ANNUAL REPORT 2016-17

Northern Health

Our Vision

Outstanding health care for our community.

Our Strategic Goals

- Patient First – Our patients' expectations are exceeded because we partner with them to deliver innovative and accessible care.
- Quality and Safety – We pursue the highest quality outcomes of care.
- Our People – Passionate and capable people have great careers and provide outstanding health care.
- Sustainability – We eliminate unnecessary processes and costs to ensure long-term financial viability and sustainability.

Our Mission

At Northern Health we are committed to the wellbeing of the people of Melbourne's north. We draw upon the richness, knowledge and strength of northern communities as we partner with them in their care.

Our Values

- Passionate – we care
- Dedicated – we are focused
- Progressive – we look to improve
- Collaborative – we are a team
- Partnership – we collaborate

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Report of Operations

Financial Statements and Accompanying Notes

Linda Kotsopoulos won the 2017 Minister for Health Volunteer Award for 'Outstanding achievement by a volunteer supporting diversity'.

Board Chair and Chief Executive Report

The 2016-17 financial year saw marked improvements in performance at Northern Health. Across a range of indicators, Northern Health not only met but exceeded benchmarks and standards.

Providing quality, patient-centred care for our community in the northern growth corridor is Northern Health's number one priority. We treat patients from more than 130 different cultural backgrounds and our staff members come from 90 different communities.

Although there's always room for improvement in a busy health service, our performance this year is something our staff and our diverse local community can all be proud of.

Demand for Northern Health's services continues to grow with inpatient activity increasing by over 18 per cent. The Northern Hospital's emergency department saw over 92,000 patients, making it the busiest in Victoria. Despite the surge in the number of presentations, our staff managed to decrease the amount of time emergency patients spent waiting for treatment.

Northern Health experienced a surge in the number of elective surgeries performed in 2016-17, however more than 94 per cent of our elective surgery patients were treated within recommended time. At Northern Health, the waiting list for elective surgery almost halved to 1,307 patients.

Northern Health also achieved Accreditation under all 15 National Standards and 29 action items were deemed not just to have been 'met' but to have been 'met with merit' by the surveyors. This is quite a rare achievement.

The year also saw the completion of our Broadmeadows Health Service Surgical Centre in record time and we are now in the process of commissioning four new theatres, a CT scanner for radiology and a brand new pharmacy so that patients can access these services locally.

Northern Health received $162 million in funding from the State Government to expand The Northern Hospital Tower Block after working extensively with the Department of Health and Human Services to develop a service plan and business case. We were delighted this investment was recognised as a high priority for the state and this funding is critically important to our ability to respond to the ongoing growth in patient numbers.

Our work on the Shared Vision for the North collaboration underscores our commitment to collaborative initiatives with our local partners including local governments, community health centres, primary care partnerships and more.

We also made strong improvements to clinical governance with the Northern Health board now receiving regular and comprehensive reporting on clinical governance, including critical incidents and KPIs which enables us to compare ourselves with other health services and benchmarks so that we can identify opportunities for improvement in a timely manner.

Going forward, Northern Health is committed to reducing clinical variance and to this end, we've launched our journey towards becoming a highly reliable health organisation. Our programs and team members are already being recognised as some of the best in the state, with our Koori Maternity Services winning the 2016 Minister for Health's Award for Improving Indigenous Health at the Victorian Public Healthcare Awards.

The tremendous efforts of our volunteers were similarly lauded at the Minister for Health's Volunteer Awards held in May 2017 where three of our outstanding volunteers were finalists in three categories, and in fact winning the Award for 'Outstanding achievement by a volunteer supporting diversity.' Our volunteers add enormous value to our services at Northern Health and their dedicated efforts are estimated to value add $1.5 million each year.

Thank you to our Northern Health staff for their fantastic work to improve our performance and meet ever-increasing demand. Our thanks also to the executive team and board members for their tireless efforts and commitment to helping Northern Health provide services of the highest quality.

In accordance with the *Financial Management Act 1994*, we are pleased to present the Report of Operations for Northern Health for the year ending 30 June 2017.

Jennifer Williams AM
Board Chair
Northern Health
25/08/2017

Siva Sivarajah
Chief Executive
Northern Health
25/08/2017

Northern Health Board

Jennifer Williams AM
Board Chair

Jennifer Williams was appointed as Northern Health Board Chair on 1 July 2015.

Jennifer has extensive experience in the health sector and has held many board positions.

She has previously worked as a Chief Executive to several large health care organisations including Austin Health (five years), Alfred Health (seven years) and most recently, as Chief Executive of the Australian Red Cross Blood Service (seven years). Jennifer is now a non-executive director.

In addition to her Northern Health role, she is also Chair of Yooralla and on the Board of the Australian Medical Research Advisory Board and the Board of InfoXchange. She has recently completed eight years on the Board of La Trobe University.

Jim Bailey

Jim Bailey joined the Northern Health Board in November 2014.

As a Graduate member of the Australian Institute of Company Directors, he has provided strategic business advice, coaching and consulting services to key executives in many companies across a number of sectors.

Jim's core profession is human resources. In 1992 he led the formation of a new, national organisation, the Australian Human Resources Institute, having worked in a number of honorary positions at state and national levels for several years at the Institute of Personnel Management Australia.

He is an active member of three boards including a not-for-profit organisation, and chairs an advisory board for a university faculty.

Juliann Byron

Juliann Byron was appointed to the Northern Health Board in December 2015.

Juliann has extensive experience as Chief Financial Officer at both public and private companies, and strong governance and strategic planning skills. She holds board positions on a number of public, private and not for profit boards.

She is a Fellow of CPA Australia, Fellow of the Australian Institute of Company Directors, and a Member of the Governance Institute of Australia.

Alison Lilley

Dr Alison Lilley is a practicing Specialist Anaesthetist who was appointed to the Northern Health Board in July 2014.

Alison has experience in both clinical medicine and senior level management in the public health system, with past appointments including Director of Anaesthesia (10 years) and Director of Perioperative Services (six years) at the Royal Women's Hospital.

Alison has been Chair of the Senior Medical Staff Association at the Royal Women's Hospital and a member of the Industrial Relations sub-committee of the Board of the Australian Medical Association in Victoria. She is also an Examiner for the Australian and New Zealand College of Anaesthetists and a member of the Anaesthetic Advisory Committee and the Obstetric Medical Advisory Committee at Epworth HealthCare.

Melba Marginson

Melba Marginson joined the Northern Health Board in July 2016.

Melba has previously worked as Executive Director of the Victorian Immigrant and Refugee Women's Coalition, Diversity Planner of the Maribyrnong City Council, Manager of AMES Community, and Settlement Planner of the Western Region Migrant Resource Centre. She was a Director of the Victorian Women's Trust, and is currently a member of the FECCA Women's Committee. She is currently self-employed as Director of Melba Marginson & Associates.

Melba has a Masters in Public Policy and Management, with extensive experience in community development and training, particularly in the multicultural and women sectors.

Northern Health Board

Peter McDonald

Peter McDonald joined the Northern Health Board in December 2016.

Peter is an executive with the Australian Red Cross Blood Service and previously worked as Chief Financial Officer at Austin Health and Alfred Health for 12 years. Prior to these appointments, he held a number of senior management roles in Victorian Government departments.

Peter is a Council Member and Chair of the Finance and Resources Committee at La Trobe University and is also a Fellow of CPA Australia. He is a Graduate Member of the Australian Institute of Company Directors and holds both Bachelor of Arts and Master of Professional Accounting qualifications.

Peter McWilliam

Peter McWilliam was appointed to the Northern Health Board in October 2013.

Peter brings with him extensive skills in business and management derived from 37 years of experience working at RBM and Paramount Plastic Extrusions. Peter served as a General Manager and Company Director within the organisation and its subsidiary Paramount Plastics (Aust.) for 30 years, providing leadership based on inspiring effective teamwork, strong planning and organisational skills.

As a resident of the northern suburbs, Peter is familiar with its rapid growth and development and the evolving needs of the local community. Since retiring in 2010, Peter has focused on sharing his business acumen and skills to benefit health services in the northern Melbourne area.

Paula Shelton

Paula Shelton is a senior legal professional with over two decades of experience in litigation who was appointed to the Northern Health Board in July 2016.

Paula has worked in a number of roles for Slater & Gordon, Medical Panels Victoria, Shine Lawyers and presently Waller Legal. She has experience as a personal injury lawyer across areas including product liability, public liability, class actions and medical negligence has given her a passion for high quality public health care and a keen interest in medico-legal issues.

A member of the Australian Institute of Company Directors, Paula has also been active on a number of committees such as the Western Health Institutional Ethics Committee and Human Research & Ethics Committee.

John Watson

John Watson joined the Northern Health Board in August 2016.

John has had a career in state and local government for over four decades, with a number of leadership roles including Chief Executive Officer of the former Shire of Bulla, Moonee Valley City Council and Hume City Council. His Victorian Government roles include periods as a Director, and then as Executive Director, of Local Government Victoria.

John has been Chair of the Victoria Grants Commission since 2012 and was Chair of the Panel of Administrators of the Brimbank City Council from 2012 to 2016. He chairs and sits on a number of other local government audit and risk committees and is an Independent Member of the Emergency Management Victoria Program Board.

Corporate Governance

APPOINTMENT OF DIRECTORS

As described in the *Health Services Act 1988* (S.65S), Northern Health has a board of directors consisting of up to nine persons appointed by the Governor in Council on the recommendation of the Health Minister for a term of up to three years. A director of the board must not serve more than nine consecutive years.

Four new directors were appointed during 2016-17. Ms Melba Marginson and Ms Paula Shelton were appointed for three years commencing 1 July 2016, Mr John Watson was appointed on 2 August 2016 until 30 June 2019, and Mr Peter McDonald was appointed on 26 November 2016 until 30 June 2019.

Dr Alison Lilley and Mr Jim Bailey completed their initial terms of appointment on 30 June 2017.

ROLE OF THE BOARD

The role of the Board is to exercise good governance in the achievement of Northern Health's stated objectives.

Key aspects of this governance role include:

- Setting the organisation's statement of priorities and strategic plans and monitoring compliance with those statements and plans
- Developing financial and business plans, strategies and budgets to ensure the accountable and efficient provision of health services and long term financial viability of the health service
- Establishing and maintaining effective systems to ensure that the health services provided meet the needs of the communities served and that the views of users and providers of health services are taken into account
- Monitoring the performance of the health service to ensure:
  - it operates within its budget
  - audit and accounting systems accurately reflect the financial position and viability of the health service
  - effective and accountable risk management systems are in place
  - effective and accountable systems are in place to monitor and improve the quality and effectiveness of the health services provided
  - problems identified with the quality or effectiveness of the health services provided are addressed in a timely manner
  - the service continually strives to improve the quality of the services provided and to foster innovation
  - the committees established operate effectively.
- Appointing and monitoring the performance of the Chief Executive
- Establishing the organisation structure, including management structure
- Ensuring the Minister and Secretary are advised about significant board decisions and are informed of issues of public concern or risks to the health service
- Establishing a Finance Committee, an Audit Committee and a Quality Committee
- Facilitating research and education
- Adopting a code of conduct for staff.

BOARD MEETINGS AND ACCESS TO MANAGEMENT

At Board and committee meetings, the Executive and other senior members of staff regularly present information or decision items relevant to their areas of responsibility in the health service.

Between meetings, individual board members have contact with management through involvement in committees and are contacted by the Chief Executive on major issues.

Directors undertake site visits to Northern Health's separate campuses in order to view first-hand the activities and services provided at those locations.

DELEGATION OF FUNCTIONS

The Northern Health by-laws provide for the delegation of duties by the Board.

The Board has approved and periodically reviews a detailed Delegations of Authority Policy, enabling designated Northern Health Executives to perform their duties through the exercise of specified authorities.

BOARD COMMITTEES

Small groups of directors provide their expertise through participation in committees that support the functioning of the Board.

Directors and members of the Northern Health Executive were members of committees as follows:

Audit and Risk Committee

Ms Juliann Byron - Director (Chair)
Ms Jennifer Williams - Board Chair
Ms Paula Shelton - Director
Mr John Watson - Director (from October 2016)

The following executive staff attend this Committee:

Mr Siva Sivarajah - Chief Executive
Mr Basil Ireland - Chief Financial Officer
Dr Alison Dwyer - Chief Medical Officer
Ms Michelle Fenwick - Executive Director, People and Culture

Meetings were also attended by representatives from Northern Health's internal and external auditors.

The Audit and Risk Committee is responsible to the Board for the provision of independent assurance and advice on the financial reporting process, including the application of accounting policies, the risk management system, the system of internal controls, and compliance with laws, regulations and the Code of Conduct.

Finance Committee

Mr Peter McWilliam - Director (Chair)

Ms Jennifer Williams - Board Chair

Ms Juliann Byron - Director

Mr Jim Bailey - Director (until December 2016)

Mr Peter McDonald - Director (from February 2017)

Mr Siva Sivarajah - Chief Executive

Mr Basil Ireland - Chief Financial Officer

Ms Jenni Smith - General Manager, Ambulatory Care, Partnerships, Research and Education / Chief Allied Health Officer

Ms Michelle Fenwick - Executive Director, People and Culture

Ms Jodie Ashworth - General Manager, Surgery, Women's and Children's, Operating Theatres and ICU / Chief Nursing and Midwifery Officer

The Finance Committee is responsible to the Board for ensuring that financial and asset management strategies and policies enhance the productivity and performance of Northern Health in line with government policies and directives. In addition the committee ensures that Northern Health adheres to its financial plans and operates within its budget.

Quality Committee

Dr Alison Lilley - Director (Chair)

Ms Jennifer Williams - Board Chair

Ms Paula Shelton - Director

Mr Jim Bailey - Director (from February 2017)

Mr Siva Sivarajah - Chief Executive

Dr Alison Dwyer - Chief Medical Officer

Ms Jodie Ashworth - General Manager, Surgery, Women's and Children's, Operating Theatres and ICU / Chief Nursing and Midwifery Officer

Ms Jenni Smith - General Manager, Ambulatory Care, Partnerships, Research and Education / Chief Allied Health Officer

The Quality Committee is responsible to the Board for ensuring that effective and accountable systems are in place to monitor and improve the quality and effectiveness of the health services provided by Northern Health. The committee ensures that any systemic problems are identified and addressed in a timely manner, and that the organisation strives to continuously improve quality and foster innovation.

Remuneration and Appointments Committee

Ms Jennifer Williams - Board Chair (Chair)

Ms Juliann Byron - Director

Mr Jim Bailey - Director

The role of the Remuneration and Appointments Committee is to advise and make recommendations to the Board in relation to Chief Executive recruitment, performance and remuneration and to monitor Northern Health's compliance with the Government Sector Executive Remuneration Policy (GSERP).

Patient Experience and Community Advisory Committee

Mr Jim Bailey - Director (Chair)

Mr Peter McWilliam - Director

Ms Melba Marginson - Director

Mr Siva Sivarajah - Chief Executive

Dr Alison Dwyer - Chief Medical Officer

Ms Jenni Smith - General Manager, Ambulatory Care, Partnerships, Research and Education / Chief Allied Health Officer

Ms Belinda Scott - General Manager, Broadmeadows Health Service and Craigieburn Health Service

Ms Anastasia Ah Tong - Consumer Representative

Ms Maureen Canzano - Consumer Representative

Ms Fiona Micelotta - Consumer Representative

Ms Nurcihan Ozturk - Consumer Representative

Ms Dalal Sleiman - Consumer Representative

Ms Jennefer Williams - Consumer Representative

Mr Tom Cobban - Consumer Representative (until July 2016)

The purpose of this committee is to advise the Board on strategies to enhance and promote consumer and community participation at all levels within the health service. The Committee seeks to enhance the Board's ability to advocate on behalf of the communities served by Northern Health.

Primary Care and Population Health Advisory Committee

Mr Peter McWilliam - Director (Chair)

Ms Juliann Byron - Director (until December 2016)

Ms Melba Marginson - Director

Mr John Watson - Director (from October 2016)

Mr Siva Sivarajah - Chief Executive

Ms Jenni Smith - General Manager, Ambulatory Care, Partnerships, Research and Education / Chief Allied Health Officer

Mr Phillip Bain - Chief Executive Officer, Plenty Valley Community Health

Ms Suzanne Miller – Chief Executive Officer, Nexus Primary Health

Mr Neil Cowen - Chief Executive Officer, Dianella Community Health

Ms Amanda Allen-Tolland - Manager, Health, Integration and Partnerships, North Division, Department of Health and Human Services

Mr Neville Kurth - Manager, Community Wellbeing, City of Whittlesea

Ms Margarita Caddick - Director, City Communities, Hume City Council

Mr John Dermanakis - Manager, Northern Area Mental Health Service

Ms Marilyn Harper - Manager, Northern Region, Royal District Nursing Service

Mr Max Lee - Executive Officer, Hume Whittlesea Primary Care Partnership

Ms Julie Watson - Executive Officer, North East Primary Care Partnership

Ms Robin Whyte - Chief Executive Officer, Eastern Melbourne Primary Health Network

Ms Elise Davies - Executive, Innovation and Integration, North West Melbourne Primary Health Network

Ms Sue Race - Chief Executive Officer, Kilmore and District Hospital

The Primary Care and Population Health Advisory Committee assists the Board with inter-agency planning and the integration of health services in the catchment area, particularly as it relates to the primary care and the acute sector. The Committee also assists the Board in identifying community health needs with a view to establishing innovative programs to improve the accessibility and responsiveness of Northern Health services. Members of the organisations represented on this committee have established a Shared Vision for the North that has identified priorities for primary health care including children and families, and the effective management of chronic disease.

