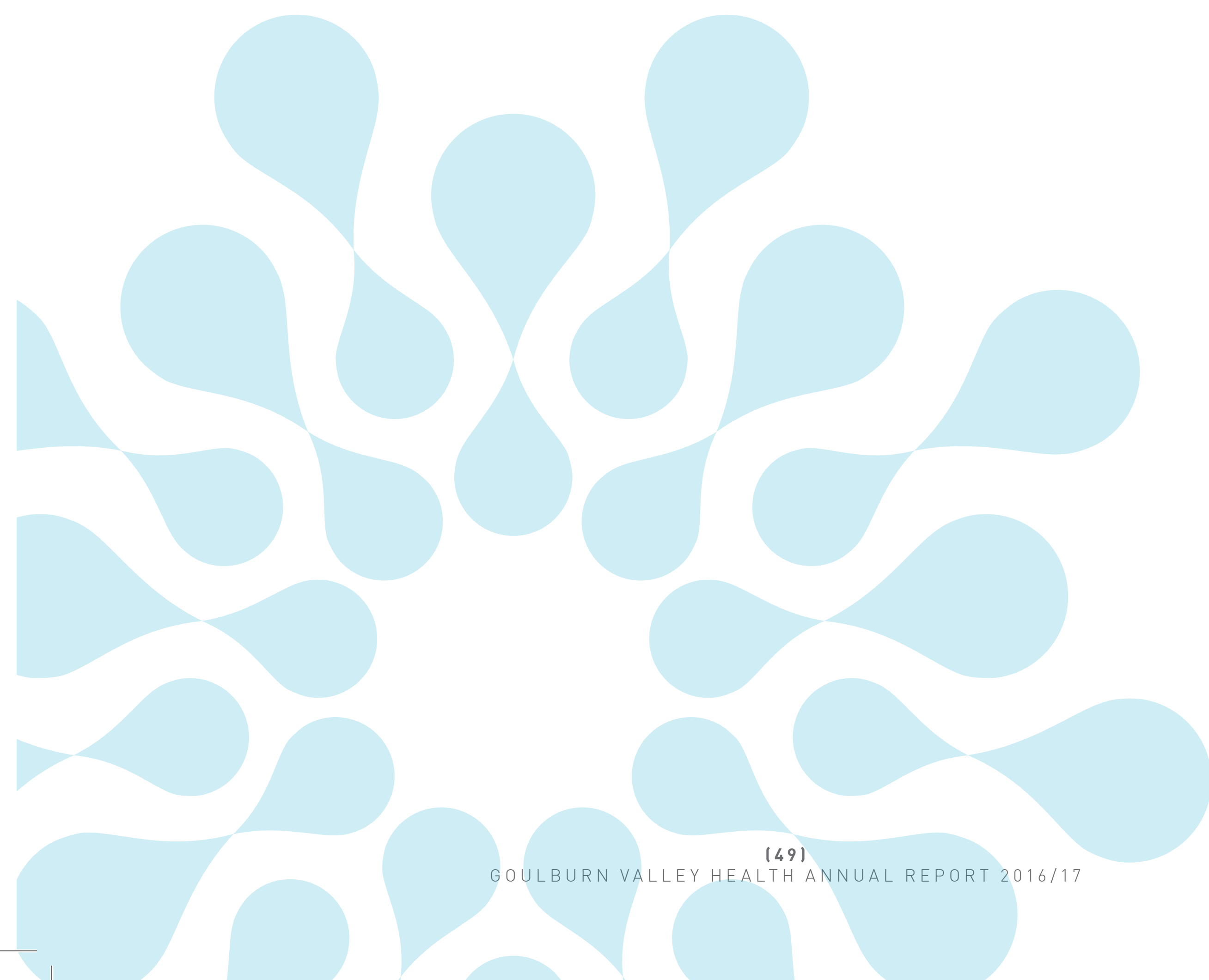
Funding type

Acute Admitted	Target	2016/17 Actuals
WIES DVA	333	283
WIES Private	3,077	3,040
WIES Public	16,121	16,187
WIES TAC	169	211
Acute Non-Admitted		
Emergency Services		31,754
Specialist Clinics - Public		39,447
Home Enteral Nutrition	356	390
Aged Care		
Aged Care Assessment Service	1,830	1,423
HACC*	8,803	9,385
Residential Aged Care	19,888	19,444
Subacute and Non-Acute Admitted		
Transition Care - Bed days	13,140	10,869
Transition Care - Home days	13,505	14,678
Subacute WIES - GEM Private	116	73
Subacute WIES - GEM Public	448	376
Subacute WIES - Palliative Care Private	14	69
Subacute WIES - Palliative Care Public	54	130
Subacute WIES - Rehabilitation Private	76	68.64
Subacute WIES - Rehabilitation Public	375	361
Subacute WIES - DVA	45	45.52
Subacute Non-Admitted		
Health Independence Program - DVA		173
Health Independence Program - Public	29,687	29,784

*HACC includes Nursing After Hours



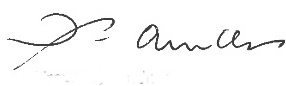
Mental Health and Drug Services	Target	2016/17 Actuals
Drug Services	1,044	904
Mental Health Ambulatory	33,759	19,880
Mental Health Residential	10,957	7,200
Mental Health Subacute	3,653	2,467
Mental Health Inpatient - Available bed days	7,305	7,300
Primary Health		
Community Health / Primary Care Programs	11,945	11,404
Other		
Health Workforce	94	106



Attestations

Attestation for compliance with Ministerial Standing Direction 3.7.1 – Risk Management Framework and Processes

I, Trevor Saunders, certify that Goulburn Valley Health has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. The Goulburn Valley Health Audit and Risk Committee has verified this.



Trevor Saunders
Chief Executive Officer
29 August 2017

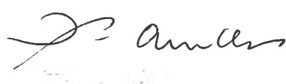
Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

Compliant

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

Goulburn Valley Health reports the following material non-compliance issues;

- There were four issues identified relating to the HPV Health Purchasing Policies and action plans have been developed to correct these issues.



Trevor Saunders
Chief Executive Officer
29 August 2017

Additional information available on request

Consistent with FRD 22H (Section 6.19) the report of operations should confirm that details in respect of the items listed below have been retained by GV Health and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

a. Declarations of pecuniary interests have been duly completed by all relevant officers

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

c. Details of publications produced by the entity about itself, and how these can be obtained

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

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

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

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

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

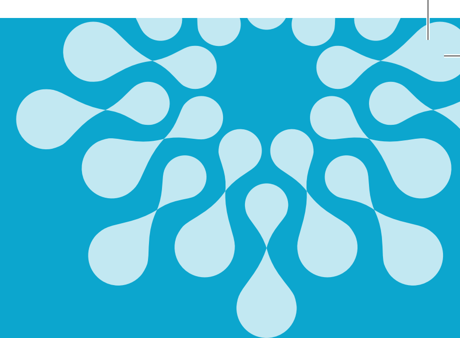
i. Details of assessments and measures undertaken to improve the occupational health and safety of employees;

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

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

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

Summary of Financial Results



For the Financial Year Ended 30 June 2017

	2017 $'000	2016 $'000	2015 $'000	2014 $'000	2013 $'000
Total Revenue	258,017	234,616	218,275	217,074	206,609
Total Expenses	260,806	242,307	226,298	219,165	210,585
Other Operating Flows Included in the Net Result	779	635	-	-	-
Net Result for the Year (Incl. Capital and Specific Items)	**(2,789)**	**(8,325)**	**(8,023)**	**(2,091)**	**(3,976)**
Total Assets	125,395	123,720	126,019	136,296	117,893
Total Liabilities	60,875	56,411	50,384	52,638	49,790
Net Assets	**64,520**	**67,309**	**75,635**	**83,658**	**68,103**
Property, Plant & Equipment Revaluation Surplus	63,992	63,992	63,992	63,992	46,346
General Purpose Surplus	19,562	19,475	19,206	18,557	18,526
Restricted Purpose Surplus	5,379	5,362	5,420	5,419	5,363
Contributed Capital	46,821	46,821	46,821	46,821	46,821
(Accumulated Deficits)	(71,234)	(68,341)	(59,804)	(51,131)	(48,953)
Total Equity	**64,520**	**67,309**	**75,635**	**83,658**	**68,103**

Significant Changes in Financial Position

Our Cash and Cash Equivalent balance increased during the year due to the increase of Monies Held in Trust (Other Current Liabilities in the Balance Sheet) which came from client's funds held over from Commonwealth Community Packages and Residential Aged Care Refundable Entrance Fees. Cash held for operations also increased due to the carryover of a DHHS Capital grant for the new Hume Region Patient Administration System and net cash generated from operating activities.

Borrowings reduced from the previous year as finance leases for information technology equipment expired and were not replaced with further leases.

Equity has decreased as a result of the entity deficit of $2.8m (2015/16 $8.33m deficit), which includes non-operating items and depreciation and amortisation of $10.0m ($10.75m in 2015/16).

Operational and Budgetary Objectives and Factors Affecting Performance

As a public health service, GV Health is required to negotiate a Statement of Priorities with the Department of Health and Human Services each year. This document is a key accountability agreement between GV Health and the Minister of Health. It recognises that resources are limited and that the allocation of these scarce resources needs to be prioritised. The Statement incorporates both system-wide priorities set by the Government and locally generated agency-specific priorities.

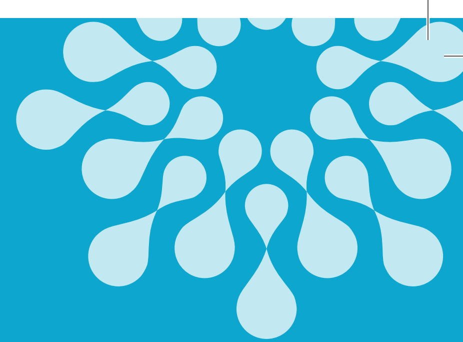
The Board budgeted for a surplus in financial position before capital items and depreciation for the 2016/17 year. The final result for the year was a surplus of $0.52m before capital items and depreciation and amortisation.

Both this organisation and the Department of Health and Human Services focus on the result before capital and depreciation, as depreciation is not a funded item. Funding for capital redevelopment and major equipment purchases are sourced from the Department of Health and Human Services; such funding is allocated according to need and after consideration of a supporting submission.

Events Subsequent to Balance Date

No matters or circumstances have arisen since the end of the financial year which significantly affect or may significantly affect the operations of the Goulburn Valley Health, the results of its operations or its state of affairs in future years

Disclosure Index



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

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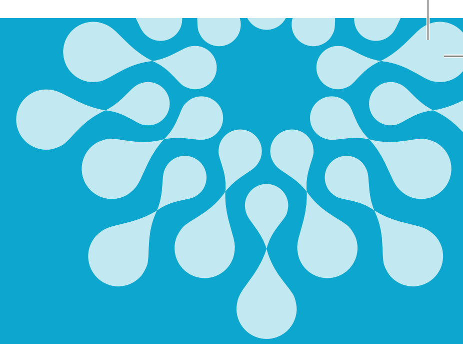

GOULBURN VALLEY HEALTH

financial report 2016/17

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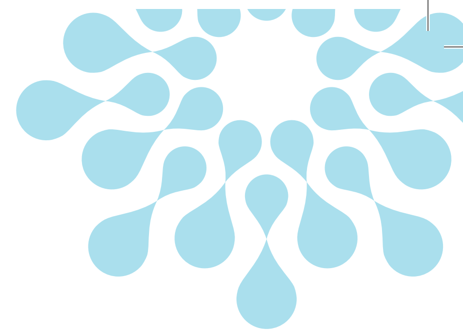


Goulburn Valley Health

Board Member's, Accountable Officer's and Chief Finance & Accounting Officer's Declaration

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

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

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

We authorise the attached financial statements for issue on the 29 August 2017.