DIRECTOR ATTENDANCE AT BOARD AND SUB COMMITTEE MEETINGS : 1 JULY 2016 - 30 JUNE 2017

	Board	Finance Committee	Audit and Risk Committee	Quality Committee	Patient Experience and Community Advisory Committee	Primary Care and Population Health Committee	Remuneration and Appointments Committee	**Total**
Number of Meetings	*11*	*11*	*6*	*6*	*6*	*5*	*1*	*46*
Jennifer Williams	*11*	*10*	*5*	*6*	*6*	*5*	*1*	*44*
Jim Bailey	*10*	*6*	*1*	*2*	*5*	*5*	*1*	*30*
Juliann Byron	*10*	*10*	*6*	*1*	*0*	*2*	*1*	*30*
Alison Lilley	*7*	*0*	*0*	*5*	*1*	*0*	*0*	*13*
Melba Marginson	*9*	*0*	*1*	*1*	*5*	*1*	*0*	*17*
Peter McDonald *appointed 26 November 2016*	*6*	*3*	*1*	*0*	*0*	*0*	*0*	*10*
Peter McWilliam	*11*	*11*	*6*	*0*	*5*	*5*	*0*	*38*
Paula Shelton	*9*	*0*	*3*	*5*	*1*	*0*	*0*	*18*
John Watson *appointed 2 August 2016*	*10*	*0*	*6*	*0*	*0*	*4*	*0*	*20*

Northern Health Executive

Siva Sivarajah

Chief Executive

Siva Sivarajah brings a wealth of knowledge, experience, partnership and leadership capabilities to Northern Health.

Siva is a highly skilled health care leader with over 25 years' experience within Victorian Health Services. Prior to joining Northern Health, Siva was the Chief Operating Officer for Monash Health (formerly Southern Health).

He has led the delivery of comprehensive health care services including acute, sub-acute, mental health and community based services. These services are provided through Monash Medical Centre, Dandenong Hospital, Casey Hospital, Moorabbin Hospital/ Monash Cancer Centre, Kingston Centre and a further 40 different small to medium sized sites.

Jodie Ashworth

General Manager, Surgery, Women's and Children's, Operating Theatres and ICU

Chief Nursing and Midwifery Officer

Jodie Ashworth has worked in the public health sector across Australia since 1989, commencing at Northern Health in 2014.

Jodie is passionate about nursing and midwifery as a profession and considers it paramount that Northern Health continues to develop standards through teaching, research and innovative practice.

Jodie has had significant managerial and operational experience at executive and senior management level that has involved financial accountability, development of service capability, responsibility for patient access and flow and multi-disciplinary team management.

Robina Bradley

General Manager, Bundoora Extended Care Centre

Robina Bradley was appointed General Manager and Director of Nursing for the Bundoora campus in 2016.

Robina has extensive experience working in hospitals across Australia including leading the service improvement strategy for St Vincent's Melbourne and has worked across acute, primary and community services.

She has worked in a number of roles within the Department of Health, Victorian Quality Council, National Institute of Clinical Studies and the Department of Justice in the implementation of policy, innovative programs, safety, quality and new business development and has developed an extensive network across the health sector.

Alison Dwyer

Chief Medical Officer

Dr Alison Dwyer commenced as the Chief Medical Officer for Northern Health in September 2015, with oversight of the medical staff and Quality and Safety portfolios.

Alison's previous experience includes Medical Director for Quality, Safety and Risk Management at Austin Health and Director of Medical Services at Royal Melbourne Hospital. She has held a number of medical administration roles in the Department of Health Victoria Quality Unit and across several metropolitan and rural health services.

She is also a surveyor for the Australian Council on Healthcare Standards.

Michelle Fenwick

Executive Director, People and Culture

Michelle Fenwick is an experienced human resources practitioner who has delivered progressive, responsive and relevant services to Northern Health.

Michelle leads Northern Health's People and Culture directorate, which include strategic employment; attraction and retention strategies; health, safety and wellbeing; learning and development; human resources and staff innovation system services. Her background is well suited to delivering sustainable workforce solutions, especially with the expected population growth.

She has a Masters in Administration in Human Resource Management / Industrial Relations and has received Candidature for her Doctorate'.

Basil Ireland

Chief Financial Officer

Basil Ireland is a highly motivated and results driven CFO, with a proven track record of success in large and complex, private and public organisations.

With over ten years' experience working at a senior financial capacity in health, Basil possesses finance, leadership and senior executive capabilities in the areas of financial management, client data management, business support and environmental support services.

He is committed to providing transparency to stakeholders, demonstrating that decisions are made equitably and through working in a collaborative manner.

Jane Poxon

General Manager, Access and Performance

Chief Nursing Informatics Officer

Jane Poxon commenced at Northern Health in 2016 as General Manager, Access and Performance and Chief Nursing Informatics Officer.

With an extensive history working in Victoria's public health sector, she is an experienced senior health care leader with a range of capabilities. As General Manager at Northern Health, Jane maintains a consistent record of performance and service delivery and strives for operational excellence at all levels.

Jane held various positions while working at Monash Health, including Director of Perioperative Services, Operations Director, General Manager South East Sector and Acting Chief Operating Officer.

Belinda Scott

General Manager, Broadmeadows Health Service and Craigieburn Health Service

Belinda Scott was appointed as General Manager, Broadmeadows Health Service and Craigieburn Health Service in 2016.

Belinda commenced at Northern Health in 1999 and has worked in roles including Program Director, Emergency Services and Director, Quality, Safety and Clinical Governance. She has also held nursing positions at Western Health and worked as a Risk Consultant with the Victorian Managed Insurance Authority.

She is passionate about engaging others to achieve performance outcomes, and was instrumental in the delivery of a $17.3M redevelopment of Broadmeadows Health Service and transition to Broadmeadows Hospital.

Jenni Smith

General Manager, Research, Education and Partnerships, Ambulatory and Community Services

Chief Allied Health Officer

Jenni Smith joined the Northern Health Executive in 2009, and was appointed as General Manager, Research, Education and Partnerships, Ambulatory and Community Services in 2016.

Jenni has an extensive background in the delivery and evaluation of health care services in both the public and private sectors. This experience includes the development and implementation of sustainable quality improvement systems and integrated care pathways. She is committed to improving health outcomes in Melbourne's north and has recently been appointed as (Adj) Associate Professor at La Trobe University.

Doris Vella

General Manager, Emergency, Medical Beds and Cardiology

Doris Vella joined Northern Health as General Manager, Emergency, Medical Beds and Cardiology, in April 2016.

Doris has over 15 years of management experience in senior health care roles. Her previous appointments include Director of Nursing and Operations (acute, subacute, community and site management experience) and acting in various roles such as Executive Director of Nursing and Allied Health, and Divisional Director.

She is the Executive Sponsor for Occupational Violence and is keen to ensure that Northern Health does everything it can to protect the safety of our staff.

Northern Health Divisional Directors

Sandra Brown

Divisional Director, Sub Acute Services

Dr Sandra Brown has worked for Northern Health since 2009 and was appointed Divisional Director, Sub Acute Services in 2017.

Sandra manages the delivery of geriatric medicine, palliative care and rehabilitation services across all Northern Health campuses, working closely with relevant site managers.

She has trained as a geriatrician and nephrologist, and has a passion for the delivery of excellent sub-acute and general medical care. Her work is inspired by a vision of safe and excellent patient care in an inclusive team, working closely with nurses, allied health and other ancillary staff.

William van Gaal

Divisional Director, Emergency Services; Director, Cardiology

Associate Professor William van Gaal is a Cardiologist and Nuclear Physician who joined Northern Health in 2007.

As the inaugural Director of Cardiology, he was instrumental in establishing Northern Health's Cardiology Unit, providing a new and local service to cardiac patients within the northern community.

William is skilled in the areas of interventional cardiology, non-invasive imaging and cardiovascular research, having trained at both the University of Melbourne and Oxford University in England. He has also lectured with the University of Melbourne and continues to foster the growth and development of junior doctors and cardiovascular research in Melbourne's north.

Lachie Hayes

Divisional Director, Ambulatory and Community Services

Chief Medical Informatics Officer

Dr Lachie Hayes commenced at Northern Health in 2009 as the inaugural Director of the Clinical Haematology Service and was appointed as Divisional Director, Ambulatory and Community services in 2014 and as Chief Medical Informatics Officer in 2016.

After graduating from the University of Adelaide, he trained at the Royal Adelaide Hospital before moving to Melbourne, where he completed his haematology training. Lachie has also undertaken additional post-fellowship training to become a dual trained Clinical and Laboratory Haematologist.

Paul Howat

Divisional Director Women's and Children's Services

Dr Paul Howat has over 20 years experience as a public specialist in Obstetrics and Gynaecology, and joined Northern Health in 2013.

Paul is responsible for Obstetrics and Gynaecology services at Northern Health, with administrative oversight of children's services, where he advocates for women and their families to obtain the best possible care. His role at Northern Health extends to the training and supervision of the next generation of Medical Specialists and GPs and teaching medical students.

Paul is a Clinical Associate Professor at University of Melbourne and the Queensland Regional Committee Chair and senior examiner at RANZCOG.

Wanda Stelmach

Divisional Director, Surgery

Ms Wanda Stelmach is a general and breast surgeon who commenced with Northern Health as a VMO surgeon at Preston and Northcote Community Hospital in 1993.

Wanda was appointed as the inaugural Head of Acute General Surgery Unit in 2009, a service she helped to create, and was made Divisional Director, Surgery in 2014. She is also the Head of Surgical Unit 2 and Chair of the Northern Health Breast Group.

She has been a Fellow of the Royal Australasian College of Surgeons since 1995, is a College examiner and is currently the Deputy Chair of the Victorian Regional Committee.

Yana Sunderland

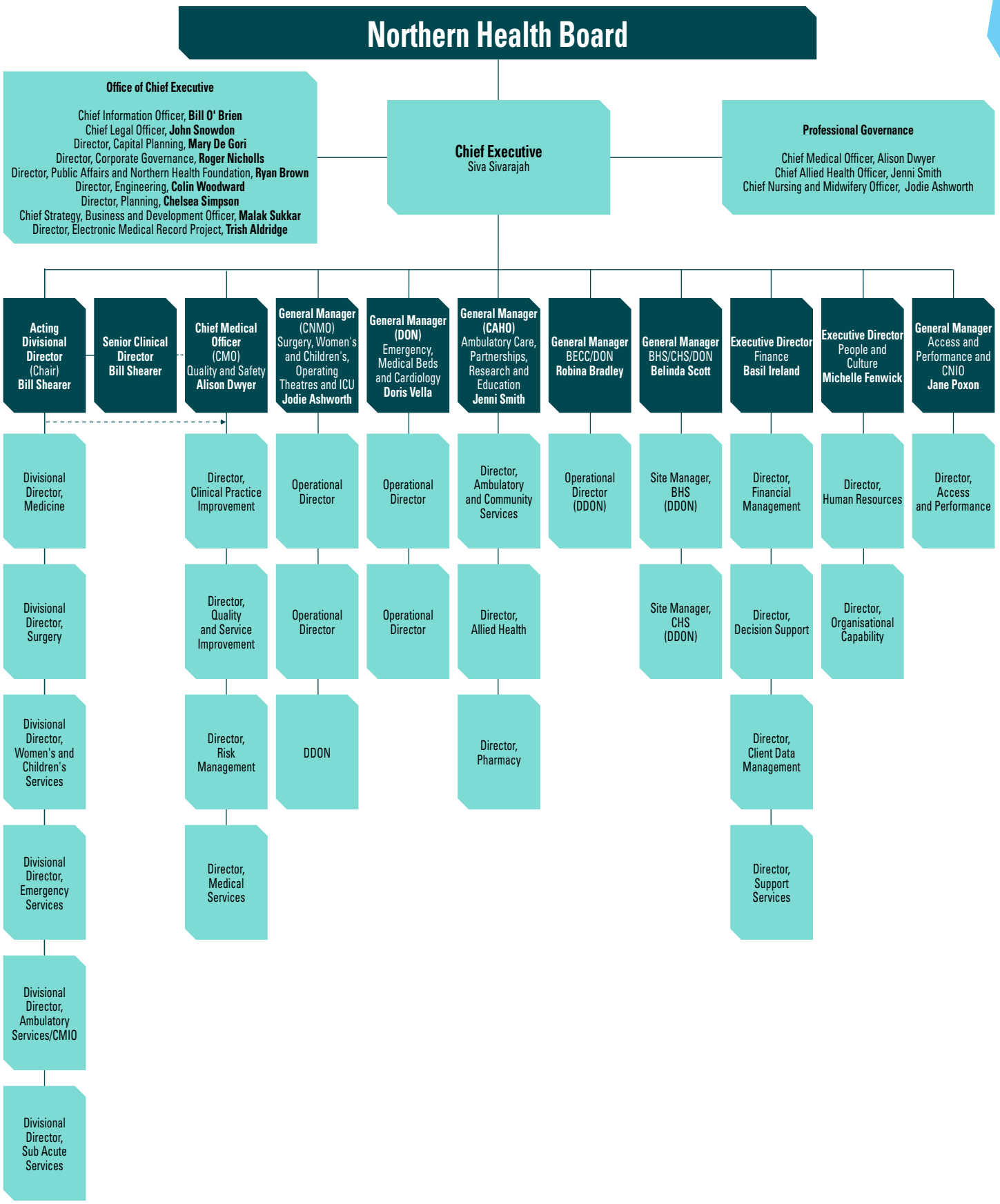
Divisional Director, Medicine

Dr Yana Sunderland has worked as a consultant in both Geriatrics and General Medicine at Northern Heath since 2010.

Yana is engaged in perioperative medicine and was responsible for establishing the PRIME service for perioperative assessment of patients requiring joint replacement at Northern Health and has a strong interest in medical education.

She has also worked as the regional examiner for the FRACP clinical exam at Northern Health from 2012 – 2014 and has been extensively involved in physician training with the Central North West Consortium of basic physician training and was appointed as Director of the Consortium in 2013.

Organisational Structure



Our Services

Northern Health is the major provider of acute, sub-acute and ambulatory specialist services in Melbourne's north. Our campuses include Broadmeadows Health Service, Bundoora Extended Care Centre, Craigieburn Health Service, Panch Health Service and The Northern Hospital in Epping.

We provide a range of inpatient and outpatient services, including:

- Emergency and intensive care
- Acute medical, surgical and maternity services
- Sub-acute, palliative care and aged care
- Specialist clinics and community-based services.

Northern Health is situated in the Northern Growth Corridor and our catchment includes three of Victoria's six growth areas: the City of Hume, the City of Whittlesea and the Shire of Mitchell.

The northern growth corridor population is expected to grow by 58 per cent, or over 220,000 people, between 2016 and 2031. This includes 17 per cent growth between 2016 and 2021; an increase of over 66,000 people, within the next five years.[1]

Northern Health treats patients from many different socio-economic backgrounds, who are born in more than 185 countries, speak over 106 different languages and follow over 90 different religions/beliefs. The breadth of complex disease in the community is significant, with residents of the outer north having generally poorer health status, including higher than average levels of type 2 diabetes, heart disease and high-blood pressure, higher rates of smoking and higher rates of family violence incidents.

Our busy emergency department treated over 92,000 patients in 2016-17, with an average of 1,763 emergency presentations, including 366 paediatric patients and 488 ambulance arrivals, each week. 3,589 babies were delivered in the past 12 months, and our dedicated staff continue to provide over 6,000 outpatient appointment and community visits and perform around 453 elective and emergency operations each week.

Northern Health is committed to providing outstanding health care for our community, and will continue to develop services and pathways to services that our patients need.

[1] Department of Environment, Land, Water and Planning, *Victoria in Future 2016,* accessible at: https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future-2016

Admitted Patients, Sub Acute and Emergency Services

$418m

- Access
- Ambulatory and Community
- Broadmeadows Health Service
- Craigieburn Health Service
- Bundoora Extended Care Centre
- Medical, Emergency, Oncology and Cardiology Services
- Surgical, Women's, Children's and Intensive Care Services
- Hospital Admission Risk Program

Non Admitted Services

$21m

- Outpatients
- Breastfeeding Centre
- Thoracic Surgery: Non-Admitted
- Diabetes Services and Hand Therapy
- Birthing Support
- Paediatric Medicine
- Plastic and Reconstructive Surgery
- Pharmacy
- Allied Health Education
- Pastoral Care
- Discharge Planning and Support Service
- Ambulatory Care Entry and Triage Service

Aged Care Services

$16m

- Bundoora Extended Care Centre
- Ambulatory and Community
- Ian Brand Nursing Home
- Aged Care Assessment Services
- Home Care Packages

Other $40m

- Allied Health Services
- Capital Programs
- Finance and Data Management
- Diagnostic Services
- Environmental Services
- Engagement, Communications and Fundraising
- Engineering and Building Services
- ICT
- People and Culture
- Medical Support Services
- Patient Experience and Consumer Participation
- Specific and Restricted Purpose Funds

Our Achievements

OUR PEOPLE

Passionate and capable people have great careers and provide outstanding health care.

Australia Day Awards:

On Australia Day 2017, several Northern Health and Northern Health Foundation representatives were recipients of prestigious Australia Day Awards. This included Northern Health Board Chair, Jennifer Williams AM, who was made a Member (AM) of the Order of Australia in the General Division for significant service to the community through leadership roles in the public health sector, and NGO governance.

Patron of the Northern Health Foundation, Paul Wheelton OAM, was made a Member (AM) of the Order of Australia in the General Division for significant service to a range of charitable organisations in Victoria through governance, fundraising and philanthropic contributions.

Former Northern Health Board Chair, Marilyn Beaumont OAM, was also awarded a Medal (OAM) of the Order of Australia in the General Division. She was recognised by the Governor General for her advocacy for mental health, sexual health and reproduction reform, women's rights and six years of leadership on the Northern Health Board.

Victorian Public Healthcare Awards:

At the 2016 Victorian Public Healthcare Awards, Northern Health's Koori Maternity Service received the Minister for Health's Award for Improving Indigenous Health - Closing the Gap.

The Koori Maternity Service was first launched in 2013, and aims to provide accessible and culturally appropriate pregnancy care that improves birth outcomes for Koori families in the north. The service also provides linkages to pathways for community support services that improve the wider health and wellbeing of Koori mothers, their newborns and families.

Outcomes have been overwhelmingly positive, including increased birth weights, decreased smoking and alcohol consumption while pregnant, and a positive impact on the broader health of mothers and babies.

By providing a holistic and culturally appropriate service, the Koori Maternity Service is changing lives, improving health and wellbeing and strengthening Northern Health's connections with our diverse community. This award is a fantastic achievement, not only for Northern Health, but for all of the northern community.

Minister for Health Volunteer Awards:

Volunteers play an important part in helping Northern Health deliver our vision of outstanding health care for our community.

Northern Health counted a total of 341 volunteers last year who provided 26,000 hours of volunteer service; contributing an estimated value of $1.5 million to our health service.

This year, Northern Health had three finalists in the Minister's Volunteer Awards; Linda Kotsopoulos, Mandy Davis and Pam Luke. Linda was nominated for 'Outstanding achievement by a volunteer supporting diversity'; Mandy in the category of 'Outstanding achievement by a volunteer improving public health care'; and Pam for 'Outstanding achievement by a volunteer improving the patient experience'.

We were delighted that Linda won the Minister for Health Volunteer Award for 'Outstanding achievement by a volunteer supporting diversity'.

Linda has volunteered at the Kath Atkinson Wing (KAW) of Northern Health's Bundoora Extended Care Centre for 11 years. KAW provides comprehensive geriatric assessment to older patients with behavioural and psychological symptoms of dementia. A bilingual speaker, Linda makes Greek and Italian coffee and bakes cakes for patients to enjoy during their time at KAW.

Diversity in Melbourne's north:

Northern Health operates in one of Melbourne's most culturally diverse population catchments. There are 196 countries in the world and in the 2016-17 financial year, Northern Health provided care for people who were born in more than 184 of them, with 106 different languages spoken and 90 different religions and beliefs cited.

The Northern Health model of language services provision is one of the most advanced in Australia. In an average year, TALS at Northern Health provides approximately 55,000 interpreting occasions in over 100 languages, more than 90 transcultural training sessions to over 1,000 staff members, and translates dozens of documents in the top eight languages.

Northern Health demonstrates a whole of organisation approach to cultural diversity, and will endeavour to continue leading the way in responding to, and fostering multiculturalism.

Our Achievements

PATIENT FIRST

Our patients' expectations are exceeded because we partner with them to deliver innovative and accessible care.

Early Stroke Discharge Service:

In 2016, as part of the state-wide Subacute Stroke Initiative, Northern Health received funding from the Victorian Stroke Clinical Network to commence an Early Supported Stroke Discharge (ESD) service. The goal of the ESD service is to help patients with stroke return home earlier, by providing rehabilitation within the patient's home environment or closest Community Therapy Service (CTS) - at Bundoora Extended Care Centre, Broadmeadows Health Service or Craigieburn Health Service. There are strong links between the acute and rehabilitation services and the ESD team with both hospital staff and ESD team members identifying appropriate patients for the program. The ESD service focuses on goal-orientated, coordinated multidisciplinary care and patients receive simultaneous allied health and nursing input. Intense home-based therapy may be offered for up to four weeks. Since the twelve month pilot commenced in July 2016, 79 patients have been managed in the ESD service.

Strengthening Northern Health's response to family violence:

The launch of Northern Health's response to family violence was held on 31 March 2017. Strengthening Northern Health's response to family violence aims to improve the care we provide for our patients by educating our staff on the underlying causes, statistics and impacts of family violence. Northern Health's catchment has one of the highest incidences of family violence in the state, and hospital statistics have shown that presentations related to family violence at Northern Health are on the rise.

Northern Health was included in Phase 3 of the Department of Health and Human Services roll out of this project in 2016-17. Initial training, focusing on a general awareness or understanding, has been developed for all employees and clinical 'train the trainer' sessions have been established in areas and departments with patients at risk.

The Emergency Department, Women's Health, Allied Health, Transcultural and Language Services, and Client Data Management have participated in face-to-face clinician training. Manager training is being provided by external expert agencies. In total, 969 staff (over 20 per cent of all Northern Health staff) received training initially, with clinical training extended to Ambulatory, Northern at Home, Observation Unit and Medical and Surgical Units.

Training will now be spread across the rest of the organisation including all sites and community-based programs.

Baby boom in Melbourne's North:

With the northern growth corridor expected to grow by 59 per cent, or over 230,000 people by 2031, The Northern Hospital assists in the birth of an average of 69 babies each week.

In January 2017 Northern Health delivered the highest number of babies in a single month, 340 newborns —166 boys and 174 girls — including four sets of twins. That's a baby born almost every two hours!

The Maternity Unit at The Northern Hospital currently has 28 beds; nine delivery suites and a Level 2 Special Care Nursery. Care on the unit is delivered by midwives who work in close collaboration with obstetricians, paediatricians, anaesthetists, physiotherapists, social workers, dietitians and other disciplines.

Opening of the Koori Maternity Birthing Room:

The Northern Hospital partnered with our local Aboriginal community—including Wurundjeri Elders, staff members, and patients and families—to open our first Koori Maternity Birthing Room in February 2017.

The award-winning Koori Maternity Service was first launched in 2013, to provide accessible and culturally appropriate pregnancy care that improves birth outcomes for Koori families in the north. The service also provides linkages to pathways for community support services that improve the wider health and wellbeing of Koori mothers, their newborns and families.

The Koori Maternity Birthing Room is both culturally safe and inclusive for the mothers of our Koori Maternity Service to welcome new life into the northern community. It is a space that pays respect to the traditional custodians of the land on which Northern Health's campuses are built, the Wurundjeri people, and a room that will be a part of Wurundjeri future.

Our Achievements

QUALITY AND SAFETY

We pursue the highest quality outcomes of care.

Volunteer Simulated Patient program:

The Northern Health Volunteer Simulated Patient program was developed to enhance simulation education opportunities using Northern Health volunteers as simulated patients. Learning through simulation provides a safe, structured approach to education that simulates real-life experiences as a learning tool for health professionals and undergraduate students.

Northern Health volunteers are trained to portray a patient with a specific condition or relative or healthcare professional. Many of the Northern Health volunteer simulated patients have been patients of Northern Health and volunteer in the program to support the care of future patients. Northern Health volunteers have participated in simulation education programs with undergraduate students and staff from medicine, nursing, physiotherapy, social work, speech pathology, occupational therapy and dietetics.

The volunteers have participated in a range of scenarios which have included learning outcomes to improve communication with patients and carers, working collaboratively in a team, clinical assessment and treatment skills and providing patient centred care.

Step on Sepsis:

Step on Sepsis is a sepsis management program developed at The Northern Hospital that aims to optimise the management of patients experiencing, or at risk of developing, a severe infection which can lead to sepsis. Step on Sepsis was introduced in the Emergency Department in 2013 as a quality improvement project. During this time, antimicrobial delivery times were successfully reduced from a median of 156 minutes to a median of 120 minutes.

In August 2016, the Infectious Diseases and Emergency Department teams at The Northern Hospital launched Step on Sepsis hospital wide. This launch was followed by education sessions for both nursing and medical staff, as well as the release of updated antimicrobial guidelines to assist with prescribing of antibiotics. A Step on Sepsis management tool was also developed and made available for staff on the wards, on lanyard cards and electronically. This management tool can be used to guide staff in recognising and providing appropriate care to patients at risk of developing sepsis.

Achieving Accreditation:

In June 2017, Northern Health was presented with its Certificate of Accreditation by Dr Christine Dennis, CEO of The Australian Council on Healthcare Standards, following the accreditation survey held at Northern Health in March, 2017.

Of 367 individual actions assessed, the surveyors indicated that Northern Health had met and passed each of these actions, with 29 of these upgraded to a Met with Merit status.

The survey team congratulated Northern Health on its considerable management journey in partnership with its growing multicultural community and committed staff.

“Clearly when any organisation achieves what you have achieved, it requires good leadership, not just from the Board and CEO, but throughout the organisation,” said Dr Dennis at the presentation.

The survey team were impressed with the many examples at Northern Health where our consumers had worked with us to improve the patient experience through the design of new facilities, training our staff and developing culturally sensitive services such as the Koori Maternity Service.

Advanced nursing roles across Northern Health:

Northern Health has increased Nurse Practitioner services across the organisation with an increase to five Nurse Practitioners in Emergency as a strategy to provide effective and efficient care in the Emergency Department.

There is a new Heart Failure Nurse Practitioner and Nurse Practitioner Candidates in Neonatal and Heart Failure. In addition we have developed advanced nursing roles in key areas such as: Acute Pain Management, Nurse Endoscopist Trainee, Gastroenterology and Urology to improve access to appropriate and timely care for our community.

Our Achievements

SUSTAINABILITY

We eliminate unnecessary processes and costs to ensure long-term viability and sustainability.

Victorian Government announcement helping us grow:

On 2 May 2017, the Victorian Government announced $162.7 million in funding for Northern Health from the State Budget. The funds will see the addition of four storeys to Northern Health's Tower Block as part of Stage 2 of this development.

This is the largest investment in health for Melbourne's northern community, and will fund an additional 96 medical and surgical beds across three floors, three new operating theatres, 18 Intensive Care and High Dependency beds, and a greater capacity for pharmacy, mortuary, kitchen, loading dock and supply services at The Northern Hospital. Stage 1 of the tower development was completed in June 2016.

Broadmeadows Health Service Upgrade:

Broadmeadows Health Service has just completed a $17.3 million upgrade begun in September 2016, which includes the development of two additional theatres, expansion of on-site pharmacy and radiology services and enhancement of pathology collection.

This expansion has helped better manage surgical patients of higher acuity, increased the range and complexity of surgical procedures performed at Broadmeadows and helped more residents in Melbourne's north receive surgery locally and in a timely manner.

The increase in surgical capacity at Broadmeadows Health Service has also enabled a reconfiguration of theatre services across Northern Health.

A sustainable workforce:

Northern Health has grown rapidly – from 1800 employees in 2007 to 4400 employees in 2017– many of whom live in the vicinity of our campuses. In 2016, 28 per cent of our staff came from the City Of Whittlesea, 13 per cent from Hume and 8 per cent from Banyule.

Northern Health has a 98 per cent staff retention rate which it is proud of. At our Service Awards presentation in September 2016, hundreds of staff members were recognised across all of Northern Health's campuses for their years of service to the organisation. Northern Health has 939 staff with over 10 years' experience and service, 245 who have had 20 years' service and 12 loyal staff who were recognised by Chief Executive Siva Sivarajah at the presentations for over four decades of service to Northern Health.

Linking with other health services:

HealthLinks is a three-year project being implemented in hospitals across Victoria, including Northern Health.

The HealthLinks Chronic Care (HLCC) project targets people with chronic and complex needs who are frequently admitted to The Northern Hospital with the aim of reducing unnecessary hospital admissions and Emergency Department presentations. The project aims to provide alternate care pathways in the community or sub-acute setting, co-designing a more integrated service between patients, service providers and hospitals and establishing a more cost effective and sustainable model of care.

HealthLinks dashboard has been created to assist with identifying and monitoring the patient's activity. Discharge Planning Support Service (DPSS) have prioritised HealthLinks patients for discharge planning and re-admission risk. DPSS has streamlined its assessment process and developed an electronic Initial Needs Identification tool (INI) to standardise assessment, improve communication with Health Independence Programs (HIP), and reduce duplication and rework. Every fortnight, a working party of senior clinicians review patient histories to identify gaps in service provision and opportunities for improvements at the patient and system level.

The Northern Hospital working bee:

Members of the Board and Executive participated in a working bee at The Northern Hospital on Sunday 14 August 2016 and again on 7 May 2017, affirming their commitment to creating a welcoming and clean environment for both our community and our staff. BankVic volunteers and staff, many of whom live locally, joined in the efforts to improve the look and feel of our campus.

2017 Northern Health Run Walk 'N' Chalk

Statement of Priorities

In 2016-17 Northern Health will contribute to the achievement of the State Government's commitments by:

Domain	Action	Deliverable	Outcome
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.	Northern Health is developing a comprehensive guideline for end-of-life care. An organisation wide plan to ensure that Northern Health delivers end-of-life care in accordance with EQuIP national Standard 12 - Provision of Care, and Palliative Care Australia's 'Standards for Providing Quality Palliative Care For All Australians' will focus on training and improving access to resources this financial year. Northern Health will also strengthen links with community palliative care providers to improve access for Northern Health patients.	Achieved.
	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.	Incorporation of Advanced Care Planning (ACP) in the Morbidity and Mortality framework: Presence of an Advanced Care Plan alert in the Patient Master Index will be included in the morbidity and mortality review reports. The Northern Health Mortality Audit Tool is a single comprehensive mortality tool for all deaths. It is currently paper-based. Northern Health is currently tendering for an electronic tool for supporting mortality audit processes.	Achieved.
	Progress implementation of a whole-of-organisation model for responding to family violence.	A multidisciplinary steering committee including consumers and external expert stakeholders has been established with approved TOR and commenced work on scoping the implementation of the Royal Melbourne Hospital/ Bendigo Health toolkit. Costings have been obtained for the rollout of Royal Women's Hospital	Achieved.

Domain	Action	Deliverable	Outcome
		toolkit. Designation of EFT for a project officer to coordinate rollout of the toolkit will be allocated. RWH toolkit implementation will be staggered in 2016-17 with a focus on Emergency, Women's and Children's and Aged Care.	
	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.	Foetal surveillance policy to be established with directives related to: • Foetal Surveillance Education Program (FSEP) mandatory training requirements • Level of FSEP training to be achieved according to clinical role • Level 3 competent FSEP on each shift in birth suite and maternity assessment unit • Mandatory requirement for all obstetric registrars and consultants to achieve level 3 FSEP • Monitoring of compliance by head of units with key performance Indicator (KPI) of 100 per cent to be achieved and maintained	Achieved.
	Use patient feedback, including the Victorian Healthcare Experience Survey 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.	Evaluation of the recommendations arising from Patient Co-Design Projects (including in the areas of Intensive Care Unit (ICU), Day Oncology and Speech/Dietetics), to ensure recommendations are implemented and improve patient experience. Northern Health Victorian Health Experience Survey (VHES) data has also identified opportunities for improvement in (1) cleaning (2) information for patients on discharge. Improvement work focusing on improving cleaning and information for patients on discharge is being developed.	Achieved.

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
	Develop a whole-of-hospital approach to reduce the use of restrictive practices for patients, including seclusion and restraint.	A review of policies relating to restrictive practices for patients including seclusion and restraint will be done in partnership with psychiatry. An audit will be undertaken against best practice. An improvement project using Plan Study Act methodology, including stakeholder engagement, will assist in closing any gaps identified.	Achieved.
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.	Northern Health will undertake a review of specialist clinic waiting lists to remove duplicates and those patients who have already received services or no longer require care by October 2016. Strategies to improve general practitioner (GP) engagement with Northern Health finalised October 2016. Shared care pathways will be incrementally introduced over 2016-17. Northern Health will partner with the two Primary Health Networks to improve primary care offered to patients waiting for specialist appointments via health pathways.	Achieved.
	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.	Revision and refinement of ED's streaming model including the implementation of the Observation Unit and revised model of care for the Short Stay Unit (SSU) to meet access and timeline KPI targets. Implementation of a nurse in the ED to receive patients from Ambulance Victoria to assist in meeting Ambulance Transfer Time in less than 40 minutes. Two improvement projects will focus on; 1) why patients did not wait for treatment 2) why patients re-presented in 48	Achieved.