Rebecca Woolstencroft
Board Chair
Goulburn Valley Health

Shepparton
29 August 2017

Trevor Saunders
Chief Executive Officer
Goulburn Valley Health

Shepparton
29 August 2017

Salvatore Costanzo
Executive Director Finance and Business Services
Goulburn Valley Health

Shepparton
29 August 2017

VAGO

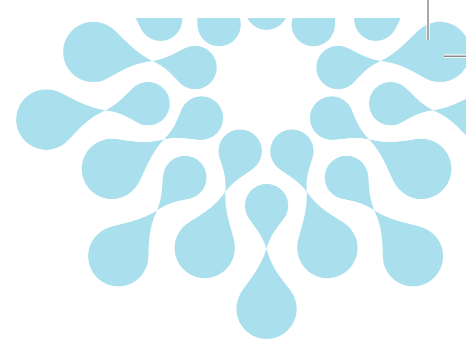
Victorian Auditor-General's Office

Independent Auditor's Report

To the Board of Goulburn Valley Health

Opinion	I have audited the financial report of Goulburn Valley Health (the health service) which comprises the: • balance sheet as at 30 June 2017 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including a summary of significant accounting policies • board member's, accountable officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2017 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. My responsibilities under the Act are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, and using the going concern basis of accounting unless it is inappropriate to do so.

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



Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
31 August 2017

Ron Mak
as delegate for the Auditor-General of Victoria

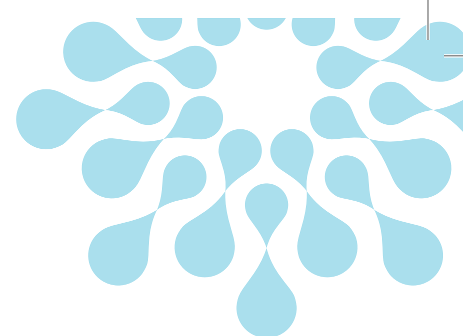
Goulburn Valley Health

Comprehensive Operating Statement

For the Financial Year Ended 30 June 2017

	Note	Total 2017 $'000	Total 2016 $'000
Revenue from Operating Activities	**2.1**	247,369	229,937
Revenue from Non-Operating Activities	**2.1**	506	518
Employee Expenses	**3.1**	(162,462)	(153,417)
Non Salary Labour Costs	**3.1**	(13,914)	(11,973)
Supplies and Consumables	**3.1**	(42,416)	(39,097)
Other Expenses	**3.1**	(28,566)	(26,223)
Net Result Before Capital & Specific Items		**518**	**(254)**
Capital Purpose Income	**2.1**	10,142	4,162
Depreciation & Amortisation	**3.1**	(9,998)	(10,075)
Specific Expenses	**3.1**	(14)	(270)
Finance Costs	**3.1**	(17)	(42)
Capital Purpose Expenditure	**3.1**	(4,198)	(1,212)
Net Result After Capital & Specific Items		**(3,568)**	**(7,691)**
Other Economic Flows Included in Net Result			
Revaluation of Long Service Leave	**3.5**	779	(635)
Total Other Economic Flows Included in Net Result		**779**	**(635)**
Net Result for the Year		**(2,789)**	**(8,326)**

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



Goulburn Valley Health
Balance Sheet
For the Financial Year Ended 30 June 2017

	Note	Total 2017 $'000	Total 2016 $'000
Current Assets			
Cash and Cash Equivalents	**6.2**	15,491	10,124
Receivables	**5.1**	5,520	6,350
Inventories	**5.2**	2,235	2,011
Prepayments and Other Assets	**5.4**	898	817
Total Current Assets		**24,144**	**19,302**
Non-Current Assets			
Receivables	**5.1**	1,343	1,330
Property, Plant and Equipment	**4.1**	98,928	102,050
Intangible Assets	**4.3**	980	1,038
Total Non-Current Assets		**101,251**	**104,418**
TOTAL ASSETS		**125,395**	**123,720**
Current Liabilities			
Payables	**5.5**	12,365	10,588
Borrowings	**6.1**	721	953
Provisions	**3.5**	33,199	31,827
Other Current Liabilities	**5.3**	7,129	5,065
Total Current Liabilities		**53,414**	**48,433**
Non-Current Liabilities			
Borrowings	**6.1**	2,655	3,283
Provisions	**3.5**	4,805	4,696
Total Non-Current Liabilities		**7,461**	**7,978**
TOTAL LIABILITIES		**60,875**	**56,411**
NET ASSETS		**64,520**	**67,309**
EQUITY			
Property, Plant and Equipment Revaluation Surplus	**8.1a**	63,992	63,992
General Purpose Surplus	**8.1a**	19,562	19,475
Restricted Specific Purpose Surplus	**8.1b**	5,379	5,362
Contributed Capital	**8.1b**	46,821	46,821
Accumulated Deficits	**8.1c**	(71,234)	(68,341)
TOTAL EQUITY		**64,520**	**67,309**
Contingent Assets and Contingent Liabilities	**7.3**		
Commitments	**6.3**		

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

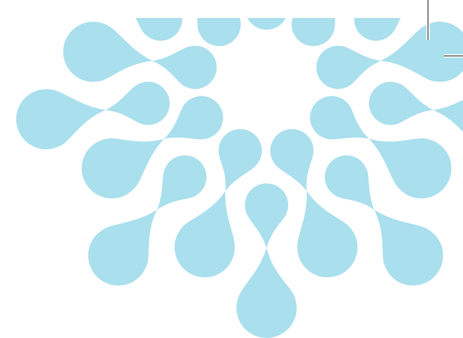
Goulburn Valley Health

Statement of Changes in Equity

For the Financial Year Ended 30 June 2017

	Note	Property, Plant & Equipment Revaluation Surplus $'000	General Purpose Surplus $'000	Restricted Specific Purpose Surplus $'000	Contributions by Owners $'000	Accumulated Surpluses/ (Deficits) $'000	Total $'000
Balance at 1 July 2015		**63,992**	**19,206**	**5,420**	**46,821**	**(59,804)**	**75,635**
Net Result for the Year		-	-	-	-	(8,326)	(8,326)
Transfer to Accumulated Surplus	**8.1(c)**	-	269	(59)	-	(211)	-
Balance at 30 June 2016		**63,992**	**19,475**	**5,362**	**46,821**	**(68,341)**	**67,309**
Net Result for the Year		-	-	-	-	(2,789)	(2,789)
Transfer to Accumulated Surplus	**8.1(c)**	-	87	17	-	(104)	-
Balance at 30 June 2017		**63,992**	**19,562**	**5,379**	**46,821**	**(71,234)**	**64,520**

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



Goulburn Valley Health
Cash Flow Statement
For the Financial Year Ended 30 June 2017

	Note	Total 2017 $'000	Total 2016 $'000
Cash Flows from Operating Activities			
Operating Grants from Government		211,303	195,616
Capital Grants from Government		6,204	2,416
Patient and Resident Fees Received		18,154	17,211
Private Practice Fees Received		3,802	3,098
Donations Received		289	682
GST Received from ATO		6,198	6,402
Interest Received		600	563
Other Capital Receipts		29	840
Other Receipts		16,025	14,303
Total Receipts		**262,604**	**241,131**
Employee Expenses Paid		(160,250)	(150,535)
Non Salary Labour Costs		(15,305)	(12,915)
Payments for Supplies, Consumables and Services		(79,038)	(72,034)
Total Payments		**(254,593)**	**(235,484)**
Net Cash Flow From/(Used In) from Operating Activities	**8.2**	**8,010**	**5,646**
Cash Flows from Investing Activities			
Payments for Non-Financial Assets		(3,908)	(9,329)
Proceeds from Sale of Non-Financial Assets		62	79
Net Cash Inflow/(Outflow) from Investing Activities		**(3,846)**	**(9,250)**
Cash Flows from Financing Activities			
Proceeds from Borrowing		(525)	3,850
Proceeds from Finance Leases		85	232
Repayment of Finance Leases		(420)	(487)
Net Cash Flows From/(Used In) Financing Activities		**(860)**	**3,595**
Net Increase/(Decrease) in Cash and Cash Equivalents Held		**3,304**	**(9)**
Cash & Cash Equivalents at Beginning of Financial Year		5,058	5,067
Cash & Cash Equivalents at End of Financial Year	**6.2**	**8,362**	**5,058**

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

Basis of Presentation

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

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

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

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

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

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

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

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Goulburn Valley Health for the period ending 30 June 2017. The report provides users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the Financial Management Act 1994 and applicable AASBs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 Presentation of Financial Statements.

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

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 AASBs.

The annual financial statements were authorised for issue by the Board of Goulburn Valley Health on 29th August 2017.

(b) Reporting entity

The financial statements include all the controlled activities of the Goulburn Valley Health.

Its principal address is:

Graham Street,
Shepparton, Victoria, 3630

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

Objectives and funding

Goulburn Valley Health's overall objective is Healthy Communities and

Improve the Quality of Life to Victorians.

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

(c) Basis of accounting preparation and measurement

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

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

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

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

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

- non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed when new indices are published by the Valuer General to ensure that the carrying amounts do not materially differ from their fair values;
- the fair value of assets other than land is generally based on their depreciated replacement value.

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

(d) Principles of consolidation

Intersegment Transactions

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

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

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

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

Structure

2.1 Analysis of Revenue by Source

2.2 Assets Received Free of Charge or For Nominal Consideration

NOTE 2.1: ANALYSIS OF REVENUE BY SOURCE

	Admitted Patients 2017 $'000	Non-Admitted 2017 $'000	EDS. 2017 $'000	Mental Health 2017 $'000	RAC Incl. Mental Health 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Government Grants	125,424	8,931	12,954	23,739	4,957	13,283	1,359	20,980	211,627
Indirect Contributions by Department of Health and Human Services	43	-	-	38	3	20	6	13	123
Patient & Resident Fees	5,660	31	253	-	1,341	471	10	907	8,674
Other Revenue from Operating Activities	899	41	18	1,503	-	42	-	5,375	7,879
Transfer Pricing	17,544	-	-	-	-	-	-	(17,544)	-
Commercial Activities	-	-	-	-	-	-	-	19,066	19,066
Total Revenue from Operating Activities	**149,569**	**9,004**	**13,225**	**25,280**	**6,302**	**13,817**	**1,376**	**28,798**	**247,369**
Interest	-	-	-	-	-	-	-	506	506
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**506**	**506**
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	-	10,045	10,045
Capital Interest	-	-	-	-	-	-	-	96	96
Total Capital Purpose Revenue	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**10,142**	**10,142**
Total Revenue	**149,569**	**9,004**	**13,225**	**25,280**	**6,302**	**13,817**	**1,376**	**39,445**	**258,017**

	Admitted Patients 2016 $'000	Non-Admitted 2016 $'000	EDS. 2016 $'000	Mental Health 2016 $'000	RAC Incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Government Grants	119,540	8,718	8,891	21,608	4,640	11,624	1,453	19,058	195,533
Indirect Contributions by Department of Health and Human Services	44	-	-	39	3	21	6	13	126
Patient & Resident Fees	5,717	37	250	72	1,271	500	7	858	8,711
Other Revenue from Operating Activities	729	60	1	847	7	39	54	5,431	7,168
Transfer Pricing	16,367	-	-	-	-	-	-	(16,367)	-
Commercial Activities	-	-	-	-	-	-	-	18,399	18,399
Total Revenue from Operating Activities	**142,396**	**8,815**	**9,142**	**22,566**	**5,921**	**12,183**	**1,520**	**27,393**	**229,937**
Interest	-	-	-	-	-	-	-	518	518
Total Revenue from Non-Operating Activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**518**	**518**
Capital Purpose Income (excluding Interest)	-	-	-	-	-	-	-	4,101	4,101
Capital Interest	-	-	-	-	-	-	-	61	61
Total Capital Purpose Revenue	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**4,162**	**4,162**
Total Revenue	**142,396**	**8,815**	**9,142**	**22,566**	**5,921**	**12,183**	**1,520**	**32,073**	**234,616**

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

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

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

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

In accordance with AASB 1004 Contributions, government grants and other transfers of income (other than contributions by owners) are recognised as income when 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 and Human Services

- Insurance is recognised as revenue following advice from the Department of Health and Human Services.

Patient and Resident Fees

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

Private Practice Fees

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

Revenue from Commerical Activites

Revenue from commercial activities such as commercial laboratory medicine is recognised at the time invoices are raised.