Domain	Action	Deliverable	Outcome
		hours. These two projects will include a detailed diagnostic phase and solution development phase, with solutions developed for identified problems.	
	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 (HIP) or telemedicine).	Northern Health will continue to implement identified actions to increase care outside the hospital walls, including: 1) Implementing a telemedicine process for triaging urgent care patients with Kilmore and District Hospital by March 2017 2) Expansion of the Northern Health Hospital in the Home service from 30 beds to 40 beds by September 2016 3) Further refining our Health Independence Program model, with the inclusion of the HealthLinks initiative and by continuing to build integration between Health Independence Program (HIP) services; Hospital Admission Risk Program (HARP), Sub-Acute Ambulatory Care Services (SACS), Rehabilitation. Further, we will consolidate the HIP programs to ensure that 90 per cent of patients assessed as at risk of readmission are provided with post-discharge support within five working days of discharge and are assessed and linked to community services as required.	Achieved.
	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.	Extend operating time from three and a half to four hour sessions. Introduce a new model of care for managing the theatre bookings process including surgical liaison nurses optimising patients for surgery. Northern Health is continuing to develop strategic urban and rural partnerships to	Achieved.

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
		ensure our community receive timely surgical care. Partnership agreements with Kilmore and District Hospital (for general surgical, Ear Nose Throat (ENT) and vascular work) will continue for 2016-17 and Northern Health has commenced surgical partnership discussion with Seymour Health (for urology, plastics and orthopaedic surgery), St. Vincent's (for orthopaedic surgery) and The Royal Children's Hospital (to accept referrals of waitlisted patients from the northern growth corridor back to Northern Health for paediatric general surgery). Implementation of a number of improvement strategies within theatre to improve theatre utilisation across The Northern Hospital and Broadmeadows Health Service (BHS).	
	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.	Service plans have been developed and clinical services redefined to ensure readiness for the full transition on June 30 2017. Patients to transition to National Disability Insurance Scheme (NDIS) have been identified. Transition will be planned and negotiated. Mechanisms to provide integrated care with other NDIS providers will be implemented and evaluated over 2016-17. Workforce, Information Technology (IT) and financial resources have been developed to ensure NDIS compliance. Reporting mechanisms to track actual revenue against forecast budgets are in place with mechanisms for escalation of poor performance to be developed.	Achieved.

Domain	Action	Deliverable	Outcome
	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.	Continue to implement practice improvement program components and KPIs, developed by the National Organ and Tissue Authority and Donatelife Victoria. Map KPIs to Australian Commission on Safety and Quality in Heath Care Standards 1: Governance for safety and quality in health care 9: Recognising and responding to clinical deterioration in acute health care and 12: Provision of care. Continue training on the Collaborative Request Model. Progress staff and targeted community education and training programs to create awareness of organ and tissue donation among a variety of cultural and religious groups within the Northern Health catchment area. Continue weekly audit of all Northern Health deaths to elicit any missed potential donors. Maintain compliance with reporting requirements identified by DonateLife Victoria.	Achieved.
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.	Northern Health will continue to work with closely with our local and regional health and community partners (for example, PH's, Hume City Council, Whittlesea City Council, Hume-Whittlesea Primary Care Partnership, Dianella Health, Plenty Valley Community Health) to address community health and wellbeing. Northern Health is currently participating in a number of planning projects with our community health, local government and health partners to improve local services. Further, through the Northern Health Primary Care and Population Health committee, Northern Health works with our agency partners to identify and respond to population health issues.	Achieved.

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
	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.	Northern Health works with partner agencies to reinforce communitywide prevention strategies. Northern Health will continue working with our mental health partners to address the mental health needs of our community, for example, by working with the two Primary Health Networks (PHN) to facilitate a continuum of care for shared clients and working as part of the North West Mental Health Alliance to monitor quality measures for mental health.	Achieved.
	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.	Members of the Patient Experience Community Advisory Committee (PECAC) are representative of our diverse community and many are community leaders. Transcultural health care policy reflects the demographics of our community and is inclusive of our staff demographics. Development of a governance framework for diversity and good citizenship based on the World Health Organisation (WHO) equity principles which will underpin service planning, delivery and evaluation and guide relevant human resource practices. The framework will be in place by December 2016.	Achieved.

Domain	Action	Deliverable	Outcome
	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.	Northern Health staff are guided by the Aboriginal Access and Equity Policy. Northern Health consults with Aboriginal people through peak Aboriginal bodies on all appropriate matters. Northern Health provides governance and oversight through the Northern Health Aboriginal Advisory Committee that has both internal and external representation. Northern Health has an Aboriginal Liaison Officer and an Aboriginal Home and Community Care Officer that support Aboriginal and Torres Strait Islander consumers using services of Northern Health. We are currently raising awareness through a campaign of "asking the question" to improve identification of Aboriginal and Torres Strait Islander (ATSI) consumers.	Achieved.
	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.	Melbourne Health North West Mental Health Service (NWMHS) will take the lead in managing mental health patients in the outer north. Northern Health will work with our partners more broadly at the state service level in preventing reliance on the hospital system. This will include: 1) Developing agreed KPIs to monitor performance 2) Improve process for transferring mental health patients from Ambulance Victoria through environmental and service redesign 3) Improve transfer of patients out of Emergency Department (ED) through improved partnership with North West Mental Health and develop an escalation process for stranded patients.	Achieved. Achieved Northern Health component. Northern Health is working with North Western Mental Service to continue to progress remaining actions.

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
	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.	Development of a governance framework for diversity based on the WHO principles to underpin service and human resource practices. The overarching plan is to meet all the rainbow tick accreditation criteria. Northern Health will work to raise awareness re: diversity in our population and respect (for all types of diversity) across the Northern Health workforce. This work will be undertaken using key organisational and community champions to raise awareness and educate Northern Health staff across the organisation, including front of house staff, cleaning, support staff and clinical staff.	In Progress. Northern Health has undertaken a range of actions to prepare for Rainbow eQuality accreditation and improve inclusive practice in 2016-17. These include: 1. Development of a Diversity Governance Framework and Committee, whose terms of reference include the LGBTI community. A LGBTI Working Group has been established to progress Northern Health's actions to improve inclusive practice and reports to the Diversity Governance Committee. This working group will work in partnership with community stakeholder groups to foster a positive culture for LGBTI staff, patients and carers. 2. Completion of the Gay and Lesbian Health Victoria (GLHV) Audit Tool to assess Northern Health inclusiveness undertaken with areas for improvement identified 3. Scheduling of 'HOW2' training 4. Scheduling of GLHV training to the Northern Health leadership team 5. Gender sensitivity training completed by of all Aged Care Assessment staff and community workers, including some staff trained to deliver training. Next steps to progress Northern Health's preparedness for Rainbow eQuality tick accreditation and to be more responsive to the needs of LGBTI consumers include: • Continuing to update and/or add and embed new policies to ensure inclusive practice is embedded at Northern Health • Further progress interventions identified for improvement in the GLHV Audit Tool (for example, ensuring patient information brochures use gender sensitive and gender neutral language and incorporating LGBTI friendly branding at each Northern Health site).

Domain	Action	Deliverable	Outcome
	Further engagement with relevant academic institutions and other partners to increase participation in clinical trials.	The opening of the Northern Centre for Health Education & Research in 2015 laid a foundation for strengthening Northern Health's partnership with La Trobe University and the University of Melbourne. Northern Health launched an Education and Research Plan for 2015-20 which names key research focus area based on population health data: aged care; women's and children's; chronic disease; and social determinants of health. Northern Health will continue to develop research links and pursue new opportunities with these partners, other universities and industry sponsors to pursue research in these areas. Examples of Northern Health's participation in clinical trials this financial year include: 1) Increase in clinical trials in 2016-17 by working in collaboration with National Ageing Research Institute to participate in clinical trials for people ageing in the community. 2) Northern Health has undertaken improvement work in the Pharmacy department and obtained a required refrigerator to increase involvement in clinical drug trials.	Achieved.
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	Following the review of the governance of safety and quality in Victorian Health Services, Northern Health will improve the monitoring of the implementation of recommendations arising from incident reviews, and evaluate whether the recommendation has addressed the patient safety risk identified in the incident. Measurement will include: percentage of recommendations evaluated within six months of implementation. Northern Health will also undertake an analysis of the trends of our four highest incidents:	Achieved.

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
	that clinical governance arrangements undergo frequent and formal review, evaluation and amendment to drive continuous improvement.	falls, pressure injuries, medication incidents, violence and aggression. Evaluate mechanisms of feedback to the clinical workforce from incident reviews.	
	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.	Northern Health has a Board endorsed anti-bullying and harassment policy. Bullying and harassment are now registered on the Northern Health risk register as an 'extreme' risk. Key actions for 2016-17 will be reporting of incidents. Incidents are currently being tracked via excel spreadsheet. Northern Health is reviewing a monitoring tool at a neighbouring health service to determine if it meets business requirements (case tracker system). In the interim reporting will occur via Chief Executive reports and reports to responsible Executive Directors/ General Managers. Board, Executive and Management has been trained in policies, procedures and respecting one-another. Chief Executive newsletter established to communicate expectations re: bullying and harassment and action plan and resources being sourced and developed. Reporting updates are scheduled for board meetings and monitored on a quarterly basis.	Achieved.

Domain	Action	Deliverable	Outcome
	Board and senior management ensure that an organisation 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 (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.	An Occupational Health and Safety (OH&S) Strategic Plan has been endorsed by the OH&S Executive Committee and covers all identified items in this deliverable as well as bullying and harassment. A communication strategy will soon be completed and launched. OH&S policies have been displayed across all campuses. OH&S KPI metrics have been confirmed with the committee. OH&S KPIs have been endorsed. Specific OH&S KPIs for General Managers are being built into performance plans. Occupational violence metrics analysis has been completed across Northern Health. Specific disciplines require general or tailored training. HITH (300 employees) completed to-date with Management of Clinical Aggression (MOCA) and physical evasive training. Next steps include scheduling Emergency Department (194 employees) and two wards (97 staff) during the second quarter of 2016-17. Outcomes from investigations and incidents will be communicated back to staff via Safety First Associate Director and Operations Directors. Reporting and monitoring processes will be developed in the second quarter of 2016-17.	Achieved.
	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.	A workforce plan will be developed in 2016-17 that will address all of these elements. The framework for the plan has been developed and will be presented to the Chief Executive in August. Next steps will be to populate with EFT/classification data (skills today versus skills tomorrow) which will include all labour categories. Chiefs will meet to determine to short, medium and long-term plans in regards to capability. Plan will be completed in the third quarter of 2016-17.	Achieved.

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
	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 (3) includes consumers and the community.	This item will be addressed as part of the previously mentioned actions relating to bullying and harassment. Northern Health has received Patient Management System and has presented to Executive. To be presented to Board in August, and will inform the development of the bullying and harassment/ workforce culture.	Achieved.
	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.	Department of Health and Human Services Victoria Children at Risk eLearning course to be implemented and made mandatory for all clinical staff across Women's Children's and Emergency Services. Paediatric risk of harm policy currently in place. To be reviewed to include a code of conduct for staff to establish expectation of behaviour with children. Working With Children's check policy to be reviewed including the review of staff cohort mandated to have valid WWC. Children at risk and strategies to identify and reduce/remove risk will be included in orientation program.	Achieved.
	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.	Implementation of Staff Vaccination Database to capture currency and accuracy of staff health immunisation status. Comply with DHHS guidelines for staff influenza vaccination, including strategies for limiting exposure to susceptible patients from staff that decline vaccination.	Achieved.

Domain	Action	Deliverable	Outcome
Financial sustainability	Further enhance cash management strategies to improve cash sustainability and meet financial obligations as they are due.	In 2015-16, Northern Health undertook service realignments to improve efficiency and achievement of public/private Weighted Inlier Equivalent Separation (WIES). Continued improvement of available cash position resulted (2014-15 negative $7M, 2015-16 negative $0.4M, 2016-17 positive $1M). At the May 2016 Board meeting, The Northern Health Board approved a five year cash strategy that sets out cash management principles that the business must follow to ensure Northern Health's available cash becomes positive. In 2016-17, the agency will continue to focus on efficiency initiatives including improvements in length of stay and theatre throughput.	Achieved.
	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.	Northern Health will work with the Government to achieve net zero carbon by 2050. Through the Environmental Management Sustainability Committee Northern Health will determine actions for implementation to address environmental sustainability in 2016-17. Northern Health will achieve carbon reduction in 2016-2017 if it can replace its building automation systems at Broadmeadows Health Service (BHS), upgrade the system at The Northern Hospital (TNH) and replace the boiler at TNH. These three projects form part of our submission for Medical Equipment Infrastructure Renewal Program > $300,000. Northern Health has scheduled a meeting with the Department of Health and Human Services to share best practice and areas that other agencies are targeting. Northern Health is interested in increasing the amount of recycling we are doing. Northern Health has commenced a motor vehicle fleet renewal	Achieved.

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
		program as some of our motor vehicles are close to 10 years old. These will be replaced with smaller more fuel efficient vehicles. Public reporting of environmental sustainability data will continue. Northern Health will also continue existing environmental sustainability initiatives such as, continuing the replacement of regular lights with LED lights.	

Performance Priorities

QUALITY AND SAFETY

Key Performance Indicator	Target	2016-17 Actuals	Rating
Accreditation			
Compliance with NSQHS Standards accreditation	Full compliance	Achieved	✓
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Achieved	✓
Cleaning Standard Measure			
Overall compliance with standards	Full compliance	Achieved	✓
Very high risk (Category A)	90 points	Achieved	✓
High risk (Category B)	85 points	Achieved	✓
Moderate risk (Category C)	85 points	Achieved	✓
Infection Prevention and Control			
Compliance with the Hand Hygiene Australia program	80%	85%	✓
Percentage of healthcare workers immunised for influenza	75%	81.7%	✓
Patient Experience			
Victorian Healthcare Experience Survey - data submission[1]	Full compliance	Not Achieved	✗
Victorian Healthcare Experience Survey - Patient Experience Quarter 1 experience	95% positive	83 %	✗
Victorian Healthcare Experience Survey - Patient Experience Quarter 2	95% positive experience	90%	✗
Victorian Healthcare Experience Survey - Patient Experience Quarter 3	95% positive experience	81%	✗
Victorian Healthcare Experience Survey - Discharge Care Quarter 1	75% very positive response	75%	✓
Victorian Healthcare Experience Survey - Discharge Care Quarter 2	75% very positive response	80%	✓
Victorian Healthcare Experience Survey – Discharge Care Quarter 3	75% very positive response	67%	✗
Healthcare Associate Infections			
Number of patients with surgical site infection	No outliers	Not Achieved	✗
ICU central line-associated blood stream infection	No outliers	No outliers	✓
SAB rate per occupied bed days[2]	< 2/10,000	0.6/10,000	✓
Maternity and Newborn[3]			
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%	0.01%	✓
Rate of severe foetal growth restriction in singleton pregnancy undelivered by 40 weeks	≤ 28.6%	23.3%	✓
Continuing Care			
Functional independence gain from admission to discharge, relative to length of stay	≥ 0.39 (GEM) and ≥ 0.645 (rehab)	0.44 (GEM) 0.848 (rehab)	✓

GOVERNANCE AND LEADERSHIP

Key Performance Indicator	Target	2016-17 Actuals	Rating
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	79%	✓

ACCESS AND TIMELINESS

Key Performance Indicator	Target	2016-17 Actuals	Rating
Emergency care			
Percentage of ambulance patients transferred within 40 minutes	90%	88%	✗
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%	78%	✗
Percentage of emergency patients with a length of stay less than four hours	81%	63%	✗
Number of patients with a length of stay in the Emergency Department greater than 24 hours	0	0	✓
Elective surgery			
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%	88%	✗
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[4]	1,990	1,307[5]	✓
Number of hospital initiated postponements per 100 scheduled admissions	≤ 8 /100	5	✓
Number of patients admitted from the elective surgery waiting list – annual total	7,951	8,621[5]	✓
Specialist clinics			
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	71%	✗
Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days	90%	97%	✓

FINANCIAL SUSTAINABILITY

Key Performance Indicator	Target	2016-17 Actuals	Rating
Finance			
Operating result ($m)	0.1	1.6	✓
Trade creditors	60 days	54	✓
Patient fee debtors	60 days	43	✓
Public and private WIES[6] performance to target	100%	104%	✓
Adjusted current asset ratio	0.7	0.7	✓
Number of days with available cash	14 days	8.20	✗
Asset management			
Basic asset management plan	Full compliance	Partial Compliance	✗

[1]Not achieved due to data submitted after due date
[2]SAB is staphylococcus aureus bacteraemia
[3]Based on the *Victorian Perinatal Services Performance Indicator Reports*, (PSPI) Should be consulted for a description on the utility and business rules for these indicators. Note that data for 2016 and 2017 is provisional.
[4]The target shown is the number of patients on the elective surgery waiting list as at 30 June 2017.
[5]Based on interim data correct as of 22 August 2017.
[6]WIES is a Weighted Inlier Equivalent Separation.