Donations and Other Bequests

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

Interest Revenue

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

Category groups

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

- Admitted Patient Services (Admitted Patients) comprises all acute and subacute admitted patient services, where services are delivered in public hospitals.
- Mental Health Services (Mental Health) comprises all specialised mental health services providing a range of inpatient, community based residential, rehabilitation and ambulatory services which treat and support people with a mental illness and their families and carers. These services aim to identify mental illness early, and seek to reduce its impact through providing timely acute care services and appropriate longer-term accommodation and support for those living with a mental illness.
- Non Admitted Services comprises acute and subacute non admitted services, where services are delivered in public hospital clinics and provide models of integrated community care, which significantly reduces the demand for hospital beds and supports the transition from hospital to home in a safe and timely manner.
- Emergency Department Services (EDs) comprises all emergency department services.
- Aged Care comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.
- Primary, Community and Dental Health comprises a range of home based, community based, community, primary health and dental services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health services.
- Residential Aged Care including Mental Health (RAC incl. Mental Health) referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services in receipt of supplementary funding from the department 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 and secure extended care units.

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

NOTE 2.2: ASSETS RECEIVED FREE OF CHARGE OR FOR NOMINAL CONSIDERATION

	Total 2017 $'000	Total 2016 $'000
During the reporting period, the fair value of assets received free of charge, was as follows;		
Plant & Equipment	-	18
Total	**-**	**18**

NOTE 3: THE COST OF DELIVERING SERVICES

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

Structure

3.1 Analysis of Expenses by Source

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

3.3 Specific Expenses

3.4 Finance Costs

3.5 Provisions

3.6 Superannuation

NOTE 3.1: ANALYSIS OF EXPENSES BY SOURCE

	Admitted Patients 2017 $'000	Non-Admitted 2017 $'000	EDS. 2017 $'000	Mental Health 2017 $'000	RAC Incl. Mental Health 2017 $'000	Aged Care 2017 $'000	Primary Health 2017 $'000	Other 2017 $'000	Total 2017 $'000
Employee Expenses	67,755	2,085	11,412	15,841	4,255	7,847	771	52,495	162,462
Other Operating Expenses									
Non Salary Labour Costs	6,392	13	1,082	975	-	170	140	5,141	13,914
Supplies & Consumables	16,027	286	687	2,442	251	3,111	27	19,585	42,416
Other Expenses	8,107	116	2,106	1,145	234	323	22	16,512	28,566
Transfer Pricing	49,932	2,000	8,824	2,495	3,876	1,606	177	(68,909)	-
Total Expenditure from Operating Activities	**148,213**	**4,500**	**24,112**	**22,897**	**8,615**	**13,057**	**1,138**	**24,824**	**247,357**
Finance Costs (refer note 3.4)	-	-	-	-	-	-	-	17	17
Other Non-Operating Expenses									
Specific Expenses	-	-	-	-	-	-	-	14	14
Expenditure for Capital Purposes	-	-	-	-	-	-	-	4,198	4,198
Depreciation & Amortisation (refer note 4.2)	-	-	-	-	-	-	-	9,998	9,998
Total Other Expenses	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**14,228**	**14,228**
Total Expenses	**148,213**	**4,500**	**24,112**	**22,897**	**8,615**	**13,057**	**1,138**	**39,052**	**261,585**

NOTE 3.1: ANALYSIS OF EXPENSES BY SOURCE (CONTINUED)

	Admitted Patients 2016 $'000	Non-Admitted 2016 $'000	EDS. 2016 $'000	Mental Health 2016 $'000	RAC Incl. Mental Health 2016 $'000	Aged Care 2016 $'000	Primary Health 2016 $'000	Other 2016 $'000	Total 2016 $'000
Employee Expenses	63,299	1,941	11,396	15,664	4,196	7,488	808	48,626	153,417
Other Operating Expenses									
Non Salary Labour Costs	6,189	25	393	561	19	74	109	4,603	11,973
Supplies & Consumables	13,597	267	686	2,342	225	2,572	39	19,368	39,097
Other Expenses	7,744	102	1,915	1,057	278	305	18	14,803	26,223
Transfer Pricing	42,806	3,595	8,248	1,837	3,664	1,657	261	(62,067)	-
Total Expenditure from Operating Activities	**133,634**	**5,930**	**22,637**	**21,462**	**8,382**	**12,096**	**1,234**	**25,333**	**230,709**
Finance Costs (refer note 3.4)	-	-	-	-	-	-	-	42	42
Other Non-Operating Expenses									
Specific Expenses	-	-	-	-	-	-	-	270	270
Expenditure for Capital Purposes	-	-	-	-	-	-	-	1,212	1,212
Depreciation & Amortisation (refer note 4.2)	-	-	-	-	-	-	-	10,075	10,075
Total Other Expenses	-	-	-	-	-	-	-	**11,599**	**11,599**
Total Expenses	**133,634**	**5,930**	**22,637**	**21,462**	**8,382**	**12,096**	**1,234**	**36,932**	**242,307**

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;
- fringe benefits tax;
- leave entitlements;
- termination payments;
- workcover premiums; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

Grants and other transfers

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

Other operating expenses

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

Supplies and consumables

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

Bad and doubtful debts

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

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

Contributions of resources provided free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another agency as a consequence of a restructuring of administrative arrangements. In the latter case, such a transfer will be recognised at its carrying amount. 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.

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

Net gain/ (loss) on non-financial assets

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

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

Refer to Note 4.1 Property Plant and Equipment.

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

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

Amortisation of non-produced intangible assets

Intangible non-produced assets with finite lives are amortised as an 'other economic flow' on a systematic 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.

Impairment of non-financial assets

Goodwill and intangible assets with indefinite useful lives (and intangible assets not available for use) are tested annually for impairment and whenever there is an indication that the asset may be impaired.

Revaluations of financial instrument at fair value

Refer to Note 7.1 Financial Instruments.

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

Refer to Note 1 (d) Basis of consolidation.

Other gains/ (losses) from other economic flows

Other gains/ (losses) include:

a. the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and

b. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

NOTE 3.2: ANALYSIS OF EXPENSE AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS

	Total Expense 2017 $'000	Total Expense 2016 $'000	Total Revenue 2017 $'000	Total Revenue 2016 $'000
Private Practice & Other Patient Activities	581	2,810	2,896	2,805
Laboratory Medicine	5,319	5,409	4,934	4,827
Diagnostics Imaging	6,002	4,615	5,967	5,096
Cafeteria and Catering Services	1,151	1,154	1,249	1,271
Patient Transport*	(84)	(78)	-	-
Car Park	90	102	498	548
Regional Services	2,731	2,678	3,014	3,006
Retail Aids and Equipment Outlet	422	406	326	417
Other Activities				
Fundraising & Community Support	67	45	159	384
Restricted Funds	37	126	23	46
Total	**16,315**	**17,267**	**19,066**	**18,399**

* Patient Transport includes transfer pricing between the Hospital & Community Initiatives programs

NOTE 3.3: SPECIFIC EXPENSES

	Total 2017 $'000	Total 2016 $'000
Voluntary Departure Packages	14	247
Write Down on Inventories	-	23
Total	**14**	**270**

NOTE 3.4: FINANCE COSTS

	Total 2017 $'000	Total 2016 $'000
Interest on RAC Accommodation Deposits	1	10
Finance Charges on Finance Leases (i)	16	32
Total Finance Costs	**17**	**42**

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

Finance costs include:

- Interest on bank overdrafts and short-term and long-term borrowings (Interest expense is recognised in the period in which it is incurred);
- Interest on RAC Accomdation Deposits

NOTE 3.5: EMPLOYEE BENEFITS IN THE BALANCE SHEET

	Total 2017 $'000	Total 2016 $'000
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	11,993	11,144
- Unconditional and expected to be settled wholly after 12 months (iii)	1,066	987
Long Service Leave		
- Unconditional and expected to be settled wholly within 12 months (ii)	2,288	2,157
- Unconditional and expected to be settled wholly after 12 months (iii)	11,693	11,549
Accrued Days off		
- Unconditional and expected to be settled within 12 months (ii)	390	352
Accrued Wages and Salaries		
- Unconditional and expected to be settled within 12 months (ii)	2,928	2,899
	30,358	**29,087**
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months (ii)	1,516	1,425
- Unconditional and expected to be settled after 12 months (iii)	1,325	1,315
	2,841	**2,740**
Total Current Provisions	**33,199**	**31,827**
Non-Current Provisions		
Employee Benefits (i)	4,353	4,249
Provisions related to Employee Benefit On-Costs	452	446
Total Non Current Provisions	**4,805**	**4,696**
Total Provisions	**38,005**	**36,522**
Total Current Provisions		
(a) Current Employee Benefits and Related On-Costs		
Unconditional Long Service Leave Entitlements	15,434	15,144
Annual Leave Entitlements	14,406	13,394
Accrued Wages and Salaries	2,928	2,899
Accrued Days Off	431	389
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (ii)	4,805	4,696
Total Employee Benefits and Related on-Costs	**38,005**	**36,522**

Notes:

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

(ii) The amounts disclosed are nominal amounts

(iii) The amounts disclosed are discounted to present values

Movements in provisions	Total 2017 $'000	Total 2016 $'000
Movement in Long Service Leave:		
Balance at start of year	**19,840**	**21,076**
Provision made during the year		
- Revaluations	(779)	635
- Expense recognising Employee Service	3,511	2,938
Settlement made during the year	(2,332)	(4,808)
Balance at end of year	**20,240**	**19,840**

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

Employee benefits

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

Wages and salaries, annual leave and accrued days off

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

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

- Undiscounted value – if the Health Service expects to wholly settle within 12 months; or
- Present value – if the Health Service does not expect to wholly settle within 12 months.

Long service leave (LSL)

Liability for LSL is recognised in the provision for employee benefits.

Unconditional LSL 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. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- Undiscounted value – if the Health Service expects to wholly settle within 12 months; and
- Present value – where the entity does not expect to settle a component of this current liability within 12 months.

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

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

Termination benefits

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

The Health Service recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy.

On-costs related to employee expense

Provision for on-costs, workers compensation and superannuation are recognised together with provisions for employee benefits.

NOTE 3.6: SUPERANNUATION

	Total 2017 $'000	Total 2016 $'000
(i) Defined benefit plans:		
First State Super	278	282
Defined contribution plans:		
First State Super	7,248	6,916
HESTA Superannuation	4,704	4,352
Other	395	328
Total	**12,626**	**11,877**

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

The Health Service does not recognise any defined benefit liability in respect of the plan(s) because the entity 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 & Finance discloses the State's defined benefits liabilities in its disclosure for administered items.

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

The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Services are as follows:

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 expensed when incurred.

Defined benefit superannuation plans

The amount charged to the comprehensive operating statement in respect of defined benefit superannuation plans represents the contributions made by 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 Goulburn Valley Health are entitled to receive superannuation benefits and Goulburn Valley Health contributes to both the defined benefit and defined contribution plans. The defined benefit plan(s) provide benefits based on years of service and final average salary.

The name and details of the major employee superannuation funds and contributions made by the Goulburn Valley Health are disclosed in Note 3.6: Superannuation.