Activity and Funding

Funding type	Activity
Acute Admitted	
WIES DVA	391
WIES Private	6,106
WIES Public	52,309
WIES TAC	282
Acute Non-Admitted	
Home Renal Dialysis	26
Home Enteral Nutrition	319
Aged Care	
HACC	6,566
Residential Aged Care	10,871
Radiotherapy Non Admitted Shared Care	188
Subacute and Non-Acute Admitted	
Transition Care - Bed days	8,350
Transition Care - Home days	14,730
Subacute WIES - GEM Private	329
Subacute WIES - GEM Public	1,897
Subacute WIES - Palliative Care Private	85
Subacute WIES - Palliative Care Public	369
Subacute WIES - Rehabilitation Private	90
Subacute WIES - Rehabilitation Public	517
Subacute WIES - DVA	68
Subacute Non-Admitted	
Health Independence Program - Public	99,516
Other	
Health Workforce	193

Northern Health's Koori Maternity Service won the Minister for Health's Award for Improving Indigenous Health - Closing the Gap at the 2016 Victorian Public Healthcare Awards

Corporate Information

GENERAL INFORMATION

Northern Health was established in July 2000 under the *Health Services (Governance and Accountability) Act 2004* and under the auspices of the Minister for Health. It provides a wide range of health care services to the northern growth corridor, a catchment of over 395,000[1] people living in Melbourne's middle to outer northern suburbs and the semi-rural regions beyond the urban fringe.

Northern Health comprises:

- Broadmeadows Health Service
- Bundoora Extended Care Centre
- Craigieburn Health Service
- Panch Health Service
- The Northern Hospital.

CONSULTANCIES

Details of consultancies (under $10,000)

In 2016-17, there were five 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 was $16,597 (excl. GST).

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

In 2016-17, there were six 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 $ 523,428 (excl. GST). Details of individual consultancies are detailed below.

Consultant	Purpose of consultancy	Period	Total project fee (excl.GST)	Consulting (excl.GST)	Commitments
BATMAN DISCRETIONARY TRUST (TRADING AS PROVIDER ASSIST)	Report on residents at Ian Brand Nursing Home	December 2016 to June 2017	$110,680	$110,680	-
ERNST and YOUNG	Consultancy on the High Reliability Organisation (HRO) Project to assess how Northern Health can address safety and quality challenges to improve patient care and organisational performance. and financial recovery planning.	November 2016 to March 2017	$171,912	$171,912	-
LIGHTFOOT SOLUTIONS AUSTRALIA	Analysis of the impact of Winter on Health Service Performance. Developing a winter resilience plan to support planning and identify areas for improvement.	April 2017 to June 2017	$45,000	$45,000	-
MKM HEALTH	ICT Strategy – Electronic Medical Records.	October 2016 to November 2016	$63,750	$63,750	-
PRICE WATERHOUSE COOPERS	Business Case for Electronic Medical Records.	October 2016 to November 2016	$102,086	$102,086	-
RIVOR	Payroll Services Review	March 2017 to April 2017	30,000	30,000	-

[1]Department of Environment, Land, Water and Planning, Victoria in Future 2016, accessible at: https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future-2016

OCCUPATIONAL HEALTH AND SAFETY CLAIMS

- 2016-17: 37
- 2015-16: 34
- 2014-15: 30
- 2013-14: 31
- 2012-13: 21
- 2011-12: 25
- 2010-11: 26

These are standard WorkCover claims, which are defined as those claims that are over the statutory employer excess and reported to the Victorian WorkCover Authority during the financial year.

OCCUPATIONAL VIOLENCE STATISTICS

- Workcover accepted claims with an occupational violence cause per 100 FTE:
  - o 0.107
- Accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked:
  - o 0.666
- Occupational violence incidents reported:
  - o 376
- Occupational violence incidents reported per 100 FTE:
  - o 13.42
- Percentage of occupational violence incidents resulting in a staff injury, illness or condition:
  - o 2.4%

Definitions

For the purposes of the above statistics the following definitions apply.

Occupational violence

Any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

Incident

Occupational health and safety incidents reported in the health service incident reporting system. Code Grey reporting is not included.

Accepted WorkCover claims

Accepted WorkCover claims that were lodged in 2016-17.

Lost time

Is defined as greater than one day.

BUILDING ACT 1993

During the financial year, it has been Northern Health's practice to obtain building permits for new projects, and certificates of occupancy or certificates of final inspection for all completed projects.

Registered building practitioners have been involved with all new building work projects and were supervised by Northern Health's Director of Capital Planning and Development.

Completed and operational as at 30 June 2017:

- Broadmeadows Health Service Surgical Centre Redevelopment
- Northern Centre for Health Education & Research, Level Three North Fitout.

Current projects in design phase:

- The Northern Hospital Tower Expansion – Stage Two.

NATIONAL COMPETITION POLICY

Services that are regularly market tested in accordance with the State Government's Competitive Neutrality Guidelines include:

- Patient Transport
- Waste Management
- Car Parking
- Fleet Management
- Supply
- Medical Imaging/Radiology
- Pathology
- Food Service
- Biomedical Engineering
- Cleaning Services
- Laundry
- Security
- Retail Services
- Financial Services
- Information and Communications Technology
- Clinical Services
- Building and Engineering Services
- Community Services
- Electricity
- Gas Supply
- Telecommunications
- Pharmaceutical

Market testing of services will continue as scheduled, and according to the contract cycle, into the 2017-18 financial year.

FREEDOM OF INFORMATION

944 Freedom of Information applications were received by Northern Health during the 2016-17 financial year.

All applications were processed according to the provisions of the *Freedom of Information Act 1982*, which provides a legally enforceable right of access to information held by government agencies.

All Northern Health campuses provide a report on these requests to the Freedom of Information Commissioner.

The applications were processed as follows:

- 772 granted in full
- 60 granted in part
- 3 denied
- 11 withdrawn
- 74 not finalised
- 24 applications with no document (patient did not attend organisation for requested dates).

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 Northern 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

Corporate Information (cont'd)

(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.

ENVIRONMENTAL PERFORMANCE

Northern Health continues to reduce its environmental impact and actively contribute to the implementation of the Victorian Government's policy to be net zero carbon by 2050. Northern Health's performance is continually monitored in accordance with its Statement of Priorities.

Northern Health continues to improve its management of waste, particularly in the area of clinical waste. The Clinical Waste audit conducted by an external authority in February 2017 demonstrated that Northern Health had improved its segregation of waste/clinical waste and sharps disposal. The audit identified the following improvement:

- Combined sharps/bulk waste (17 per cent improvement)
- Sharps (8 per cent improvement)
- Bulk (26 per cent improvement).

The audit also indicated that Northern Health had exceeded the state averages in all three areas identified above.

During the 2016-17 financial year, Northern Health has improved its recycling rate to 28 per cent. In addition, Northern Health has also reinvigorated its PVC recycling program.

Other initiatives contributing to Northern Health's continued effort to reduce its environmental impact are as follows:

- LED lighting replacement program.
- Building automation system upgrade at both The Northern Hospital and Broadmeadows Health Service. This provides the automatic centralised control of heating, ventilation and air conditioning, lighting and other systems to improve utilities usage and associated costs.
- Boiler replacement program that will assist in the reduction of natural gas consumption.
- Fleet vehicle replacement program.

VICTORIAN INDUSTRY PARTICIPATION POLICY

Northern Health complies with the intent of the *Victorian Industry Participation Policy (VIPP) Act (Vic) 2003* which is to encourage, where possible, local industry participation in the supply of goods and services to government agencies. No contracts were awarded under this policy in 2016-17.

MERIT AND EQUITY PRINCIPLES

Merit and equity principles are encompassed in all employment and diversity management activities throughout Northern Health.

CARERS AND CARE RELATIONSHIPS

Northern Health is dedicated to providing the highest quality of care in the safest possible environment for every patient.

Northern Health complies with the intent of the *Carers Recognition Act 2012* which seeks to: recognise, promote and value the role of people in care relationships; recognise the different needs of persons in care relationships; and support and recognise that care relationships bring benefits to the persons in the care relationship and to the community.

Our *Quality Account*, which will be released late this year, provides details on our services and the changes we are making to improve care and patient outcomes.

PROTECTED DISCLOSURE ACT 2012

Under the Protected Disclosure Act 2012, complaints about certain serious misconduct or corruption involving public health services in Victoria should be made directly to the Independent Broad-based Anti-corruption Commission (IBAC) in order to remain protected under the Act. Northern Health encourages individuals to make any disclosures which are protected disclosures within the meaning of the Act with IBAC.

CAR PARKING FEES

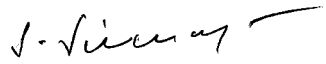
Northern Health complies with the DHHS hospital circular on car parking fees effective 1 February 2016 and details of car parking fees and concession benefits can be viewed at www.nh.org.au

SAFE PATIENT CARE ACT 2015

Northern Health complies with the intent of the *Safe Patient Care Act (Vic) 2015* which guarantees nurse to patient and midwife to patient ratios.

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

I, Siva Sivarajah certify that Northern Health has complied with Ministerial Direction 3.7.1 – Risk Management Framework and Processes. Northern Health's Audit and Risk Committee has verified this.



Siva Sivarajah
Chief Executive
Northern Health
XX/08/2017

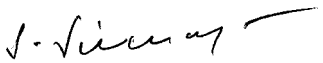
Attestation on Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

Material Non-Compliance

I, Siva Sivarajah certify that Northern Health has put in place appropriate internal controls and processes to ensure that it has complied with the requirements as 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; except for the following material non-compliance issue that have been reported to HPV.

Northern Health reports the following material non-compliance issue:

- There was one issue identified relating to HPV Collective Agreement HPVC2016-108 Biopharmaceutical -Infliximab



Siva Sivarajah
Chief Executive
Northern Health
XX/08/2017

INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE

The total ICT expenditure incurred during 2016-17 is $7.03m (excluding GST) with the details shown below.

Business As Usual (BAU) ICT Expenditure ($000)* (excluding GST)	Non-BAU ICT Expenditure ($000)	Operational Expenditure ($000)	Capital Expenditure ($000)
$5,336	$1,699	$647	$1,052

Corporate Information (cont'd)

WORKFORCE INFORMATION

The Full Time Equivalent (FTE) head count for Northern Health as at 30 June 2016 and 30 June 2017 is provided below.

Labour category	June Current Month FTE		June YTD FTE		June Headcount	
	2016	2017	2016	2017	2016	2017
Grand Total	2,699	2,954	2,609	2,802	3,715	4,020
Nursing Services	1,283	1,449	1,219	1,347	1,811	1,985
Administration and Clerical	425	450	425	435	571	598
Medical Support Services	163	164	161	164	204	207
Hotel and Allied Services	132	139	132	135	176	183
Medical Officers	61	71	57	62	69	75
Hospital Medical Officers	285	305	268	297	303	341
Sessional Medical Officers	73	83	68	76	215	241
Ancillary Support Services	278	293	278	285	366	390

FINANCIAL RESULTS

Northern Health's major financial objective is to provide the necessary resources to meet anticipated activity levels, address essential capital needs and ensure cash sustainability.

We enjoyed an operating surplus for the 2016-17 financial year (before capital and specific items) of $1.6m.

Acute inpatient activity grew by 18 per cent year on year which brought with it some productivity benefits.

We increased capital expenditure (excluding specific major DHHS funded capital projects for example the Broadmeadows expansion) from $3.6m (2015-16) to $7.5m (2016-17).

Available cash increased from 4.9 days (2015-16) to 8.2 days (2016-17), this was achieved by a combination of a strong operating result and an improvement in our working capital.

The financial results for Northern Health over the past five financial years are shown below.

Report of Operations Disclosure	2017 000's	2016 000's	2015 000's	2014 000's	2013 000's
Total Revenue	505,222	457,197	397,861	393,122	363,790
Total Expenses	494,534	452,872	416,471	385,295	356,132
Net Result (Including Capital and Specific Items)	10,688	4,325	(18,610)	7,827	7,658
Operating Result of the Parent Entity[1]	1,553	156	(8,884)	1,839	8,760
Accumulated Deficits	(42,720)	(53,408)	(57,419)	(41,511)	(48,909)
Total Assets	464,930	433,050	417,273	430,567	317,437
Total Liabilities	130,063	119,833	108,379	103,062	88,709
Net Assets	334,867	313,217	308,894	327,505	228,728
Total Equity	**334,867**	**313,217**	**308,894**	**327,505**	**228,728**

[1]The result for which Northern Health is monitored in its Statement of Priorities.

Disclosure Information

The annual report of Northern Health is prepared in accordance with all relevant Victorian legislation.

This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

MINISTERIAL DIRECTIONS

REPORT OF OPERATIONS

Legislation	Requirement	Page Ref
CHARTER AND PURPOSE		
FRD 22H	Manner of establishment and the relevant Ministers	A46
FRD 22H	Purpose, functions, powers and duties	A9 - 11
FRD 22H	Initiatives and key achievements	A21 - 24
FRD 22H	Nature and range of services provided	A16 - 20
MANAGEMENT AND STRUCTURE		
FRD 22H	Organisational structure	
FINANCIAL AND OTHER INFORMATION		
FRD 10A	Disclosure index	A51 - 52
FRD 11A	Disclosure of ex gratia expenses	F41
FRD 21C	Responsible person and executive officer disclosures	A5 and F1
FRD 22H	Application and operation of *Protected Disclosure 2012*	A49
FRD 22H	Application and operation of *Carers Recognition Act 2012*	A48
FRD 22H	Application and operation of *Freedom of Information Act 1982*	A47
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	A47
FRD 22H	Details of consultancies over $10,000	A46
FRD 22H	Details of consultancies under $10,000	A46
FRD 22H	Employment and conduct principles	A21 - 24
FRD 22H	Information and communication technology expenditure	A48
FRD 22H	Major changes or factors affecting performance	A5 and A54
FRD 22H	Occupational violence	A47
FRD 22H	Operational and budgetary objectives and performance against objectives	A26-49 and A48
FRD 24C	Reporting of office-based environmental impacts	A24 and A48
FRD 22H	Significant changes in financial position during the year	A50
FRD 22H	Statement on National Competition Policy	A47
FRD 22H	Subsequent events	F41
FRD 22H	Summary of the financial results for the year	A43 and A50
FRD 22H	Additional information available on request	A47 - 48
FRD 22H	Workforce data disclosures including a statement on the application of employment and conduct principles	A50
SD 3.7.1	Risk management framework and processes.	A49

Disclosure Information (cont'd)

Legislation	Requirement	Page Ref
FRD 25C	Victorian industry Participation Policy disclosures	A48
FRD 29B	Workforce data disclosures	A50
FRD 103F	Non-financial physical assets	F19
FRD 110A	Cash flow statements	F7
FRD 112D	Defined benefit superannuation obligations	F18
SD 5.2.3	Declaration in report of operations	A5
OTHER REQUIREMENTS UNDER STANDING DIRECTIONS 4.2		
SD 5.2.2	Declaration in financial statements	F1
SD 5.2.1(a)	Compliance with Australian accounting standards and other authoritative pronouncements	F9
SD 5.2.1(a)	Compliance with Ministerial Directions	F9
LEGISLATION		
Freedom of Information Act 1982		A47
Protected Disclosure Act 2012		A49
Carers Recognition Act 2012		A48
Victorian Industry Participation Policy Act 2003		A48
Building Act 1993		A47
Financial Management Act 1994		A5
Safe Patient Care Act 2015		A49

NORTHERN HEALTH

FINANCIAL REPORT 2016/17

Northern Health

Board Member's, Accountable Officer's and Chief Finance and Accounting Officer's declaration

We certify that the attached financial report for Northern Health, including controlled entities, has 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 Northern Health Comprehensive Operating Statement, the Balance Sheet, Statement of Changes in Equity, Cash Flow Statement and notes forming part of the financial report, presents fairly the financial transactions during the year ended 30 June 2017 and financial position of Northern Health at 30 June 2017.

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

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

Ms Jennifer Williams
Board Chair

Northern Health
24th August 2017

Mr Siva Sivarajah
Chief Executive Officer

Northern Health
24th August 2017

Mr Basil Ireland
Chief Financial Officer

Northern Health
24th August 2017

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Northern Health

Opinion

I have audited the consolidated financial report of Northern Health (the health service) and its controlled entities (together the consolidated entity), which comprises the:

- consolidated entity and health service balance sheets as at 30 June 2017
- consolidated entity and health service comprehensive operating statements for the year then ended
- consolidated entity and health service statements of changes in equity for the year then ended
- consolidated entity and health service cash flow statements for the year then ended
- notes to the financial statements, including a summary of significant accounting policies
- board member's, accountable officer's and chief finance and accounting officer's declaration.