Superannuation liabilities

The Goulburn Valley Health 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.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure

4.1 Property, Plant & Equipment

4.2 Depreciation and Amortisation

4.3 Intangible Assets

NOTE 4.1: PROPERTY, PLANT & EQUIPMENT

(a) Gross Carrying Amount and Accumulated Depreciation

	Total 2017 $'000	Total 2016 $'000
Land		
Land at Fair Value	10,006	10,006
Total Land	**10,006**	**10,006**
Buildings		
Buildings at Fair Value	94,352	92,963
Less Accumulated Depreciation	19,649	12,946
Building Leasehold Improvements at Cost	2,447	2,366
Less Accumulated Depreciation	1,618	1,145
Buildings Under Construction at Cost	5,733	1,808
Total Buildings	**81,265**	**83,046**
Plant and Equipment		
Plant & Non Medical Equipment at Fair Value	4,718	4,588
Less Accumulated Depreciation	3,117	2,687
Vehicles at Fair Value	4,160	4,333
Less Accumulated Depreciation	3,078	2,889
Computers & Communication at Fair Value	1,916	1,768
Less Accumulated Depreciation	1,617	1,463
Furniture & Fittings at Fair Value	450	391
Less Accumulated Depreciation	317	282
Leased Assets at Fair Value	870	1,122
Less Accumulated Depreciation	796	761
Total Plant & Equipment	**3,189**	**4,121**
Medical Equipment at Fair Value	12,036	11,337
Less Accumulated Depreciation	7,776	6,716
Total Medical Equipment at Fair Value	**4,259**	**4,621**
Hume Rural Health Alliance Plant & Equipment		
Plant & Non Medical Equipment at Fair Value	21	22
Less Accumulated Depreciation	19	19
Leased Assets at Fair Value	432	500
Less Accumulated Depreciation	225	246
Total Hume Rural Health Alliance Plant & Equipment	**209**	**257**
Total Property, Plant and Equipment	**98,928**	**102,050**

NOTE 4.1: PROPERTY, PLANT & EQUIPMENT (CONTINUED)

(b) Reconciliations of the Carrying Amounts of Each Class of Asset

	Land $'000	Buildings $'000	Work In Progress $'000	Plant and Equipment $'000	Medical Equipment $'000	Leased Assets $'000	HRHA $'000	Total $'000
Balance at 1 July 2015	**7,630**	**85,195**	**374**	**4,184**	**4,998**	**706**	**168**	**103,255**
Additions	2,376	1,494	3,226	839	727	14	221	8,897
Disposals	-	-	-	(72)	(5)	-	-	(77)
Hume Rural Health Alliance % share adjustment	-	-	-	-	-	-	(3)	(3)
Net Transfers between Classes	-	1,549	(1,549)	-	-	-	-	-
Assets Received Free of Charge	-	-	-	-	-	-	-	-
Transfers to Intangible Assets	-	-	(243)	-	-	-	-	(243)
Depreciation (Note 4.2)	-	(7,000)	-	(1,192)	(1,100)	(359)	(128)	(9,779)
Balance at 1 July 2016	**10,006**	**81,238**	**1,808**	**3,759**	**4,620**	**361**	**258**	**102,050**
Additions	-	-	5,468	500	701	-	85	6,754
Disposals	-	-	(4)	(119)	-	-	-	(123)
Hume Rural Health Alliance % share adjustment	-	-	-	-	-	-	(8)	(8)
Net Transfers between Classes	-	1,470	(1,504)	34	-	-	-	-
Transfers to Intangible Assets	-	-	(36)	-	-	-	-	(36)
Depreciation (Note 4.2)	-	(7,176)	-	(1,057)	(1,063)	(287)	(126)	(9,709)
Balance at 30 June 2017	**10,006**	**75,532**	**5,733**	**3,118**	**4,259**	**74**	**209**	**98,928**

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 valuation was 30th June 2014.

NOTE 4.1: PROPERTY, PLANT & EQUIPMENT (CONTINUED)

(c) Fair Value Measurement Hierarchy for Assets

Land at fair value	Carrying Amount as at 30 June 2017 $'000	Fair value measurement at end of reporting period using: Level 1 (i) $'000	Level 2 (i) $'000	Level 3 (i) $'000
Non-Specialised Land	5,886	-	5,886	-
Specialised Land				
GVH, Graham St, Shepparton	3,620	-	-	3,620
Tatura Hospital/Nursing Home	240	-	-	240
Waranga Hospital/Nursing Home	135	-	-	135
Waranga Hostel	125	-	-	125
Total of Land at fair value	**10,006**	**-**	**5,886**	**4,120**
Buildings at fair value				
Non-Specialised Buildings	537	-	537	-
Specialised Buildings	74,995	-	-	74,995
Total of Buildings at fair value	**75,532**	**-**	**537**	**74,995**
Plant and Equipment at fair value				
Vehicles	1,082	-	-	1,082
Plant and Equipment	-			
Plant and Non-Medical Equipment	1,601	-	-	1,601
Computers and Communications	299	-	-	299
Furniture and Fittings	133	-	-	133
Leased Assets	74	-	-	74
HRHA Assets	209	-	-	209
Total Plant and Equipment at fair value	**3,398**	**-**	**-**	**3,398**
Medical Equipment at fair value				
Medical Equipment at fair value	4,259	-	-	4,259
Total Medical Equipment at fair value	**4,259**	**-**	**-**	**4,259**
Assets under construction at fair value				
Buildings	5,733	-	-	5,733
Total Assets under construction at fair value	**5,733**	**-**	**-**	**5,733**
	98,928	**-**	**6,423**	**92,505**

(i) Classified in accordance with the fair value hierarchy

(ii) Vehicles are categorised to Level 3 assets if the depreciated replacement cost is used in estimating the fair value.

There have been no transfers between levels during the period

NOTE 4.1: PROPERTY, PLANT & EQUIPMENT (CONTINUED)

Land at fair value	Carrying Amount as at 30 June 2016 $'000	Fair value measurement at end of reporting period using: Level 1 (i) $'000	Level 2 (i) $'000	Level 3 (i) $'000
Non-Specialised Land	5,886	-	5,886	-
Specialised Land				
GVH, Graham St, Shepparton	3,620	-	-	3,620
Tatura Hospital/Nursing Home	240	-	-	240
Waranga Hospital/Nursing Home	135	-	-	135
Waranga Hostel	125	-	-	125
Total of Land at fair value	**10,006**	**-**	**5,886**	**4,120**
Buildings at fair value				
Non-Specialised Buildings	498	-	498	-
Specialised Buildings	82,548	-	-	82,548
Total of Buildings at fair value	**83,046**	**-**	**498**	**82,548**
Plant and Equipment at fair value				
Vehicles	1,444	-	-	1,444
Plant and Equipment				
Plant and Non-Medical Equipment	1,901	-	-	1,901
Computers and Communications	305	-	-	305
Furniture and Fittings	109	-	-	109
Leased Assets	361	-	-	361
HRHA Assets	257	-	-	257
Total Plant and Equipment at fair value	**4,377**	**-**	**-**	**4,377**
Medical Equipment at fair value				
Medical Equipment at fair value	4,621	-	-	4,621
Total Medical Equipment at fair value	**4,621**	**-**	**-**	**4,621**
	102,050	**-**	**6,384**	**95,666**

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

the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 7.4);

superannuation expense (refer to Note 3.6);

actuarial assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.5)

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

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

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

NOTE 4.1: PROPERTY, PLANT & EQUIPMENT (CONTINUED)

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

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

The Valuer-General Victoria (VGV) is Goulburn Valley Health's independent valuation agency.

Goulburn Valley Health, in conjunction with VGV monitors the changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required.

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

Fair value measurement

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

The fair value measurement is based on the following assumptions:

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

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

Valuation hierarchy

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

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

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

NOTE 4.1: PROPERTY, PLANT & EQUIPMENT (CONTINUED)

(d) Reconciliation of Level 3 Fair Value

30 June 2017	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Assets Under Contruction $'000	Leased Assets $'000	HRHA $'000
Opening Balance	**4,120**	**80,672**	**3,759**	**4,621**	**1,876**	**361**	**257**
Purchases (sales)	-	-	382	701	5,468	-	77
Transfers in (out) of Level 3	-	1,470	34	-	(1,611)	-	-
Gains or losses recognised in net result							
- Depreciation	-	(7,146)	(1,060)	(1,063)	-	(287)	(126)
Subtotal	**-**	**(7,146)**	**(1,060)**	**(1,063)**	**-**	**(287)**	**(126)**
Closing Balance	**4,120**	**74,995**	**3,116**	**4,259**	**5,733**	**74**	**209**

30 June 2016	Land $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Assets Under Contruction $'000	Leased Assets $'000	HRHA $'000
Opening Balance	**4,120**	**84,569**	**4,182**	**4,999**	**375**	**707**	**168**
Purchases (sales)	-	2,997	769	722	1,501	13	218
Gains or losses recognised in net result							
- Depreciation	-	(6,894)	(1,192)	(1,100)	-	(359)	(129)
Subtotal	**-**	**(6,894)**	**(1,192)**	**(1,100)**	**-**	**(359)**	**(129)**
Closing Balance	**4,120**	**80,672**	**3,759**	**4,621**	**1,876**	**361**	**257**

Non-specialised land and non-specialised buildings

Non-specialised land, non-specialised buildings and artworks are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.

For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers , Victorian Valuer General, to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2014.

To the extent that non-specialised land, non-specialised buildings and artworks do not contain significant, unobservable adjustments, these assets are classified as Level 2 under the market approach.

NOTE 4.1: PROPERTY, PLANT & EQUIPMENT (CONTINUED)

Specialised land and specialised buildings

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

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

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

An independent valuation of the Health Service's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2014.

Vehicles

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

Plant and equipment

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

There were no changes in valuation techniques throughout the period to 30 June 2017.

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

NOTE 4.1: PROPERTY, PLANT & EQUIPMENT

(e) Description of Significant Unobservable Inputs to Level 3 Valuations:

	Valuation technique (i)	Significant unobservable inputs (i)
Specialised land		
Graham Street Shepparton Campus Tatura Campus Rushworth Hospital and Nursing Home Waranga Hostel	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings		
Graham Street Shepparton Campus Tatura Campus Rushworth Hospital and Nursing Home Waranga Hostel Ambermere Orr Street Shepparton Site	Depreciated replacement cost	Direct cost per square metre
Plant and equipment at fair value		
Plant and Non Medical Equipment Computers and Communication Furniture and Fittings	Depreciated replacement cost	Cost per unit Useful life of PPE
Vehicles		
Motor Vehicles	Depreciated replacement cost	Cost per unit Useful life of Vehicles
Medical equipment at fair value		
Medical Equipment	Depreciated replacement cost	Cost per unit Useful life of medical equipment

(i) CSO adjustments of 20% were applied to reduce the market approach value for the Department's specialised land.

Refer to Note 7.4 for guidance on fair value measurement indicative expectations.

Property, plant and equipment

All non-current physical assets are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and accumulated impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/ machinery of government are transferred at their carrying amount.

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 4.1 *Property, Plant and Equipment.*

Crown land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

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

NOTE 4.1: PROPERTY, PLANT & EQUIPMENT (CONTINUED)

Leasehold improvements

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

Revaluations of non-current physical assets

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

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

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

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

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

In accordance with FRD 103F, Goulburn Valley Health non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required and did not identify any significant movement that would require a revalution.

NOTE 4.2: DEPRECIATION AND AMORTISATION

	Total 2017 $'000	Total 2016 $'000
Depreciation		
Buildings	6,702	6,560
Plant & Equipment	149	159
Medical Equipment	1,063	1,100
Non Medical Equipment	283	311
Motor Vehicles	427	537
Computers & Communications	165	146
Furniture & Fittings	35	37
Lease Equipment - Software	285	359
Leased Buildings	473	441
Hume Rural Health Alliance	126	128
Total	**9,709**	**9,779**
Amortisation		
Software	282	289
Hume Rural Health Alliance	8	8
Total	**289**	**296**
Total Depreciation and Amortisation	**9,998**	**10,075**

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets that have finite useful lives are depreciated (i.e. excludes land assets held for sale, and investment properties). Depreciation begins when the asset is available for use, which is when it is in the location and condition necessary for it to be capable of operating in a manner intended by management.

Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate.

This depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of $1000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2017	2016
Buildings	30 to 40 Years	30 to 40 Years
Plant & Equipment	10 years	10 years
Medical Equipment	5 to 8 years	5 to 8 years
Computers and Communication	3 years	3 years
Furniture and Fitting	5 years	5 years
Motor Vehicles	7 years	7 years

As part of the buildings valuation, building values were separated into components and each component assessed for its useful life which is represented above.

NOTE 4.3: INTANGIBLE ASSETS

	Total 2017 $'000	Total 2016 $'000
Software - WIP	331	296
Software	2,417	2,627
Less Accumulated Amortisation	2,006	1,724
Total Software	**411**	**608**
Hume Rural Health Alliance - WIP	206	94
Hume Rural Health Alliance - Software	53	54
Less Accumulated Amortisation	21	14
Total HRHA Software	**32**	**40**
Total Intangible Assets	**980**	**1,038**

Reconciliation of the carrying amounts of intangible assets at the beginning and end of the previous and current financial year:

	Software $'000	Software WIP $'000	HRHA $'000	HRHA WIP $'000	Total $'000
Balance at 1 July 2015	**535**	**5**	**49**	**49**	**638**
Additions	361	48	-	45	454
Disposals	-	-	-	-	-
Revaluation Increments/ (Decrements)	-	-	-	-	-
Net Transfers between Classes	-	243	-	-	243
Assets Received Free of Charge	-	-	-	-	-
Amortisation	288	-	9	-	297
Balance at 1 July 2016	**608**	**296**	**40**	**94**	**1,038**
Additions	85	-	-	112	197
Disposals	-	-	-	-	-
Revaluation Increments/ (Decrements)	-	-	-	-	-
Transfers from Property, Plant & Equipment	-	35	-	-	35
Assets Received Free of Charge	-	-	-	-	-
Amortisation	282	-	8	-	290
Balance at 30 June 2017	**411**	**331**	**32**	**206**	**980**

(i) The consumption of separately acquired intangible assets is included in the 'amortisation' line item, where the consumption of the internally generated intangible assets is included in 'net gain/(loss) on non-financial assets' line item on the comprehensive operating statement.

(ii) Impairment losses are included in the line item 'net gain/(loss) on non-financial assets' in the comprehensive operating statement.

Intangible assets

Intangible assets represent identifiable non-monetary assets without physical substance such as patents, trademarks, and computer software and development costs (where applicable).

Intangible assets are initially recognised at cost. Subsequently, intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses. Costs incurred subsequent to initial acquisition are capitalised when it is expected that additional future economic benefits will flow to the Health Service.

Expenditure on research activities is recognised as an expense in the period on which it is incurred.

When the recognition criteria in AASB 138 *Intangible Assets* are met, internally generated intangible assets are recognised and measured at cost less accumulated depreciation/amortisation and impairment.

An internally-generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

a. the technical feasibility of completing the intangible asset so that it will be available for use or sale;

b. an intention to complete the intangible asset and use or sell it;

c. the ability to use or sell the intangible asset;

d. the intangible asset will generate probable future economic benefits;

e. the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and

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

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

Amortisation

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

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the asset concerned is tested as to whether its carrying amount exceeds its 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 Health Service 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 produced assets with finite lives are depreciated as an expense from transactions on a systematic basis over the asset's useful life.

Intangible assets with finite useful lives are amortised over a 3-5 years.

NOTE 5: OTHER ASSETS AND LIABILITIES

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

Structure

5.1 Receivables

5.2 Inventories

5.3 Other Liabilities

5.4 Prepayments and Other Assets

5.5 Payables

NOTE 5.1: RECEIVABLES

	Total 2017 $'000	Total 2016 $'000
Current		
Contractual		
Trade Debtors	303	167
Patient Fees - Health Service Agreement	2,502	2,148
Patient Fees - Hospital & Community Initiatives	685	896
Patient Fees - Private Practice	206	456
Accrued Investment Income	35	32
Other Accrued Revenue	996	1,646
Hume Rural Health Alliance	388	145
Less Allowance for Doubtful Debts		
Trade Debtors	(391)	(209)
Patient Fees - Health Service Agreement	(65)	(89)
Patient Fees - Hospital & Community Initiatives	(15)	(38)
Total Contractual Receivables	**4,646**	**5,154**
Statutory		
Dental Health Services Victoria Accrued Grants	382	204
Department of Health and Human Services	-	414
GST Receivable	492	579
Total Statutory Receivables	**875**	**1,197**
Total Current Receivables	**5,520**	**6,350**
Non Current		
Contractual		
Trade Debtors	70	88
Total Non Current Contractual Receivables	**70**	**88**
Statutory		
Long Service Leave - Department of Health and Human Services	1,273	1,242
Total Non Current Statutory Receivables	**1,273**	**1,242**
Total Non Current Receivables	**1,343**	**1,330**
Total Receivables	**6,863**	**7,680**
(a) Movement in the Allowance for Doubtful Debts		
Balance at Beginning of Year	336	278
Amounts Written Off During the Year	(164)	(223)
Increase/(Decrease) in Allowance Recognised in Net Result	298	282
Balance at End of Year	**471**	**336**

(b) Ageing Analysis of Receivables

Please refer to Note 7.1 for the ageing analysis of contractual receivables.

(c) Nature and Extent of Risk Arising from Receivables

Please refer to Note 7.1 for the nature and extent of risk arising from contractual receivables.

Receivables consist of:

- contractual receivables, which includes mainly debtors in relation to goods and services, loans to third parties, accrued investment income, and finance lease receivables; and
- statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax ("GST") input tax credits recoverable.

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

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 when there is objective evidence that the debts may not be collected and bad debts are written off when identified.

NOTE 5.2: INVENTORIES

	Total 2017 $'000	Total 2016 $'000
At Cost		
Main Store	507	461
Ward Medical & Surgical Supplies	777	635
Pathology	118	130
Engineering	45	45
Pharmaceuticals	671	620
Cafeteria Supplies	11	14
Biomedical Engineering	75	75
Retail Aids and Equipment Outlet	32	31
Total Inventories	**2,235**	**2,011**

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

Inventories held for distribution are measured at cost, adjusted for any loss of service potential.

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

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

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

NOTE 5.3: OTHER LIABILITIES

	Total 2017 $'000	Total 2016 $'000
Current		
Monies Held in Trust		
Patient Monies Held in Trust	2,000	892
Accommodation Bonds (Refundable Entrance Fees)	3,894	2,632
Employee Trust Funds	77	92
Community Funds	43	43
Government Grants - Hume Region Programs	1,018	1,308
Research Funding	98	98
Total Current	**7,129**	**5,065**
Total Other Liabilities	**7,129**	**5,065**
Total Monies Held in Trust		
Represented by the following assets:		
Cash Assets (Refer Note 6.2)	7,129	5,065
Total	**7,129**	**5,065**

NOTE 5.4: PREPAYMENTS AND OTHER NON-FINANCIAL ASSETS

	Total 2017 $'000	Total 2016 $'000
Current		
Prepayments	878	806
Hume Rural Health Alliance - Prepayment	20	11
Total Other Assets	**898**	**817**

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

NOTE 5.5: PAYABLES

	Total 2017 $'000	Total 2016 $'000
Current		
Contractual		
Trade Creditors	4,015	4,567
Accrued Expenses	7,402	4,519
Prepaid Ineligible Non Insured Patient Services	-	1
Income in Advance - Other	233	-
Hume Rural Health Alliance	73	82
Total Contractual Payables	**11,724**	**9,169**
Statutory		
GST Payable	87	95
FBT Payable	9	26
Income In Advance - Department of Health and Human Services	505	1,200
Income In Advance - Commonwealth	40	98
Total Statutory Payables	**642**	**1,419**
Total Payables	**12,365**	**10,588**

(a) Maturity analysis of payables

Please refer to Note 7.1 for ageing analysis of contractual payables.

(b) Nature and extent of risk arising from payables

Please refer to Note 7.1 for the nature and extent of risks arising from contractual 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 classified as financial instruments and are initially recognised at fair value, and then subsequently carried at amortised cost. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from a contract.

NOTE 6: HOW WE FINANCE OUR OPERATIONS

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

This section includes disclosures of balances that are financial instruments (such as borrowings and cash balances). Note: 7.1 provides additional, specific financial instrument disclosures.

Structure

6.1 Borrowings

6.2 Cash and Cash Equivalents

6.3 Commitments for Expenditure

NOTE 6.1: BORROWINGS

	Total 2017 $'000	Total 2016 $'000
Current		
Finance Lease Liability (i)	74	287
Department of Health and Human Services Loan (ii)	550	550
Hume Rural Health Alliance Finance Lease Liability (i)	97	116
Total Current	**721**	**953**
Non Current		
Finance Lease Liability (i)	-	74
Department of Health and Human Services Loan (ii)	2,545	3,070
Hume Rural Health Alliance Finance Lease Liability (i)	110	139
Total Non-Current	**2,655**	**3,283**
Total Borrowings	**3,376**	**4,236**

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

(ii) They are unsecured loans which bear no interest.

Finance costs of the Health Service incurred during the year are accounted for as follows:		
Amount of finance costs recognised as expenses	17	42

(a) Maturity analysis of borrowings

Please refer to note 7.1(d) for the ageing analysis of borrowings.

(b) Nature and extent of risk arising from borrowings

Please refer to Note 7.1 for the nature and extent of risks arising from contractual payables

(c) Defaults and breachs

During the year and prior year, there were no defaults and breaches of any of the borrowings.

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

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

For service concession arrangements, the commencement of the lease term is deemed to be the date the asset is commissioned.

All other leases are classified as operating leases.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables. Finance lease receivables are initially recorded at amounts equal to the present value of the minimum lease payments receivable plus the present value of any unguaranteed residual value expected to accrue at the end of the lease term. Finance lease receipts are apportioned between periodic interest income and reduction of the lease receivable over the term of the lease in order to reflect a constant periodic rate of return on the net investment outstanding in respect of the lease.

Entity as lessee

Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease. The lease asset is accounted for as a non-financial physical asset and is depreciated over the shorter of the estimated useful life of the asset or the term of the lease. If there is certainty that the health service will obtain the ownership of the lease asset by the end of the lease term, the asset shall be depreciated over the useful life of the asset. If there is no reasonable certainty that the lessee will obtain ownership by the end of the lease term, the asset shall be fully depreciated over the shorter of the lease term and its useful life. Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the comprehensive operating statement. Contingent rentals associated with finance leases are recognised as an expense in the period in which they are incurred.

Borrowings

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs. The measurement basis subsequent to initial recognition depends on whether the Health Service has categorised its borrowings as either, financial liabilities designated at fair value through profit or loss, or financial liabilities at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowings using the effective interest method.

The classification depends on the nature and purpose of the borrowing. The Health Service determines the classification of its borrowing at initial recognition.

Operating leases

Entity as lessee

Operating lease payments, including any contingent rentals, are recognised as an expense in the comprehensive operating statement on a straight line basis over the lease term, except where another systematic basis is more representative of the time pattern of the benefits derived from the use of the leased asset. The leased asset is not recognised in the balance sheet.

Leasehold Improvements

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

NOTE 6.2: CASH AND CASH EQUIVALENTS

For the purposes of the Cash Flow Statement, cash assets 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 2017 $'000	**Total 2016 $'000**
Cash on Hand	17	22
Cash at Bank	13,434	8,309
Short Term Deposits	1,500	1,500
Hume Rural Health Alliance	539	293
Total Cash and Cash Equivalents	**15,491**	**10,124**
Represented by:		
Total Cash for Health Service Operations (as per Cash Flow Statement)	8,362	5,058
Cash for Monies Held in Trust	7,129	5,065
Total Cash and Cash Equivalents	**15,491**	**10,124**

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and cash at bank, deposits at call and highly liquid investments (with an original maturity of three months or less), which are held for the purpose of meeting short term cash commitments rather than for investment purposes, which are readily convertible to known amounts of cash with an insignificant risk of changes in value.

NOTE 6.3: COMMITMENTS FOR EXPENDITURE

	Total 2017 $'000	Total 2016 $'000
Capital Expenditure Commitments		
Payable		
Buildings	9,457	1,804
Total Capital Expenditure Commitments	**9,457**	**1,804**
Lease Commitments		
Payable		
Non Medical Equipment	-	311
Motor Vehicles	95	130
Total Lease Commitments	**95**	**441**
Total Commitments	**9,552**	**2,245**

	Total 2017 $'000	Total 2016 $'000
(b) Commitments		
Capital Expenditure Commitments		
Less than 1 year	8,038	1,804
Longer than 1 year and not later than 5 years	1,419	-
Total Capital Expenditure Commitments	**9,457**	**1,804**
Finance Lease Commitments		
Less than 1 year	60	310
Longer than 1 year and not later than 5 years	35	131
Total Lease Commitments	**95**	**441**
Total Commitments for Expenditure (Inclusive of GST)	9,553	2,245
Less GST Recoverable from the Australian Taxation Office	(868)	(204)
Total Commitments for Expenditure (Exclusive of GST)	**8,684**	**2,041**

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note at their nominal value and are inclusive of the GST payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are sated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

NOTE 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

Introduction

The hospital is exposed to risk from its activities and outside factors. In addition, it is often necessary to make judgements and estimates associated with recognition and measurement of items in the financial statements. This section sets out financial instrument specific information, (including exposures to financial risks) as well as those items that are contingent in nature or require a higher level of judgement to be applied, which for the hospital is related mainly to fair value determination.

Structure

7.1 Financial Instruments

7.2 Net Gain/ (Loss) on Disposal of Non-Financial Assets

7.3 Contingent Assets and Contingent Liabilities

7.4 Fair Value Determination

NOTE 7.1: FINANCIAL INSTRUMENTS

Financial risk management objectivise and policies

Goulburn Valley Health's principal financial instruments comprise of:

- cash assets
- term deposits
- receivables (excluding statutory receivables)
- payables (excluding statutory payables)
- borrowings (finance leases payables)
- accommodation bonds and other trust funds

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 Health Service's main financial risks include credit risk, liquidity risk, interest rate risk and foreign currency risk. The Health Service manages these financial risks in accordance with its financial risk management policy.