In my opinion, the financial report presents fairly, in all material respects, the financial positions of the consolidated entity and the health service as at 30 June 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 that Act and those standards 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 and the consolidated entity in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in 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 and the consolidated entity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

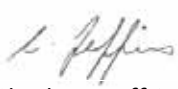
Auditor's responsibilities for the audit of the financial report

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 and the consolidated entity's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board
- conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the health service and the consolidated entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the health service and the consolidated entity to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation
- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the health service and consolidated entity to express an opinion on the financial report. I remain responsible for the direction, supervision and performance of the audit of the health service and the consolidated entity. I remain solely responsible for my audit opinion.

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



MELBOURNE
25 August 2017

Charlotte Jeffries
as delegate for the Auditor-General of Victoria

Northern Health
Comprehensive Operating Statement
For the Year Ended 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Revenue from Operating Activities	2.1	464,515	421,210	464,515	421,189
Revenue from Non-Operating Activities	2.1	6,885	7,145	7,979	8,054
Employee Expenses	3.1	(331,505)	(297,876)	(331,765)	(298,089)
Non Salary Labour Costs	3.1	(9,329)	(9,662)	(9,331)	(9,662)
Supplies and Consumables	3.1	(84,577)	(78,206)	(84,581)	(78,206)
Other Expenses	3.1	(44,436)	(42,455)	(44,651)	(42,750)
Net Result Before Capital and Specific Items		**1,553**	**156**	**2,166**	**536**
Capital Purpose Income	2.1	32,868	28,228	32,655	27,928
Depreciation and Amortisation	4.2	(23,818)	(22,924)	(23,819)	(22,924)
Specific Expenses	3.3	(163)	(803)	(163)	(803)
Finance Costs	3.4	(15)	(27)	(15)	(27)
Assets provided Free of Charge	2.2	-	11	-	11
Expenditure for Capital Purpose	3.1	(781)	(312)	(781)	(312)
Net Result after Capital and Specific items		**9,644**	**4,329**	**10,043**	**4,409**
Other economic flows included in net result					
Net Gain/(Loss) on Non-Financial Assets	7.2	47	(84)	47	(84)
Revaluation of Long Service Leave	3.1	598	-	598	-
Total Other Economic Flows Included in Net Result		**645**	**(84)**	**645**	**(84)**
NET RESULT FOR THE YEAR		**10,289**	**4,245**	**10,688**	**4,325**
Other comprehensive income					
Items that will not be reclassified to net result					
Changes in physical asset revaluation surplus	8.1	10,962	-	10,962	-
Total other comprehensive income		**10,962**	**-**	**10,962**	**-**
COMPREHENSIVE RESULT		**21,251**	**4,245**	**21,650**	**4,325**

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

Northern Health
Balance Sheet
As at 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Current Assets					
Cash and Cash Equivalents	6.2	34,253	18,988	35,156	19,660
Receivables	5.1	12,099	9,473	12,099	9,473
Inventories	5.2	2,489	2,373	2,489	2,373
Prepayments and Other Assets	5.4	1,399	1,465	1,402	1,465
Total Current Assets		**50,240**	**32,299**	**51,146**	**32,971**
Non-Current Assets					
Receivables	5.1	11,130	7,417	11,130	7,417
Property, Plant and Equipment	4.1	402,223	392,286	402,223	392,286
Intangible Assets	4.3	431	376	431	376
Total Non-Current Assets		**413,784**	**400,079**	**413,784**	**400,079**
TOTAL ASSETS		**464,024**	**432,378**	**464,930**	**433,050**
Current Liabilities					
Payables	5.5	24,884	25,643	24,847	25,771
Borrowings	6.1	181	281	181	281
Provisions	3.5	77,256	66,932	77,256	66,932
Other Current Liabilities	5.3	2,358	1,748	2,358	1,748
Total Current Liabilities		**104,679**	**94,604**	**104,642**	**94,732**
Non-Current Liabilities					
Provisions	3.5	11,754	10,368	11,754	10,368
Borrowings	6.1	-	181	-	181
Other Non-Current Liabilities	5.3	13,667	14,552	13,667	14,552
Total Non-Current Liabilities		**25,421**	**25,101**	**25,421**	**25,101**
TOTAL LIABILITIES		**130,100**	**119,705**	**130,063**	**119,833**
NET ASSETS		**333,924**	**312,673**	**334,867**	**313,217**
EQUITY					
Property, Plant and Equipment Revaluation Surplus	8.1a	211,108	200,146	211,108	200,146
Restricted Specific Purpose Surplus	8.1b	243	243	5,073	4,845
Contributed Capital	8.1c	161,634	161,634	161,634	161,634
Accumulated Deficits	8.1d	(39,061)	(49,350)	(42,948)	(53,408)
TOTAL EQUITY		**333,924**	**312,673**	**334,867**	**313,217**
Commitments	6.3				
Contingent Assets and Contingent Liabilities	7.3				

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

Northern Health
Statement of Changes in Equity
For the Year Ended 30 June 2017

Consolidated	Note	Property Plant and Equipment Revaluation Surplus	Restricted Specific Purpose Surplus	Contributions by Owners	Accumulated Surplus/ (Deficits)	Total
		$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2015		200,146	4,532	161,634	(57,420)	**308,892**
Net result for the year		-	-	-	4,325	**4,325**
Other comprehensive income for the year		-	-	-	-	**-**
Transfers to accumulated surplus/ (deficit)	8.1b, 8.1d	-	313	-	(313)	**-**
Balance at 1 July 2016		**200,146**	**4,845**	**161,634**	**(53,408)**	**313,217**
Net result for the year		-	-	-	10,688	**10,688**
Other comprehensive income for the year		10,962	-	-	-	**10,962**
Transfers to accumulated surplus/ (deficit)	8.1b, 8.1d	-	228	-	(228)	**-**
		10,962	**228**	**-**	**10,460**	**21,650**
Balance at 30 June 2017		**211,108**	**5,073**	**161,634**	**(42,948)**	**334,867**

Parent	Note	Property Plant and Equipment Revaluation Surplus	Restricted Specific Purpose Surplus	Contributions by Owners	Accumulated Surplus/ (Deficits)	Total
		$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2015		200,146	329	161,634	(53,682)	**308,427**
Net result for the year		-	-	-	4,246	**4,246**
Other comprehensive income for the year		-	-	-	-	**-**
Transfers to accumulated surplus/ (deficit)	8.1a, 8.1c	-	(86)	-	86	**-**
Balance at 1 July 2016		**200,146**	**243**	**161,634**	**(49,350)**	**312,673**
Net result for the year		-	-	-	10,289	**10,289**
Other comprehensive income for the year		10,962	-	-	-	**10,962**
Transfers to accumulated surplus/ (deficit)	8.1a, 8.1c	-	19	-	(19)	**-**
		10,962	**19**	**-**	**10,270**	**21,251**
Balance at 30 June 2017		**211,108**	**262**	**161,634**	**(39,080)**	**333,924**

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

Northern Health
Cash Flow Statement
For the Year Ended 30 June 2017

	Note	Parent Entity 2017 $'000	Parent Entity 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating Grants from Government		423,598	382,427	423,598	382,427
Capital Grants from Government		27,897	29,379	27,897	29,379
Patient and Resident Fees Received		19,042	16,792	19,042	16,792
Private Practice Fees Received		3,013	3,597	3,013	3,597
Donations and Bequests Received		416	-	1,235	744
GST Received from/(paid to) ATO		9,060	9,548	9,065	9,551
Recoupment from private practice for use of hospital facilities		2,117	2,375	2,117	2,377
Interest Received		1,062	902	1,075	918
Other Receipts		17,661	15,649	17,875	15,837
Total Receipts		**503,866**	**460,669**	**504,917**	**461,622**
Employee Expenses Paid		(319,112)	(282,937)	(319,372)	(283,150)
Non Salary Labour Costs		(9,183)	(9,662)	(9,183)	(9,662)
Payments for Supplies and Consumables		(92,964)	(82,384)	(93,127)	(82,427)
Finance Costs		(14)	(27)	(14)	(27)
Other Payments		(45,304)	(50,681)	(45,701)	(51,324)
Total Payments		**(466,577)**	**(425,691)**	**(467,397)**	**(426,590)**
NET CASH INFLOW FROM OPERATING ACTIVITIES	8.2	**37,289**	**34,978**	**37,520**	**35,032**
CASH FLOWS FROM INVESTING ACTIVITIES					
Payments for Non-Financial Assets		(22,278)	(23,138)	(22,278)	(23,138)
Proceeds from sale of Non-Financial Assets		73	14	73	14
NET CASH OUTFLOW FROM INVESTING ACTIVITIES		**(22,205)**	**(23,124)**	**(22,205)**	**(23,124)**
CASH FLOWS FROM FINANCING ACTIVITIES					
Repayment of Borrowings		(280)	(310)	(280)	(310)
NET CASH OUTFLOW FROM FINANCING ACTIVITIES		**(280)**	**(310)**	**(280)**	**(310)**
NET INCREASE IN CASH AND CASH EQUIVALENTS		**14,804**	**11,544**	**15,035**	**11,598**
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		**18,981**	**7,437**	**19,653**	**8,055**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR (Excludes Patients Money Held In Trust)	6.2	**33,785**	**18,981**	**34,688**	**19,653**

This Statement should be read in conjunction with the accompanying notes

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Content

The notes to the financial statements shall:

a) present information about the basis of preparation of the financial statements and the specific accounting policies used in accordance with paragraphs 112-124 of AASB 101 *Presentation of Financial Statements* ;

b) disclose the information required by AASBs that is not presented on the face of the balance sheet, comprehensive operating statement, statement of changes in equity or cash flow statement; and

c) provide additional information that is not presented on the face of the balance sheet, comprehensive operating statement, statement of changes in equity or cash flow statement, but is relevant to an understanding of any of them.

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,* contributed capital and its repayment are treated as equity transactions and, therefore, do not form part of the income and expenses of the Northern Health Service (Northern Health).

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

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

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 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 Northern Health for the period ending 30 June 2017. The purpose of the report is to provide users with information about Northern Health's stewardship of the resources entrusted to it.

(a) Statement of compliance

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

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

Northern Health is a not-for profit entity and therefore applies the additional Aus paragraphs applicable to "not-for-profit" Health Services under the AASs.

The annual financial statements were authorised for issue by the Board of Northern Health on 24th August 2017.

(b) Reporting entity

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

Its principal address is:
185 Cooper Street
Epping
Victoria 3076.

A description of the nature of Northern Health's operations and its principal activities is included in the report of operations which are separate to these financial statements.

Objectives and funding

Northern Health's overall objective is to provide highly reliable health care to the community, and improve the quality of life for Victorians.

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

Note 1: Summary of Significant Accounting Policies (cont)

(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 Northern Health.

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; and
- 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 values of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

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

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 4.1);
- superannuation expense (refer to Note 3.6); and
- 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* , Northern Health determines the policies and procedures for both recurring fair value measurements such as property, plant and equipment, and financial instruments, and for non-recurring fair value measurements such as non-financial physical assets held for sale, in accordance with the requirements of AASB 13 and the relevant FRDs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, described as follows, 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.

For the purpose of fair value disclosures, Northern Health has determined classes of assets and liability 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, Northern 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 Northern Health's independent valuation agency.

Northern 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.

(d) Principles of consolidation

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

- the consolidated financial statements of Northern Health incorporate the assets and liabilities of all entities controlled by Northern Health as at 30 June 2017, and their income and expenses for that part of the reporting period in which control existed; and
- the consolidated financial statements exclude bodies of Northern Health that are not controlled by Northern Health and therefore are not consolidated.
- control exists when Northern Health has the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable are taken into account. The consolidated financial statements include the audited financial statements of the controlled entities listed in Note 8.12.
- the parent entity is not shown seperately in the notes.

Note 1: Summary of Significant Accounting Policies (cont)

(d) Principles of consolidation (cont)

Where control of an entity is obtained during the financial period, it's results are included in the comprehensive operating statement from the date on which control commenced. Where control ceases during the financial period, the entity's results are included for that part of the period in which control existed. Where dissimilar accounting policies are adopted by entities and their effect is considered material, adjustments are made to ensure consistent policies are adopted in these financial statements.

Bodies consolidated into the Northern Health reporting entity are:

- the Northern Health Research, Training and Equipment Trust; and
- the Health Research, Training and Equipment Foundation Limited.

Intersegment Transactions

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

(e) Scope and presentation of financial statements

Fund Accounting

Northern Health records its funds into one of three types: Operating, Specific Purpose and Capital Funds. Northern Health's Capital and Specific Purpose Funds include unspent capital donations and receipts from fund-raising activities conducted solely in respect of these funds.

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

Activities classified as *Services Supported by Health Services Agreement* (HSA) are substantially funded by the Department of Health and Human Services (DHHS). They include Residential Aged Care Services (RACS) and funding from other sources such as the Commonwealth, patients and residents under the National Healthcare Agreement. *Services Supported by Hospital and Community Initiatives* (H&CI) are funded by the Health Service's own activities or local initiatives and/or the Commonwealth, outside of the National Healthcare Agreement.

Residential Aged Care Service

The Northern Health *Residential Aged Care Service* operations are an integral part of Northern Health and shares its resources. An apportionment of land and buildings has been made based on floor space. The results of the two operations have been segregated based on actual revenue earned and expenditure incurred by each operation in Note 2 and 3 to the financial statements.

Comprehensive operating statement

The comprehensive operating statement includes the subtotal entitled 'Net Result Before Capital & Specific items' to enhance the understanding of the financial performance of Northern Health. This subtotal excludes items outside of day-today operating activities such as capital grants, assets received or provided free of charge, depreciation, expenditure using capital purpose income and items of an unusual nature and amounts such as specific income and expenses. The exclusion of these items is made to enhance matching of income and expenses so as to facilitate the comparability and consistency of results between years and Victorian Public Health Services. The 'net result before capital & specific items' is used by the management of Northern Health, DHHS and the Victorian Government to measure the ongoing operating performance of Health Services.

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

- capital purpose income, which comprises all tied grants, donations and bequests received for the purpose of acquiring non-current assets, such as capital works, plant and equipment or intangible assets. It also includes donations of plant and equipment (refer Note 2.2). Consequently, the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.
- specific income/expense comprises the following items, where material:
  - non-current asset revaluation increments/ decrements;
  - restructuring of operations;
- impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses);
- depreciation and amortisation, as described in Note 4.2;
- assets provided or received free of charge; and
- expenditure using capital purpose income, comprises expenditure which either falls below the asset capitalisation threshold or doesn't meet asset recognition criteria and therefore does not result in the recognition of an asset in the balance sheet, where funding for that expenditure is from capital purpose income.

Other economic flows are changes arising from market remeasurements. They include:

- gains and losses from disposals of non-financial assets;
- revaluations and impairments of non-financial physical and intangible assets;
- remeasurement arising from defined benefit superannuation plans: and
- fair value changes in financial instruments.

Note 1: Summary of Significant Accounting Policies (cont)

Balance sheet

Assets and liabilities are categorised either as current or non-current. Non-current assets or liabilities are those expected to be recovered/settled more than 12 months after the reporting period. Details are disclosed in the notes where relevant.

The net result is equivalent to profit or loss derived in accordance with AASs.

Statement of changes in equity

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

Cash flow statement

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

For the cash flow statement presentation purposes, cash and cash equivalents includes short-term deposits.

Rounding

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

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

Comparative information

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

Note 2: Funding delivery of our services

Northern Health's overall objective is to provide outstanding health care to the community, and improve the quality of life for Victorians.