The Health Service uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the Finance and Risk Committee of the Health Service.

The main purpose in holding financial instruments is to prudentially manage Goulburn Valley Health's financial risks within the government policy parameters.

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

Categorisation of financial instruments

2017	Contractual Financial Assets - Loans & Receivables $'000	Contractual Financial Liabilities at Amortised cost $'000
Contractual Financial Assets		
Cash and Cash Equivalents	15,491	-
Receivables		
- Trade Debtors and Patient Fees	3,685	-
- Other Receivables	1,031	-
Total Financial Assets (i)	**20,206**	**-**
Financial Liabilities		
Payables	-	11,724
Borrowings		
- DHHS Loan	-	3,095
- Finance Leases	-	280
Other Financial Liabilities		
- Accommodation Bonds	-	3,894
- Other Funds Held in Trust	-	3,235
Total Financial Liabilities	**-**	**22,229**

2016	Contractual Financial Assets - Loans & Receivables $'000	Contractual Financial Liabilities at Amortised cost $'000
Contractual Financial Assets		
Cash and Cash Equivalents	10,124	-
Receivables		
- Trade Debtors and Patient Fees	3,564	-
- Other Receivables	1,678	-
Total Financial Assets (i)	**15,365**	**-**
Financial Liabilities		
Payables	-	9,169
Borrowings		
- DHHS Loan	-	3,620
- Finance Leases	-	615
Other Financial Liabilities		
- Accommodation Bonds	-	2,632
- Other Funds Held in Trust	-	2,433
Total Financial Liabilities	**-**	**18,470**

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

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

2017	Net holding gain / loss $'000	Total interest income / (expense) $'000	Fee income / (expense) $'000	Total $'000
Financial Assets				
Cash and Cash Equivalents	-	506	-	506
Total Financial Assets	**-**	**506**	**-**	**506**
Financial Liabilities				
At Amortised Cost	-	17	-	17
Total Financial Liabilities	**-**	**17**	**-**	**17**

2016				
Financial Assets				
Cash and Cash Equivalents	-	518	-	518
Total Financial Assets	**-**	**518**	**-**	**518**
Financial Liabilities				
At Amortised Cost (i)	-	42	-	42
Total Financial Liabilities	**-**	**42**	**-**	**42**

(i) For financial liabilities measured at amortises cost, the net gain or loss is calculated by taking the interest expense, plus or minus foreign exchange gains or losses arising for the revaluation of financial labilities measured at amortised cost.

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

(c) Credit Risk

Credit risk arises from the contractual financial assets of the Health Service, which comprise cash and deposits and non-statutory receivables. 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 obligation to provide services, and private patient fees are recoverable from the patient or their health fund. These are unsecured debts.

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. 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 Goulburn Valley Health's 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

2017	Financial Institutions (min BBB Credit rating) $'000	Other $'000	Total $'000
Financial Assets			
Cash and Cash Equivalents	15,491	-	**15,491**
Receivables			
- Trade Debtors and Patient Fees	-	3,685	**3,685**
- Other Receivables (i)	-	1,031	**1,031**
Total Financial Assets	**15,491**	**4,716**	**20,206**

2016			
Financial Assets			
Cash and Cash Equivalents	10,124	-	**10,124**
Receivables			
- Trade Debtors and Patient Fees	-	3,564	**3,564**
- Other Receivables (i)	-	1,678	**1,678**
Total Financial Assets	**10,124**	**5,241**	**15,365**

(i) The total amounts disclosed here exclude statutory amounts (e.g.amounts owing from the Victorian Government and GST input tax credit recoverable)

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

Ageing Analysis of Financial Assets as at 30 June

			Past Due But Not Impaired			
2017	**Carrying Amount $'000**	**Not Past Due and Not Impaired $'000**	**1 - 3 Months $'000**	**3 Months - 1 Year $'000**	**1 - 5 Years $'000**	**Impaired Financial Assets $'000**
Financial Assets						
Cash and Cash Equivalents	15,491	15,491	-	-	-	-
Receivables						
- Trade Debtors and Patient Fees	3,685	2,234	772	609	70	471
- Other Receivables (i)	1,031	1,031	-	-	-	-
Total Financial Assets	**20,206**	**18,755**	**772**	**609**	**70**	**471**
2016						
Financial Assets						
Cash and Cash Equivalents	10,124	10,124	-	-	-	-
Receivables						
- Trade Debtors and Patient Fees	3,564	2,022	806	648	88	336
- Other Receivables (i)	1,678	1,678	-	-	-	-
Total Financial Assets	**15,365**	**13,823**	**806**	**648**	**88**	**336**

Contractual financial assets that are either past due or impaired

There are no material financial assets which are individually determined to be impaired. Currently Goulburn Valley Health 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 their carrying amounts as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired.

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

(d) Liquidity

Liquidity risk is the risk that Goulburn Valley Health would be unable to meet its financial obligations as and when they fall due. Goulburn Valley Health operates under the Government's fair payments policy of settling financial obligations within 30 days and in the event of a dispute, making payments within 30 days from the date of resolution.

The Health Service continuously projects its forward cash out flow commitments and measures it against projected forward cash inflows and current reserves.

Goulburn Valley Health's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed in the face of the balance sheet.

The following table discloses the contractual maturity analysis for Goulburn Valley Health's financial liabilities.

For interest rates applicable to each class of liability refer to individual notes to the financial statements.

Maturity Analysis of Financial Liabilities as at 30 June

2017	Carrying Amount $'000	Nominal Amount $'000	1 - 3 Months $'000	3 Months - 1 Year $'000	1 - 5 Years $'000
Financial Liabilities					
At amortised cost					
Payables	11,724	11,724	11,724	-	-
Borrowings					
- DHHS Loan	3,095	3,095	-	550	2,545
- Finance Leases	280	280	42	128	110
Other Financial Liabilities					
- Accommodation Bonds	3,894	3,894	-	3,894	-
- Other Funds Held in Trust	3,235	3,235	-	3,235	-
Total Financial Liabilities	**22,229**	**22,229**	**11,682**	**6,451**	**2,655**

2016					
Financial Liabilities					
At amortised cost					
Payables	9,169	9,169	9,169	-	-
Borrowings					
- DHHS Loan	3,620	3,620	-	550	3,070
- Finance Leases	615	615	134	269	212
Other Financial Liabilities					
- Accommodation Bonds	2,632	2,632	-	2,632	-
- Other Funds Held in Trust	2,433	2,433	-	2,433	-
Total Financial Liabilities	**18,470**	**18,470**	**9,035**	**4,246**	**3,282**

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

(e) Market Risk

Goulburn Valley Health'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

Goulburn Valley Health 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 time-frame between commitment and settlement.

Interest Rate Risk

Exposure to interest rate risk might arise primarily through Goulburn Valley Health's interest bearing liabilities, which at 30 June amount to $4,236m. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial liabilities, the health service mainly undertake financial liabilities with relatively even maturity profiles.

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in the market interest rates. The Health Service has minimal exposure to cash flow interest rate risks through its cash and deposits, term deposits and bank overdrafts that are at floating rate.

The Health Service manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded for cash at bank, as financial assets that can be left at floating rate without necessarily exposing the Health Service to significant bad risk, management monitors movement in interest rates on a daily basis.

Interest Rate Exposure of Financial Assets and Liabilities as at 30 June

2017	Weighted Average Effective Interest Rate (%)	Carrying Amount $'000	Fixed Interest Rate $'000	Variable Interest Rate $'000	Non Interest Bearing $'000
Financial Assets					
Cash and Cash Equivalents	2.00%	15,491	1,500	13,974	17
Receivables (i)					
- Trade Debtors and Patient Fees	-	3,685	-	-	3,685
- Other Receivables	-	1,031	-	-	1,031
		20,206	**1,500**	**13,974**	**4,733**
Financial Liabilities					
At amortised cost					
Payables (i)	-	11,724	-	-	11,724
Borrowings					
- DHHS Loan	-	3,095	-	-	3,095
- Finance Leases	4.10%	280	280	-	-
Other Financial Liabilities					
- Accommodation Bonds	-	3,894	-	-	3,894
- Other Funds Held in Trust	-	3,235	-	-	3,235
		22,229	**280**	**-**	**21,948**

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

2016					
Financial Assets					
Cash and Cash Equivalents	2.00%	10,124	1,500	8,602	22
Receivables (i)					
- Trade Debtors and Patient Fees	-	3,564	-	-	3,564
- Other Receivables	-	1,678	-	-	1,678
	15,365	**1,500**	**1,500**	**8,602**	**5,263**
Financial Liabilities					
At amortised cost					
Payables (i)	-	9,169	-	-	9,169
Borrowings					
- DHHS Loan	-	3,620	-	-	3,620
- Finance Leases	4.10%	615	615	-	-
Other Financial Liabilities					
- Accommodation Bonds	-	2,632	-	-	2,632
- Other Funds Held in Trust	-	2,433	-	-	2,433
		18,470	**615**	**-**	**17,855**

(i) the carrying amount must exclude types of statutory financial assets and liabilities (i.e. GST input tax credit and GST payable)

Sensitivity Disclosure Analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets,

Goulburn Valley Health 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 markets interest rates (AUD) from year-end rates of 1.5%;
- 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 Goulburn Valley Health at year end as presented to key management personnel, if changes in the relevant risk occur.

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

(e) Market Risk (continued)

		Interest Rate Risk			
		-1%		`+1%	
2017	**Carrying Amount $'000**	**Profit $`000**	**Equity $`000**	**Profit $`000**	**Equity $`000**
Financial Assets					
Cash & Cash Equivalents	15,491	(155)	(155)	155	155
Receivables (i)					
- Trade Debtors and Patient Fees	3,685	-	-	-	-
- Other Receivables	1,031	-	-	-	-
Financial Liabilities					
At amortised cost					
Payables	11,724	-	-	-	-
Borrowings					
- DHHS Loan	3,095	-	-	-	-
- Finance Leases	280	3	3	(3)	(3)
Other Financial Liabilities					
- Accommodation Bonds	3,894	-	-	-	-
- Other Funds Held in Trust	3,235	-	-	-	-
		(152)	**(152)**	**152**	**152**
2016					
Financial Assets					
Cash & Cash Equivalents	10,124	(101)	(101)	101	101
Receivables (i)					
- Trade Debtors and Patient Fees	3,564	-	-	-	-
- Other Receivables	1,678	-	-	-	-
Financial Liabilities					
At amortised cost					
Payables	9,169	-	-	-	-
Borrowings					
- DHHS Loan	3,620		-	-	-
- Finance Leases	615	6	6	(6)	(6)
Other Financial Liabilities					
- Accommodation Bonds	2,632	-	-	-	-
- Other Funds Held in Trust	2,433	-	-	-	-
		(95)	**(95)**	**95**	**95**

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

(f) Fair Value

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

*Level 1 - the fair value of financial instrument assets and liabilities 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.

Comparison between carrying amount and fair value

	Carrying Amount 2017 $'000	Fair Value 2017 $'000	Carrying Amount 2016 $'000	Fair Value 2016 $'000
Financial Assets				
Cash & Cash Equivalents	15,491	15,491	10,124	10,124
Receivables (i)				
- Trade Debtors and Patient Fees	3,685	3,685	3,564	3,564
- Other Receivables	1,031	1,031	1,678	1,678
Total Financial Assets	**20,206**	**20,206**	**15,365**	**15,365**
Financial Liabilities				
At amortised cost				
Payables	11,724	11,724	9,169	9,169
Borrowings				
- DHHS Loan	3,095	3,095	3,620	3,620
- Finance Leases	280	280	615	615
Other Financial Liabilities				
- Accommodation Bonds	3,894	3,894	2,632	2,632
- Other Funds Held in Trust	3,235	3,235	2,433	2,433
Total Financial Liabilities	**22,229**	**22,229**	**18,470**	**18,470**

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 Goulburn Valley 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.

NOTE 7.1: FINANCIAL INSTRUMENTS (CONTINUED)

(f) Fair Value (continued)

The following refers to financial instruments unless otherwise stated.

Receivables

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.

Receivables category includes cash and deposits (refer to Note 5.1), trade receivables and other receivables, but not statutory receivables.

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 or 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.

NOTE 7.2: NET GAIN/ (LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS

Proceeds from Disposals of Non-Financial Assets	**Total 2017 $'000**	**Total 2016 $'000**
Medical Equipment	-	7
Plant & Equipment	-	15
Vehicles	62	57
Total Proceeds from Disposals of Non-Financial Assets	**62**	**79**
Less: Written Down Value of Non-Financial Assets Disposed		
Medical Equipment	-	5
Plant & Equipment	1	5
Vehicles	118	66
Total Written Down Value of Non-Current Assets Disposed	**119**	**77**
Net Gains /(Loss) on Disposal of Non-Financial Assets	**57**	**2**

Disposal of non-financial assets
Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to Note 8.1 – 'comprehensive income'.

Impairment of non-financial assets
Goodwill and intangible assets with indefinite lives (and intangible assets not yet available for use) are tested annually for impairment (as described below) and whenever there is an indication that the asset may be impaired.

All other non-financial assets are assessed annually for indications of impairment, except for:

- inventories
- assets arising from construction contracts.

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

If there is an indication that there has been a reversal 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 of disposal. Recoverable amount for assets held primarily to generate net cash inflows is measured at the higher of the present value of future cash flows expected to be obtained from the asset and fair value less costs of disposal.

NOTE 7.3: CONTINGENT ASSETS AND CONTINGENT LIABILITIES

Goulburn Valley Health does not have any contingent assets or liabilities as at the 30th June 2017 (2016 $Nil).

NOTE 7.4: FAIR VALUE DETERMINATION

Asset Class	Example of types of assets	Expected fair value level	Likely valuation approach	Significant inputs (Level 3 Only)
Non-specialised land	In areas where there is an active market: - vacant land - land not subject to restrictions as to use or sale	Level 2	Market approach	N/A
Specialised land	Land subject to restrictions as to use and/or sale Land in areas where there is not an active market	Level 3	Market approach	CSO adjustments
Non-specialised buildings	For general/commercial buildings that are just built	Level 2	Market approach	N/A
Specialised buildings	Specialised buildings with limited alternative uses and/or substantial customisation e.g. prisons, hospitals, and schools	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Dwellings	Employee housing	Level 2, where there is an active market in the area Level 3, where there is no active market in the area	Market approach Depreciated replacement cost approach	N/A Cost per square metre Useful life
Infrastructure	Any type	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and Equipment	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Cost per unit Useful life
Vehicles	If there is an active resale market available;	Level 2	Market approach	N/A
	If there is no active resale market available	Level 3	Depreciated replacement cost approach	Cost per unit Useful life

NOTE 8: OTHER DISCLOSURES

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

Structure

8.1 Equity

8.2 Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) From Operating Activities

8.3 Operating Segments

8.4 Responsible Persons Disclosures

8.5 Executive Officer Disclosures

8.6 Related Parties

8.7 Remuneration of Auditors

8.8 AASBs Issued That Are Not Yet Effective

8.9 Events Occurring After the Balance Sheet Date

8.10 Controlled Entities

8.11 Economic Dependency

8.12 Alternative Presentation of Comprehensive Operating Statement

8.13 Glossary of Terms and Style Conventions

NOTE 8.1: EQUITY

	Total 2017 $'000	Total 2016 $'000
(a) Surpluses		
Property, Plant and Equipment Revaluation Reserve		
Balance at the Beginning of the Reporting Period	63,992	63,992
Increase in the Value of Land	-	-
Increase in the Value of Buildings	-	-
Balance at the End of the Reporting Period	**63,992**	**63,992**
Represented by:		
Land	5,293	5,293
Buildings	58,699	58,699
Total	**63,992**	**63,992**
General Purpose Surplus		
Balance at the Beginning of the Reporting Period	19,475	19,206
Transfer to and from Accumulated Deficit	87	269
Balance at the End of the Reporting Period	**19,562**	**19,475**
(b) Restricted Specific Purpose Surplus		
Balance at the Beginning of the Reporting Period	5,362	5,420
Transfer to and from Accumulated Deficit	17	(59)
Balance at the End of the Reporting Period	**5,379**	**5,362**
Total Surpluses	**88,933**	**88,829**
Contributed Capital		
Balance at the Beginning of the Reporting Period	46,821	46,821
Capital Contributions received from Victorian Government	-	-
Balance at the End of the Reporting Period	**46,821**	**46,821**
(c) Accumulated (Deficits)		
Balance at the Beginning of the Reporting Period	(68,341)	(59,804)
Net Result for the Year	(2,789)	(8,326)
Transfers to and from General Surplus	(87)	(269)
Transfers to and from Restricted Purpose Surplus	(17)	59
Balance at the End of the Reporting Period	**(71,234)**	**(68,341)**
Total Equity at End of Financial Year	**64,520**	**67,309**

NOTE 8.1: EQUITY (CONTINUED)

Contributed capital

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

Transfers of net assets arising from administrative restructurings are treated as contributions by owners. Transfers of net liabilities arising from administrative restructures are to go through the comprehensive operating statement.

Property, plant & equipment revaluation surplus

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

General purpose surplus

These are accumulated funds of surplus revenue over expenditure from fund raising activities and community supoort programs.

Specific restricted purpose surplus

A specific restricted purpose surplus 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.

NOTE 8.2: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES

	Total 2017 $'000	Total 2016 $'000
Net Result for the Period	(2,789)	(8,326)
Non-cash movements:		
Depreciation & Amortisation	9,998	10,075
Provision for Doubtful Debts		
Resources/Assets Provided Free of Charge	-	(18)
DHHS Non Cash Capital	(3,027)	-
Movements Included In Investing and Financing Activities		
Net (Gain)/Loss of Disposal of Non-Financial Physical Assets	57	(1)
Discount on Interest Free DHHS Loan	-	(230)
Movements in Asset and Liabilities;		
Change in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	817	2,169
(Increase)/Decrease in Prepayments	(81)	112
Increase/(Decrease) in Payables	1,778	601
Increase/(Decrease) in Provisions	1,482	909
Change in Inventories	(224)	355
Net Cash Inflow/Outflow from Operating Activities	**8,010**	**5,646**

NOTE 8.3: OPERATING SEGMENTS

	Residential Aged Care Services		All Other Services			
	2017 $'000	2016 $'000	2017 $'000	2016 $'000	Total 2017 $'000	Total 2016 $'000
External Segment Revenue	6,302	5,921	251,209	228,177	257,511	234,099
External Segment Expenses	4,739	4,719	256,846	237,589	261,585	242,307
Intersegment Expenses	3,876	3,664	(3,876)	(3,664)	-	-
Net Result From Ordinary Activities	**2,313**	**2,461**	**1,760**	**5,748**	**4,074**	**8,209**
Interest Income	-	-	(506)	(518)	(506)	(518)
Other Economic Flows	-	-	(779)	635	(779)	635
Net Result for Year	**2,313**	**2,461**	**475**	**5,864**	**2,789**	**8,326**
OTHER INFORMATION						
Assets	-	-	125,395	123,720	125,395	123,720
Liabilities	-	-	(60,875)	(56,411)	(60,875)	(56,411)

The major services from which the above segments derive revenue are:

Business Segments	**Services**
Residential Aged Care Services (RAC)	Provider of residential aged care beds
Other HSA & H&CI Services - Acute and Community Services	

Pricing between inter-segments is at cost

Geographical Segment

Goulburn Valley Health operates predominantly in Shepparton, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets relate to operations in Shepparton, Victoria.

NOTE 8.4: RESPONSIBLE PERSONS DISCLOSURES

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

	Period	
Responsible Ministers:		
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01-07-16	30-06-17
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01-07-16	30-06-17
Governing Boards		
Mr P. Ryan	01-07-16	30-06-17
Mr W. Parsons	01-07-16	30-06-17
Ms R. Knaggs	01-07-16	30-06-17
Ms B. Evans	01-07-16	30-06-17
Mr S. Merrylees	01-07-16	30-06-17
Mr R. Coates	01-07-16	30-06-17
Ms J. Breen	01-07-16	30-06-17
Ms N. Goodall	01-07-16	30-06-17
A/Prof R. King	29-11-16	30-06-17
Dr M. Walsh *(Ministerial delegate, Dr Michael Walsh was appointed for a 12 month period in December to support the organisation)*	29-12-16	30-06-17
Accountable Officers		
Ms F. Brew	01-07-16	12-09-16
Mr M. Alexander	12-09-16	31-01-17
Mr T. Saunders	01-02-17	30-06-17

Remuneration

Remuneration received or receivable by responsible persons was in the range: $520k – $530k.

NOTE 8.5: EXECUTIVE OFFICER DISCLOSURES

Executive Officers' Remuneration

Remuneration of executives

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

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

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

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

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

Share-based payments are cash or other assets paid or payable as agreed between the health service and the employee, provided specific vesting conditions, if any, are met.

Remuneration of Executive Officers	**Total Remuneration**	
	2017 $'000	**2016(i) $'000**
Short-term employee benefits	1,224	
Post-employment benefits	95	
Other long-term benefits	27	
Termination benefits	-	
Share-based payments	-	
Total Remuneration (i)(ii)	**1,346**	
Total Number of Executives	**10**	
Total Annualised Employee Equivalent (AEE) (iii)	**5.54**	

Notes:

(i) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD 21B. Remuneration previously excluded non-monetary benefits and comprised any money consideration if benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable form a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-16 reporting period.

(ii) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are also reported within the related parties note disclosure (Note 8.6)

(iii) Annualised employee equivalent is based on the time fraction worked over the reporting period.

NOTE 8.6: RELATED PARTIES

Goulburn Valley Health is a wholly owned and controlled entity of the State of Victoria. Related parties of the hospital include:

- all key management personnel and their close family members;
- all cabinet ministers and their close family members; and
- all hospitals and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

All related party transactions have been entered into on an arm's length basis.

Key management personnel (KMP) of the hospital include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the hospital. The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the Parliamentary Salaries and Superannuation Act 1968, and is reported within the Department of Parliamentary Services' Financial Report.

Compensation	**2017 $'000**
Short term employee benefits	1,694
Post-employment benefits	135
Other long-term benefits	33
Termination benefits	-
Share-based payments	-
Total	**1,863**

Transactions with Key Management Personnel and Other Related Parties

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the Public Administration Act 2004 and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

Significant Transactions with Government Related Entities

Goulburn Valley Health received funding from the Department of Health and Human Services of $186.9m (2016 $170.6m)

Aggregated disclosure note

During the year, Ms Roslyn Knaggs has an association with Watters Electrical who provide electrical engineering services to the Health Service on normal commercial terms and conditions. Total payments for 2016/17 were $92,314 ($107,534 for 2015/16)

NOTE 8.7: REMUNERATION OF AUDITORS

	Total 2017 $'000	**Total 2016 $'000**
Victorian Auditor-General's Office - Audit of Financial Statements	52	54
Other Providers		
Internal Audit Services	95	112
Total	**147**	**165**

NOTE 8.8: AASBS ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2017 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30 June 2017, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Goulburn Valley Health has not and does not intend to adopt these standards early.

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning or ending on	Impact on financial statements
AASB 9 Financial Instruments	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 Jan 2018	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. While there will be no significant impact arising from AASB 9, there will be a change to the way financial instruments are disclosed.
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: • The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and • Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1 Jan 2018	The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). Hedge accounting will be more closely aligned with common risk management practices making it easier to have an effective hedge. For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 2014-1 Amendments to Australian Accounting Standards [Part E Financial Instruments]	Amends various AASs to reflect the AASB's decision to defer the mandatory application date of AASB 9 to annual reporting periods beginning on or after 1 January 2018 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 Jan 2018	This amending standard will defer the application period of AASB 9 to the 2018-19 reporting period in accordance with the transition requirements.

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning or ending on	Impact on financial statements
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 15 Revenue from Contracts with Customers	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2018	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications.
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends. Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. Dividends are recognised in the profit and loss only when: • the entity's right to receive payment of the dividend is established; • it is probable that the economic benefits associated with the dividend will flow to the entity; and • the amount can be measured reliably.	1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.
AASB 2015-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1 Jan 2018	This amending standard will defer the application period of AASB 15 for for-profit entities to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: • A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation;	1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified for AASB 15 above.