Northern Health predominately receives income based on parliamentary appropriations to enable it to fulfil its objectives as well as 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 Consolidated Revenue by Source

2017

	Admitted Patients 2017 $'000	Non Admitted Patients 2017 $'000	Emergency Department Services 2017 $'000	Residential Aged Care Services 2017 $'000	Aged Care 2017 $'000	Other 2017 $'000	Total Consol'd 2017 $'000
Government Grants	367,880	31,642	13,482	2,885	11,864	-	427,753
Indirect contributions by DHHS*	3,973	-	-	-	-	-	3,973
Patient and Resident Fees	16,790	86	1,027	609	275	-	18,787
Commercial Activities	3	61	-	-	-	10,222	10,286
Other Revenue from Operating Activities**	2,474	512	599	63	68	-	3,716
Total Revenue from Operating Activities	**391,120**	**32,301**	**15,108**	**3,557**	**12,207**	**10,222**	**464,515**
Interest	745	-	-	-	-	35	780
Other Revenue from Non-Operating Activities	-	-	-	-	-	7,199	7,199
Total Revenue from Non-Operating Activities	**745**	**-**	**-**	**-**	**-**	**7,234**	**7,979**
Capital Purpose Income (excluding interest)	-	-	-	147	-	2,812	2,959
Capital Interest	-	-	-	-	-	295	295
Government Grants	-	-	-	-	-	29,401	29,401
Total Capital Purpose Income	**-**	**-**	**-**	**147**	**-**	**32,508**	**32,655**
Proceeds from Disposals of Non-Current Assets	-	-	-	-	-	73	73
Total Revenue	**391,865**	**32,301**	**15,108**	**3,704**	**12,207**	**50,037**	**505,222**

2016

	Admitted Patients 2016 $'000	Non Admitted Patients 2016 $'000	Emergency Department Services 2016 $'000	Residential Aged Care Services 2016 $'000	Aged Care 2016 $'000	Other 2016 $'000	Total Consol'd 2016 $'000
Government Grants	311,072	29,641	29,401	2,511	10,532	-	383,157
Indirect contributions by DHHS*	6,739	-	-	-	-	-	6,739
Patient and Resident Fees	15,313	131	4	574	92	-	16,113
Commercial Activities	-	-	-	-	-	10,757	10,757
Other Revenue from Operating Activities**	3,953	123	276	28	43	-	4,423
Total Revenue from Operating Activities	**337,077**	**29,895**	**29,680**	**3,114**	**10,667**	**10,757**	**421,189**
Interest	576	-	-	-	-	57	633
Other Revenue from Non-Operating Activities	-	-	-	-	-	7,421	7,421
Total Revenue from Non-Operating Activities	**576**	**-**	**-**	**-**	**-**	**7,478**	**8,054**
Capital Purpose Income (excluding interest)	-	-	-	196	-	1,748	1,944
Capital Interest	-	-	-	-	-	285	285
Government Grants	-	-	-	-	-	25,699	25,699
Total Capital Purpose Income	**-**	**-**	**-**	**196**	**-**	**27,732**	**27,928**
Proceeds from Disposals of Non-Current Assets	-	-	-	-	-	14	14
Total Revenue	**337,653**	**29,895**	**29,680**	**3,310**	**10,667**	**45,981**	**457,185**

* Indirect contributions comprise Insurance payments made by DHHS on behalf of Northern Health (known as Indirect Contributions). These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses. Indirect contributions also comprise DHHS Long Service Leave (LSL) revenue. During 2015-16 Northern Health transitioned to the DHHS Long Service Leave (LSL) model, which resulted in a $4.8 million revaluation of the present value of the LSL liability. The increase in the LSL expense is largely offset by an equivalent increase in DHHS Long Service Leave revenue.

** Northern Health allocates Other Revenue from Operating Activities which is supported by the Health Services Agreement across the clinical categories based on their proportionate share of salary and wages expenses.

Category groups

Northern 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.

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 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.

Residential Aged Care referred to in the past as psychogeriatric residential services, comprises those Commonwealth-licensed residential aged care services.

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

Note 2.2: Assets received free of charge or for nominal consideration

	Consol'd 2017 $'000	Consol'd 2016 $'000
During the reporting period fair value of assets received free of charge was as follows:		
Medical Equipment	-	11
Total	**-**	**11**

Note 3: The Cost of delivering services

This section provides an account of the expenses incurred by the health service in delivering services and outputs. In Note 2, the funds that enable the provision of services were disclosed whilst in this note, the cost associated with the 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

2017

	Admitted Patients 2017 $'000	Non Admitted Patients 2017 $'000	Emergency Department Services 2017 $'000	Residential Aged Care Services 2017 $'000	Aged Care 2017 $'000	Other 2017 $'000***	Total Consol'd 2017 $'000
Employee Expenses	260,790	16,875	43,428	4,191	6,443	38	331,765
Other Operating Expenses							
Non Salary Labour Costs	7,416	285	1,063	83	20	463	9,331
Supplies and Consumables	60,013	2,454	13,738	502	3,091	4,782	84,581
Other Expenses from Continuing Operations*	28,317	1,096	3,199	693	813	10,532	44,651
Total Expenditure from Operating Activities	**356,537**	**20,711**	**61,429**	**5,469**	**10,368**	**15,815**	**470,328**
Finance Costs (refer Note 3.4)	-	-	-	-	-	15	15
Other Non-Operating Expenses							
Specific Expenses (refer to Note 3.3)	-	-	-	-	-	163	163
Expenditure for Capital Purposes	-	-	-	-	-	781	781
Written Down Value of Assets Sold (refer Note 7.2)	-	-	-	-	-	26	26
Depreciation and Amortisation (refer Note 4.2)	-	-	-	24	-	23,795	23,819
Revaluation of Long Service Leave	-	-	-	-	-	(598)	(598)
Total Other Expenses	**-**	**-**	**-**	**24**	**-**	**24,182**	**24,206**
Total Expenses	**356,537**	**20,711**	**61,429**	**5,493**	**10,368**	**39,998**	**494,534**

2016

	Admitted Patients 2016 $'000	Non Admitted Patients 2016 $'000	Emergency Department Services 2016 $'000	Residential Aged Care Services 2016 $'000	Aged Care 2016 $'000	Other 2016 $'000***	Total Consol'd 2016 $'000
Employee Expenses **	226,947	16,911	38,515	3,941	5,968	5,808	298,089
Other Operating Expenses							
Non Salary Labour Costs excl. Consulting	7,995	351	1,061	86	36	133	9,662
Supplies and Consumables	58,255	2,609	13,462	537	2,742	601	78,206
Other Expenses from Continuing Operations *	31,088	1,601	3,827	713	1,001	4,520	42,750
Total Expenditure from Operating Activities	**324,285**	**21,471**	**56,865**	**5,277**	**9,748**	**11,062**	**428,707**
Finance Costs (refer Note 3.4)	-	-	-	-	-	27	27
Other Non-Operating Expenses							
Specific Expenses (refer to Note 3.3)	-	-	-	-	-	803	803
Expenditure for Capital Purposes	-	-	-	-	-	312	312
Written Down Value of Assets Sold (refer Note 7.2)	-	-	-	-	-	98	98
Depreciation and Amortisation (refer Note 4.2)	-	-	-	26	-	22,899	22,925
Total Other Expenses	**-**	**-**	**-**	**26**	**-**	**24,139**	**24,165**
Total Expenses	**324,285**	**21,471**	**56,865**	**5,303**	**9,748**	**35,201**	**452,872**

* Northern Health allocates Other Expenses from Continuing Operations supported by the Health Services Agreement across the clinical categories based on their proportionate share of salary and wages expenses.

** During 2015-16 Northern Health transitioned to the DHHS LSL model, which resulted in a $4.8 million revaluation of the present value of the LSL liability. The increase in the LSL expense is largely offset by an equivalent increase in DHHS LSL revenue (refer Note 2.1).

***Refer to Note 3.2 for further details of the "Other" expenses.

Expenses from transactions

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.

Note 3.1: Analysis of Expenses by Source (Continued)

Expenses from transactions (cont)

Employee expenses

Employee expenses include:

- wages and salaries;
- annual leave;
- sick leave;
- long service leave; and
- superannuation expenses which are reported differently depending upon whether employees are members of defined benefit or defined contribution plans.

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

Refer to Note 5.1 Receivables.

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 included in net result

Other economic flows are changes in 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 value 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. Refer to Note 5.1 Receivables.

Revaluations of financial instrument at fair value

Refer to Note 7.1 Financial instruments.

Other gains/ (losses) from other comprehensive income

Other gains/ (losses) include:

- transfer of amounts from the reserves to accumulated surplus or net result due to disposal, derecognition or reclassification; and
- the revaluation of the present value of the long service leave liability due to bond rate movements, inflation rate movements and the impact of change in probability factors.

Note 3.2: Analysis of Expenses and Revenue by Internally Managed and Restricted Specific Purpose Funds

	Expense		Revenue	
	Consol'd 2017 $'000	Consol'd 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Commercial Activities				
Private Practice and other patient activities	2,280	2,783	2,809	3,603
Car Park	354	262	3,395	2,950
Property Expenses	4,290	4,618	5,792	5,831
Northern Health Foundation	1,028	510	1,239	909
Salary Packaging	330	336	2,112	1,958
Allied Health and Rehabilitation Supply Store	327	767	312	988
Other Activities				
Fundraising and Community Support	4	-	-	-
Research and Scholarship	1,252	1,223	1,346	1,385
Special and Restricted Purpose Funds	667	563	451	611
TOTAL	**10,532**	**11,062**	**17,456**	**18,235**

Note 3.3: Specific Expenses

	Consol'd 2017 $'000	Consol'd 2016 $'000
Specific Expenses		
Costs Associated with Restructure (Disaggregation/Aggregation)	163	803
Total Specific Expenses	**163**	**803**

Note 3.4: Finance Costs

	Consol'd 2017 $'000	Consol'd 2016 $'000
Interest on Long Term Borrowings	15	27
Total Finance Costs	**15**	**27**

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

Finance costs for Northern Health include:

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

Note 3.5: Employee benefits in the balance sheet

	Consol'd 2017 $'000	Consol'd 2016 $'000
Current Provisions		
Employee Benefits (i)		
Annual Leave		
- Unconditional and expected to be settled within 12 months (ii)	20,793	18,637
- Unconditional and expected to be settled after 12 months (iii)	3,429	3,078
Long Service Leave		
- Unconditional and expected to be settled within 12 months (ii)	5,503	3,966
- Unconditional and expected to be settled after 12 months (iii)	29,064	26,784
Accrued Salaries and Wages	12,210	9,039
	70,999	**61,505**
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (nominal value) (ii)	2,735	2,297
- Unconditional and expected to be settled after 12 months (present value) (iii)	3,522	3,130
	6,257	**5,428**
Total Current Provisions	**77,256**	**66,932**
Non-Current Provisions		
Employee Benefits (i)	10,605	9,384
Provisions related to employee benefit on-costs	1,149	984
Total Non-Current Provisions	**11,754**	**10,368**
TOTAL PROVISIONS	**89,010**	**77,300**

(a) Employee Benefits and Related On-Costs

Current Employee Benefits and Related On-costs		
Unconditional LSL Entitlement	38,232	33,976
Annual leave entitlements	26,814	23,917
Accrued Salaries and Wages	11,250	8,601
Accrued Days Off	960	441
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave entitlements (present value)	11,754	10,368
Total Employee Benefits and Related On-Costs	**89,010**	**77,303**

(i) Provisions for employee benefits consist of amounts for Annual Leave and Long Service Leave accrued by employees, excluding on-costs.

(ii) The amounts disclosed are nominal amounts.

(iii) The amounts are discounted to present values.

(b) Movements in provisions

	Consol'd 2017 $'000	Consol'd 2016 $'000
Movement in Long Service Leave (Current and Non-Current):		
Balance at start of year	**44,343**	**36,231**
Provision made during the year:		
- Revaluations	(598)	5,861
- Expense recognising employee service	10,270	6,462
Settlement made during the year	(4,028)	(4,211)
Balance at end of year	**49,987**	**44,343**

Provisions

Provisions are recognised when Northern Health has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.
The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation. Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

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

Employee benefits

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, annual leave and accrued days off 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 accrued days off 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.

Note 3.5: Provisions (Continued)

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 Northern Health does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- undiscounted value – if Northern Health expects to wholly settle within 12 months; and
- present value – if Northern Health does not expect to wholly settle 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 an other economic flow.

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.

Northern Health recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

On-costs related to employee expense

Provisions for on-costs, such as worker's compensation and superannuation are recognised together with provisions for employee benefits.

Note 3.6: Superannuation

	Paid Contribution for the year		Contribution Outstanding at	
	Consol'd 2017 $'000	Consol'd 2016 $'000	Consol'd 2017 $'000	Consol'd 2016 $'000
Defined benefit plans (i):				
First State Super (formerly Health Super)	232	288	18	22
Defined contribution plans:				
First State Super (formerly Health Super)	13,361	12,796	1,517	1,352
HESTA	8,392	7,194	1,026	817
Other	688	420	88	27
	22,673	**20,697**	**2,649**	**2,218**

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

Employees of Northern Health are entitled to receive superannuation benefits and Northern 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.

Northern Health does not recognise any unfunded defined benefit liability in respect of the superannuation plans 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 and Finance administers and discloses the State's defined benefit liabilities in its financial report.

However, superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of Northern Health. The name, details and amounts expensed in relation to the major employee superannuation funds and contributions made by Northern Health 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 Northern Health to the superannuation plans in respect of the services of current 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 Northern Health are entitled to receive superannuation benefits and Northern 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 Northern Health are disclosed above.

- *Superannuation liabilities*

Northern Health does not recognise any unfunded defined benefit liability in respect of the superannuation plans 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.

Note 4: Key assets to support service delivery

Northern Health controls infrastructure and other investments that are utilised in delivering services and outputs. They represent the key resources that have been entrusted to Northern Health 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 and Equipment

(a) Gross carrying amount and accumulated depreciation

	Consol'd 2017 $'000	Consol'd 2016 $'000
Land		
Land at Fair Value	58,310	47,348
Total Land	**58,310**	**47,348**
Buildings at cost	95,289	81,727
Less Accumulated Depreciation	5,551	2,967
Buildings at Fair Value	277,806	277,806
Less Accumulated Depreciation	47,964	32,064
Total Buildings	**319,580**	**324,502**
Assets under Construction		
Assets under construction at cost	2,317	725
Total Assets Under Construction	**2,317**	**725**
Medical Equipment at Fair Value	39,670	34,234
Less Accumulated Depreciation	22,784	19,934
Total Medical Equipment	**16,886**	**14,300**
Plant and Equipment		
Plant and Equipment at Fair Value	15,868	15,033
Less Accumulated Depreciation	11,205	10,090
Total Plant and Equipment	**4,663**	**4,943**
Cultural Assets		
Cultural Assets at valuation	468	468
Total Artworks	**468**	**468**
TOTAL	**402,223**	**392,286**

Note 4.1: Property, Plant and Equipment (continued)

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

	Land $'000	Buildings $'000	Assets Under Construction $'000	Medical Equipment $'000	Plant and Equipment $'000	Cultural Assets $'000	Total $'000
Balance at 1 July 2015	**47,348**	**310,783**	**11,352**	**16,340**	**5,636**	**468**	**391,927**
Additions	-	20,224	725	1,075	970	-	22,994
Disposals	-	-	-	(54)	(44)	-	(98)
Net Transfers between classes	-	11,301	(11,353)	9	43	-	-
Depreciation (Note 4.2)	-	(17,806)	-	(3,070)	(1,661)	-	(22,536)
Restated Balance at 1 July 2016	**47,348**	**324,502**	**725**	**14,300**	**4,943**	**468**	**392,286**
Additions	-	13,066	2,267	5,868	1,381	-	22,582
Disposals	-	-	-	(19)	(7)	-	(26)
Revaluation Increments/(Decrements)	10,962	-	-	-	-	-	10,962
Net Transfers between classes	-	496	(675)	58	121	-	-
Depreciation (Note 4.2)	-	(18,485)	-	(3,321)	(1,775)	-	(23,581)
Balance at 30 June 2017	**58,310**	**319,579**	**2,317**	**16,886**	**4,663**	**468**	**402,223**

Land and buildings carried at valuation

An independent valuation of Northern Health's property, was performed by *the Valuer-General Victoria (VGV)* to determine the fair value of the land and buildings. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the independent valuation is 30 June 2014.

Northern Health has undertaken a managerial revaluation of Land in accordance with FRD103F Non-Financial Physical Asset. The managerial revaluation was approved by DHHS in June 2017.

(c) Fair value measurement hierarchy for assets as at 30 June 2017

2017

	Carrying amount as at 30 June 2017	Fair value measurement at end of reporting period using:		
		Level 1 [1]	Level 2 [1]	Level 3 [1]
Non-specialised land	1,538	-	1,538	-
Specialised land	56,772	-	-	56,772
Total of land at fair value	58,310	-	1,538	56,772
Buildings at fair value				
Non-specialised	89,738	-	89,738	-
Specialised buildings	229,842	-	-	229,842
Total of building at fair value	319,580	-	89,738	229,842
Assets under construction at fair value				
Assets under construction	2,317	-	-	2,317
Total assets under construction at fair value	2,317	-	-	2,317
Medical equipment at fair value				
Medical equipment at fair value	16,886	-	-	16,886
Total Medical equipment at fair value	16,886	-	-	16,886
Plant and Non Medical equipment at fair value				
Non Medical equipment and vehicles at fair value - Plant and Equipment	4,663	-	-	4,663
Total of plant, equipment and vehicles at fair value	4,663	-	-	4,663
Cultural Assets at fair value				
Artworks	468	-	468	-
Total Cultural Assets at fair value	468	-	468	-
	402,223	**-**	**91,743**	**310,480**

[i] Classified in accordance with the fair value hierarchy.

There have been no transfers between levels during the period.

Note 4.1: Property, Plant and Equipment (continued)

(c) Fair value measurement hierarchy for assets as at 30 June 2016 (continued)

2016	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using: Level 1 [1]	Level 2 [1]	Level 3 [1]
Non-specialised land	1,538	-	1,538	-
Specialised land	45,810	-	-	45,810
Total of land at fair value	47,348	-	1,538	45,810
Buildings at fair value				
Non-specialised buildings	78,760	-	78,760	-
Specialised buildings	245,742	-		245,742
Total of building at fair value	324,502	-	78,760	245,742
Assets under construction at fair value				
Assets under construction	725	-	-	725
Total assets under construction at fair value	725	-	-	725
Medical equipment at fair value				
Medical equipment at fair value	14,300	-	-	14,300
Total Medical equipment at fair value	14,300	-	-	14,300
Plant and Equipment	4,943	-	-	4,943
Total of Plant and Equipment at fair value	4,943	-	-	4,943
Cultural Assets at fair value				
Artworks	468	-	468	-
Total Cultural Assets at fair value	468	-	468	-
	392,286	**-**	**80,766**	**311,520**

[(i)] Classified in accordance with the fair value hierarchy.