Standard/ Interpretation	Summary	Applicable for annual reporting periods beginning or ending on	Impact on financial statements
	• For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and • For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).		
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	1 Jan 2019	The assessment has indicated that as most operating leases will come on balance sheet, recognition of the right-of-use assets and lease liabilities will cause net debt to increase. Rather than expensing the lease payments, depreciation of right-of-use assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. No change for lessors.
AASB 2016-4 Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities	The standard amends AASB 136 Impairment of Assets to remove references to using depreciated replacement cost (DRC) as a measure of value in use for not-for-profit entities.	1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there is minimal impact. Given the specialised nature and restrictions of public sector assets, the existing use is presumed to be the highest and best use (HBU), hence current replacement cost under AASB 13 Fair Value Measurement is the same as the depreciated replacement cost concept under AASB 136.
AASB 1058 Income of Not-for-Profit Entities	This standard replaces AASB 1004 Contributions and establishes revenue recognition principles for transactions where the consideration to acquire an asset is significantly less than fair value to enable to not-for-profit entity to further its objectives.	1 Jan 2019	The assessment has indicated that revenue from capital grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as performance obligations are satisfied. As a result, the timing recognition of revenue will change.

Current reporting period

The following accounting pronouncements effective from the 2016-17 reporting period are considered to have insignificant impacts on public sector reporting:

AASB 1056 *Superannuation Entities*

AASB 1057 *Application of Australian Accounting Standards*

AASB 2014-1 *Amendments to Australian Accounting Standards [Part D – Consequential Amendments arising from AASB 14 Regulatory Deferral Accounts only]*

AASB 2014-3 *Amendments to Australian Accounting Standards – Accounting for Acquisitions of Interests in Joint Operations [AASB 1 & AASB 11]*

AASB 2014-6 *Amendments to Australian Accounting Standards – Agriculture: Bearer Plants [AASB 101, AASB 116, AASB 117, AASB 123, AASB 136, AASB 140 & AASB 141]*

AASB 2015-2 *Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]*

AASB 2015-5 *Amendments to Australian Accounting Standards – Investment Entities: Applying the Consolidation Exception [AASB 10, AASB 12, AASB 128]*

AASB 2015-9 *Amendments to Australian Accounting Standards – Scope and Application Paragraphs [AASB 8, AASB 133 & AASB 1057]*

AASB 2015-10 *Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128*

AASB 2016-1 *Amendments to Australian Accounting Standards – Recognition of Deferred Tax Assets for Unrealised Losses [AASB 112]*

AASB 2016-2 *Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107*

NOTE 8.9: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

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

NOTE 8.10: CONTROLLED ENTITIES

Name of Entity	Principle Activity	Ownership Interest	
		2017	2016
Hume Rural Health Alliance	Information System	14.89%	15.34%

Goulburn Valley Health 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:

	Total 2017 $'000	Total 2016 $'000
Current Assets		
Cash and Cash Equivalents	539	293
Receivables	388	145
Prepayments	20	11
Total Current Assets	**948**	**449**
Non Current Assets		
Property Plant & Equipment	209	257
Intangible Assets	237	134
Total Non Current Assets	**446**	**391**
Total Assets	**1,394**	**840**
Current Liabilities		
Payables	73	82
Borrowings	97	116
Total Current Liabilities	**170**	**197**
Non Current Liabilities		
Borrowings	110	139
Total Non Current Liabilities	**110**	**139**
Total Liabilities	**280**	**336**
Net Assets	**1,113**	**504**

Goulburn Valley Health Service's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

	Total 2017 $'000	Total 2016 $'000
Operating Revenue	1,262	1,384
Operating Expenses	(1,104)	(1,234)
Net Result before Capital and Specific Items	**158**	**150**
Capital Purpose Income	596	146
Finance Costs	(7)	(10)
Specific Expense	(14)	-
Capital Purpose Expenditure	-	-
Depreciation and Amortisation	(133)	(136)
Net Result After Capital & Specific Items	**599**	**149**
Net Result for the Year	**599**	**149**

Contingent Liability and Capital Commitments

There are no known contingent liabilities for the HRHA as at the date of this report.

NOTE 8.11: ECONOMIC DEPENDENCY

Goulburn Valley Health has obtained a letter of support from the State Government and in particular, the Department of Health and Human Services (DHHS), confirming that the department will continue to provide Goulburn Valley Health adequate cash flow to meet its current and future obligations up to 30th September 2018. A letter was also obtained for the previous financial year until the 31st October 2017. On that basis, the financial statements have been prepared on a going concern basis.

NOTE 8.12: ALTERNATIVE PRESENTATION OF COMPREHENSIVE OPERATING STATEMENT

	Note	Total 2017 $'000	Total 2016 $'000
Grants			
Operating	2.1	211,750	195,658
Capital	2.1	9,231	2,416
Interest	2.1	506	518
Sales of Goods and Services	2.1	21,823	20,896
Other Income	2.1	14,408	13,528
Other Capital Income		299	1,582
Revenue from Transactions		**258,017**	**234,598**
Employee Expenses	3.1	162,515	153,528
Operating Expenses			
Supplies and Consumables	3.1	42,418	39,100
Non Salary Labour Costs	3.1	13,914	11,973
Other	3.1	28,607	27,273
Non-Operating Expenses			
Specific Expenses	3.1	14	270
Impairment of Non-Financial Assets	3.1	-	-
Impairment of Financial Assets	3.1	-	-
Finance Costs - Other	3.1	17	42
Assets Provided Free Of Charge	3.1	-	(18)
Expenditure for Capital Purpose	3.1	4,101	48
Depreciation and Amortisation	4.2	9,998	10,075
Expenses from Transactions		**261,585**	**242,289**
Net Result from Transactions		**(3,568)**	**(7,691)**
Other Economic Flows included in Net Result			
Other Gains/(Losses) From Other Economic Flows - LSL Revaluation		779	(635)
Total Other Economic Flows Included In Net Result		**779**	**(635)**
NET RESULT FOR THE YEAR		**(2,789)**	**(8,326)**

NOTE 8.13: GLOSSARY OF TERMS AND STYLE CONVENTIONS

Actuarial gains or losses on superannuation defined benefit plans

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

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

Amortisation

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

Associates

Associates are all entities over which an entity has significant influence but not control, generally accompanying a shareholding and voting rights of between 20 per cent and 50 per cent.

Comprehensive result

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

Commitments

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

Current grants

Amounts payable or receivable for current purposes for which no economic benefits of equal value are receivable or payable in return.

Depreciation

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

Effective interest method

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

Employee benefits expenses

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

Ex gratia expenses

Ex-gratia expenses mean the voluntary payment of money or other non-monetary benefit (e.g. a write off) that is not made either to acquire goods, services or other benefits for the entity or to meet a legal liability, or to settle or resolve a possible legal liability, or claim against the entity.

Financial instrument

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

NOTE 8.13: GLOSSARY OF TERMS AND STYLE CONVENTIONS (CONTINUED)

Financial liability

A financial liability is any liability that is:

(a) A contractual obligation:

(i) to deliver cash or another financial asset to another entity; or

(ii) to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to the entity; or

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

(i) a non-derivative for which the entity is or may be obliged to deliver a variable number of the entity's own equity instruments; or

(ii) a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments. For this purpose the entity's own equity instruments do not include instruments that are themselves contracts for the future receipt or delivery of the entity's own equity instruments.

Financial statements

A complete set of financial statements comprises:

(a) Balance sheet as at the end of the period;

(b) Comprehensive operating statement for the period;

(c) A statement of changes in equity for the period;

(d) Cash flow statement for the period;

(e) Notes, comprising a summary of significant accounting policies and other explanatory information;

(f) Comparative information in respect of the preceding period as specified in paragraph 38 of AASB 101 Presentation of Financial Statements; and

(g) A statement of financial position at the beginning of the preceding period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements in accordance with paragraphs 41 of AASB 101.

Grants and other transfers

Transactions in which one unit provides goods, services, assets (or extinguishes a liability) or

labour to another unit without receiving approximately equal value in return. Grants can either be operating or capital in nature.

While grants to governments may result in the provision of some goods or services to the transferor, they do not give the transferor a claim to receive directly benefits of approximately equal value. For this reason, grants are referred to by the AASB as involuntary transfers and are termed non-reciprocal transfers. Receipt and sacrifice of approximately equal value may occur, but only by coincidence. For example, governments are not obliged to provide commensurate benefits, in the form of goods or services, to particular taxpayers in return for their taxes. Grants can be paid as general purpose grants which refer to grants that are not subject to conditions regarding their use. Alternatively, they may be paid as specific purpose grants which are paid for a particular purpose and/or have conditions attached regarding their use.

NOTE 8.13: GLOSSARY OF TERMS AND STYLE CONVENTIONS (CONTINUED)

General government sector

The general government sector comprises all government departments, offices and other bodies engaged in providing services free of charge or at prices significantly below their cost of production. General government services include those which are mainly non-market in nature, those which are largely for collective consumption by the community and those which involve the transfer or redistribution of income. These services are financed mainly through taxes, or other compulsory levies and user charges.

Intangible produced assets

Refer to produced assets in this glossary.

Intangible non-produced assets

Refer to non-produced asset in this glossary.

Interest expense

Costs incurred in connection with the borrowing of funds includes interest on bank overdrafts and short-term and long-term liabilities, amortisation of discounts or premiums relating to liabilities, interest component of finance leases repayments, and the increase in financial liabilities and non-employee provisions due to the unwinding of discounts to reflect the passage of time.

Interest income

Interest income includes unwinding over time of discounts on financial assets and interest received on bank term deposits and other investments.

Investment properties

Investment properties represent properties held to earn rentals or for capital appreciation or both. Investment properties exclude properties held to meet service delivery objectives of the State of Victoria.

Joint Arrangements

A joint arrangement is an arrangement of which two or more parties have joint control. A joint arrangement has the following characteristics:

a. The parties are bound by a contractual arrangement.

b. The contractual arrangement gives two or more of those parties joint control of the arrangement

A joint arrangement is either a joint operation or a joint venture.

Liabilities

Liabilities refers to interest-bearing liabilities mainly raised from public liabilities raised through the Treasury Corporation of Victoria, finance leases and other interest-bearing arrangements. Liabilities also include non-interest-bearing advances from government that are acquired for policy purposes.

Net acquisition of non-financial assets (from transactions)

Purchases (and other acquisitions) of non-financial assets less sales (or disposals) of non-financial assets less depreciation plus changes in inventories and other movements in non-financial assets. It includes only those increases or decreases in non-financial assets resulting from transactions and therefore excludes write-offs, impairment write-downs and revaluations.

Net result

Net result is a measure of financial performance of the operations for the period. It is the net result of items of income, gains and expenses (including losses) recognised for the period, excluding those that are classified as 'other comprehensive income'.

Net result from transactions/net operating balance Net result from transactions or net operating balance is a key fiscal aggregate and is income from transactions minus expenses from transactions. It is a summary measure of the ongoing sustainability of operations. It excludes gains and losses resulting from changes in price levels and other changes in the volume of assets.

NOTE 8.13: GLOSSARY OF TERMS AND STYLE CONVENTIONS (CONTINUED)

Net worth

Assets less liabilities, which is an economic measure of wealth.

Non-financial assets

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

Non-produced assets

Non-produced assets are assets needed for production that have not themselves been produced. They include land, subsoil assets, and certain intangible assets. Non-produced intangibles are intangible assets needed for production that have not themselves been produced. They include constructs of society such as patents.

Non-profit institution

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

Payables

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

Produced assets

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

Public financial corporation sector

Public financial corporations (PFCs) are bodies primarily engaged in the provision of financial intermediation services or auxiliary financial services. They are able to incur financial liabilities on their own account (e.g. taking deposits, issuing securities or providing insurance services).
Estimates are not published for the public financial corporation sector.

Public non-financial corporation sector

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

Receivables

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

Sales of goods and services

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

Supplies and services

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

NOTE 8.13: GLOSSARY OF TERMS AND STYLE CONVENTIONS (CONTINUED)

Taxation income

Taxation income represents income received from the State's taxpayers and includes:

- • payroll tax; land tax; duties levied principally on conveyances and land transfers;
- • gambling taxes levied mainly on private lotteries, electronic gaming machines, casino operations and racing;
- • insurance duty relating to compulsory third party, life and non-life policies;
- • insurance company contributions to fire brigades;
- • motor vehicle taxes, including registration fees and duty on registrations and transfers;
- • levies (including the environmental levy) on statutory corporations in other sectors of government; and
- • other taxes, including landfill levies, license and concession fees.

Transactions

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

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

Style conventions

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

The notation used in the tables is as follows:

zero, or rounded to zero

(xxx.x) negative numbers

201x year period

201x-1x year period

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