There have been no transfers between levels during the period.

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

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 7.4);
- superannuation expense (refer to Note 3.6); and
- 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* , Northern Health determines the policies and procedures for both recurring fair value measurements such as property, plant and equipment, and financial instruments, and for non-recurring fair value measurements such as non-financial physical assets held for sale, in accordance with the requirements of AASB 13 and the relevant FRDs.

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, described as follows, 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.

For the purpose of fair value disclosures, Northern Health has determined classes of assets and liability 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, Northern 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 VGV is Northern Health's independent valuation agency.

Northern 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.

Fair value measurement

Fair value is the price that would be received upon the sale of 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:

- that 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 Northern Health at the measurement date;
- that Northern Health 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.

Note 4.1: Property, Plant and Equipment (continued)

(d) Reconciliation of Level 3 fair value

30 June 2017	Land	Buildings	Medical equipment	Plant and Equipment	Assets under construction	Total
Opening Balance	**45,810**	**245,742**	**14,300**	**4,943**	**725**	**311,520**
Purchases / (Disposals)	-	-	5,907	1,495	1,592	8,994
Transfers In / (Out) of Level 3	-	-	-	-	-	-
- Depreciation	-	(15,900)	(3,321)	(1,775)	-	(20,996)
Subtotal	**45,810**	**229,842**	**16,886**	**4,663**	**2,317**	**299,518**
Items recognised in other comprehensive income						
- Revaluation	10,962	-	-	-	-	10,962
Subtotal	**10,962**	**-**	**-**	**-**	**-**	**10,962**
Closing Balance	**56,772**	**229,842**	**16,886**	**4,663**	**2,317**	**310,480**

30 June 2016	Land	Buildings	Medical equipment	Plant and Equipment	Assets under construction	Total
Opening Balance	**45,810**	**261,774**	**16,340**	**5,636**	**11,352**	**340,912**
Purchases / (Disposals)	-	-	1,030	969	(10,627)	(8,628)
Transfers In / (Out) of Level 3	-	-	-	-	-	-
- Depreciation	-	(16,032)	(3,070)	(1,662)	-	(20,764)
Subtotal	**45,810**	**245,742**	**14,300**	**4,943**	**725**	**311,520**
Items recognised in other comprehensive income						
- Revaluation	-	-	-	-	-	-
Subtotal	-	-	-	-	-	-
Closing Balance	**45,810**	**245,742**	**14,300**	**4,943**	**725**	**311,520**

There have been no transfers between levels during the period.

Identifying unobservable inputs (level 3) fair value measurements

Level 3 fair value inputs are unobservable valuation inputs for an asset or liability. These inputs require significant judgement and assumptions in deriving fair value for both financial and non-financial assets.

Unobservable inputs shall be used to measure fair value to the extent that relevant observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date. However, the fair value measurement objective remains the same, i.e., an exit price at the measurement date from the perspective of a market participant that holds the asset or owes the liability. Therefore, unobservable inputs shall reflect the assumptions that market participants would use when pricing the asset or liability, including assumptions about risk.

Non-specialised land, non-specialised buildings and artwork

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, an independent valuation was performed by the Valuer-General Victoria 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.

For artwork, valuation of the assets is determined by a comparison to similar examples of the artist's work in existence throughout Australia and research on price paid for similar examples offered at auction or through art galleries in recent years.

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.

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

An independent valuation of Northern Health'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

Northern Health acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by 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 and Medical Equipment

Plant and Equipment and Medical equipment is held at carrying value (depreciated cost). When the 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 value.

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

There have been no transfers between levels during the period.

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

Note 4.1: Property, Plant and Equipment (continued)

(e) Description of significant unobservable inputs to Level 3 valuations:

	Valuation technique	Significant unobservable inputs (i)
Specialised land	Market approach	Community Service Obligation (CSO) adjustment
Non - specialised land	Market approach	N/A
Specialised buildings	Depreciated replacement cost	Direct cost per square metre Useful life of specialised buildings
Plant and non medical equipment at fair value	Depreciated replacement cost	Cost per unit Useful life of PPE
Medical equipment at fair value	Depreciated replacement cost	Cost per unit Useful life of medical equipment

(i) CSO adjustments ranging from 10% to 25% were applied to reduce the market approach value for Northern Health's specialised land, with the weighted average 19% reduction applied.
The significant unobservable inputs have remained unchanged from 2016.

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.
The initial cost for non-financial physical assets under finance lease is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

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

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

Restrictive nature of cultural and heritage assets, Crown land and infrastructure assets
During the reporting period, Northern Health also holds cultural assets, heritage assets, and other non-financial physical assets (including crown land and infrastructure assets) that it intends to preserve because of their unique historical, cultural or environmental attributes.
In general, the fair value of those assets is measured at the depreciated replacement cost. However, the cost of some heritage and iconic assets may be the reproduction cost rather than the replacement cost if those assets' service potential could only be replaced by reproducing them with the same materials. In addition, as there are limitations and restrictions imposed on those assets use and/or disposal, they may impact the fair value of those assets, and should be taken into account when the fair value is determined.

Revaluations of non-financial physical assets
Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103F Non-financial 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, Northern Health's non-financial physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Note 4.2: Depreciation and Amortisation

	Consol'd 2017 $'000	Consol'd 2016 $'000
Depreciation		
Buildings	18,485	17,806
Medical Equipment	3,321	3,070
Plant and Equipment	1,775	1,661
Total Depreciation	**23,581**	**22,536**
Amortisation		
Intangible Assets	238	388
Total Amortisation	**238**	**388**
Total Depreciation and Amortisation	**23,819**	**22,924**

Depreciation

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 DHHS. Assets with a cost in excess of $1,000 are capitalised. Depreciation on depreciable assets is provided so as to allocate their cost or valuation over their estimated useful lives. From the 2017/2018 financial year the asset capitalisation threshold is increasing from $1,000 to $2,500.

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

	2017	2016
Buildings		
Structure Shell Building Fabric	5 - 53 Years	5 - 53 Years
Site Engineering Services and Central Plant	17 - 33 Years	17 - 33 Years
Central Plant		
Fit Out	2 - 18 Years	2 - 18 Years
Trunk Reticulated Building Systems	7 - 23 Years	7 - 23 Years
Medical Equipment	7 - 10 Years	7 - 10 Years
Plant and Equipment	3 - 10 Years	3 - 10 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

	Consol'd 2017 $'000	Consol'd 2016 $'000
Development Costs Capitalised	4,925	4,687
Less Accumulated Amortisation	4,549	4,311
Subtotal	**376**	**376**
Computer Software - Work in Progress	55	-
Total Intangible Assets	**431**	**376**

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

	Development Costs $'000	Total $'000
Balance at 1 July 2015	605	605
Additions	159	159
Amortisation (Note 4.2)	(388)	(388)
Balance at 1 July 2016	**376**	**376**
Additions	293	293
Amortisation (Note 4.2)	(238)	(238)
Balance at 30 June 2017	**431**	**431**

Note 4.3: Intangible Assets (cont)

Intangible assets

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

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

Amortisation

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

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each annual reporting period. In addition, an assessment is made at each reporting date to determine whether there are indicators that the intangible asset concerned is impaired. If so, the asset concerned is tested as to whether its carrying value exceeds its recoverable amount.

Northern Health 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 3 years (2016: 3 years).

Note 5: Other assets and liabilities

This section sets out those assets and liabilities that arose from the health service'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

	Consol'd 2017 $'000	Consol'd 2016 $'000
CURRENT		
Contractual		
Trade Debtors	1,534	3,068
Patient Fees	3,759	4,012
Accrued Revenue - Other	2,580	1,969
Less Allowance for Doubtful Debts		
Trade Debtors	(13)	(38)
Patient Fees	(1,475)	(1,231)
	6,385	**7,780**
Statutory		
GST Receivable	2,336	1,693
DHHS - Amounts Receivable from Government (i)	3,378	-
	5,714	**1,693**
TOTAL CURRENT RECEIVABLES	**12,099**	**9,473**
NON CURRENT		
Statutory		
DHHS - LSL	11,130	7,417
TOTAL NON-CURRENT RECEIVABLES	**11,130**	**7,417**
TOTAL RECEIVABLES	**23,229**	**16,890**

(a) Movement in the Allowance for Doubtful Debts	Consol'd 2017 $'000	Consol'd 2016 $'000
Balance at beginning of year	1,269	827
Amounts written off during the year	(568)	(679)
Increase in allowance recognised in net results	787	1,121
Balance at end of year	**1,488**	**1,269**

(i) The balance of the Receivable - DHHS depends on whether activity and grant deliverables have been met. During 2016, the balance of this account was a payable to the DHHS (Refer Note 5.5).

Receivables

Receivables consist of:

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

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

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

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

	Consol'd 2017 $'000	Consol'd 2016 $'000
Medical and Surgical Supplies (at cost)	1,465	1,340
Pharmaceuticals (at cost)	1,024	1,033
TOTAL INVENTORIES	**2,489**	**2,373**

Inventories

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.

All other inventories are measured on the basis of weighted average cost and adjusted for any loss of service potential.

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.

Note 5.3: Other Liabilities

	Consol'd 2017 $'000	Consol'd 2016 $'000
CURRENT		
Monies Held in Trust*		
- Patient Monies Held in Trust (Held in Cash)	2	7
- Accommodation Bonds (Refundable)	466	-
Income in Advance	1,890	1,741
TOTAL CURRENT OTHER LIABILITIES	**2,358**	**1,748**
NON CURRENT		
Income in Advance	13,667	14,552
TOTAL NON CURRENT OTHER LIABILITIES	**13,667**	**14,552**
TOTAL OTHER LIABILITIES	**16,025**	**16,300**
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer Note 6.2)	468	7
TOTAL	**468**	**7**

Note 5.4: Prepayments and other Assets

	Consol'd 2017 $'000	Consol'd 2016 $'000
CURRENT		
Prepayments	1,399	1,465
Deposits	3	-
TOTAL OTHER ASSETS	**1,402**	**1,465**

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

Note 5.5: Payables

	Consol'd 2017 $'000	Consol'd 2016 $'000
CURRENT		
Contractual		
Trade Creditors [(i)]	2,000	4,041
Accrued Expenses	10,926	10,024
Salaries and Wages Related Creditors	4,785	4,993
Inter Health Services	6,479	5,081
Other	657	445
	24,847	**24,584**
Statutory		
DHHS - Amounts Payable to Government [(ii)]	-	1,187
	-	**1,187**
TOTAL CURRENT	**24,847**	**25,771**
TOTAL PAYABLES	**24,847**	**25,771**

(i) Average Northern health payment terms are 45 days. No interest is charged on Trade Creditors.

(ii) The balance of the Payable - DHHS depends on whether activity and grant deliverables have been met. During 2017, the balance of this account was a receivable from DHHS (Refer Note 5.1).

(a) Maturity analysis of Payables

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

(b) Nature and extent of risk arising from Payables

Please refer to Note 7.1 for analysis on the nature and extent of risks arising from payables.

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to Northern Health prior to the end of financial year that are unpaid, and arise when Northern Health becomes obliged to make future payments in respect of the purchase of those goods and services. The normal credit terms are usually Net 45 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 Northern Health during its operations, along with the interest expenses (the cost of borrowings) and other information related to financing activities of the health service

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

	Consol'd 2017 $'000	Consol'd 2016 $'000
CURRENT		
Other	181	281
Total Australian Dollar Borrowings	**181**	**281**
TOTAL CURRENT	**181**	**281**
NON CURRENT		
Other	-	181
Total Australian Dollar Borrowings	**-**	**181**
TOTAL NON CURRENT	**-**	**181**
TOTAL BORROWINGS	**181**	**462**

(a) Maturity analysis of Borrowings
Please refer to Note 7.1 for analysis on the ageing of borrowings.
(b) Nature and extent of risk arising from Borrowings
Please refer to Note 7.1 for analysis on the nature and extent of risks arising from borrowings.
(c) Defaults and breaches
During the current and prior year, there were no defaults nor breaches of any of the borrowings.

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 Northern Health 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. Northern Health 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.

Note 6.2 Cash and cash equivalents

For the purposes of the cash flow statement, cash assets includes cash on hand and cash in banks and short-term deposits which are readily convertible to cash on hand, and are not subject to any material risks of change in value.
(Note: that Northern Health does not maintain an overdraft facility).

	Consol'd 2017 $'000	Consol'd 2016 $'000
Cash on Hand	31	29
Cash at Bank	32,659	17,631
Cash in Short-term Deposits	2,466	2,000
Total Cash and Cash Equivalents	**35,156**	**19,660**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	34,688	19,653
Cash held in Trust	468	7
Total Cash and Cash Equivalents	**35,156**	**19,660**

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

	Consol'd 2017 $'000	Consol'd 2016 $'000
Commitments other than public private partnerships		
Capital Expenditure Commitments		
Payable:		
Land and Buildings	5,419	3,141
Plant and Equipment	5,523	2,799
Intangible Assets	135	16
Total Capital Expenditure Commitments	**11,077**	**5,956**
Land and Buildings		
Not later than one year	5,419	3,141
Later than 1 year and not later than 5 years	-	-
Total	**5,419**	**3,141**
Plant and Equipment		
Not later than one year	5,523	2,799
Later than 1 year and not later than 5 years	-	-
Total	**5,523**	**2,799**
Intangible Assets		
Not later than one year	135	16
Later than 1 year and not later than 5 years	-	-
Total	**135**	**16**

	Consol'd 2017 $'000	Consol'd 2016 $'000
Other Expenditure Commitments		
Payable:		
Pathology Services	4,037	6,164
Radiology Services	41,499	51,245
Food Services	15,224	20,789
Laundry Services	1,164	537
Cleaning Services	7,349	12,544
Patient Transport	4,951	1,000
Waste Services	1,336	816
Maintenance Services	774	3,037
Security Services	1,983	4,488
Shared Services	13,452	12,449
Audit Services	337	415
Total Other Expenditure Commitments	**92,107**	**113,482**
Not later than one year	40,226	39,626
Later than 1 year and not later than 5 years	51,882	73,856
TOTAL	**92,107**	**113,482**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	894	918
Total Lease Commitments	**894**	**918**
Operating Leases		
Non-cancellable		
Not later than one year	416	447
Later than 1 year and not later than 5 years	478	471
Sub Total	**894**	**918**
TOTAL	**894**	**918**
Total Commitments for expenditure (inclusive of GST)	**104,078**	**120,356**
less GST recoverable from the Australian Tax Office	(9,462)	(10,362)
Total commitments for expenditure (exclusive of GST)	**94,616**	**109,994**

All amounts shown in the commitments note are nominal amounts inclusive of GST.

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

Note 7: Risks, contingencies & valuation uncertainties

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

(a) Financial Risk Management Objectives and Policies

Northern Health's principal financial instruments comprise of:

- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)

Details of the significant accounting policies and methods adopted including 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 provided in Note 1 to the financial statements.

Northern Health's main financial risks include credit risk, liquidity risk and interest rate risk. Northern Health manages these financial risks in accordance with its Treasury Management policy.

Northern Health uses different methods to measure and manage the different risks to which it is exposed. Overall accountability for the governance of financial risks rests with the Audit and Risk Committee of Northern Health.

The purpose of holding financial instruments is to prudentially optimise Northern Health's financial resources within the legislative and regulatory parameters.

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

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

The following refers to financial instruments unless otherwise stated.

Loans and receivables

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

Loans and receivables category includes cash and deposits, term deposits with maturity greater than three months, trade receivables, loans 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 Northern Health's contractual payables, deposits held and advances received, and interest-bearing arrangements other than those designated at fair value through profit and loss.

Note 7.1: Financial Instruments (cont)

Categorisation of financial instruments

2017	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents (including monies held in trust)	35,156	-	35,156
Receivables			
- Trade Debtors	1,521	-	1,521
- Other Receivables	4,864	-	4,864
Total Financial Assets [(i)]	**41,541**	**-**	**41,541**
Financial Liabilities			
Payables	-	24,847	24,847
Borrowings	-	181	181
Other Liabilities			
- Monies Held in Trust	-	468	468
- Income in Advance	-	15,557	15,557
Total Financial Liabilities [(ii)]	**-**	**41,053**	**41,053**

2016	Contractual financial assets - loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents (including monies held in trust)	19,660	-	19,660
Receivables			
- Trade Debtors	3,030	-	3,030
- Other Receivables	4,750	-	4,750
Total Financial Assets [(i)]	**27,440**	**-**	**27,440**
Financial Liabilities			
Payables	-	24,584	24,584
Borrowings	-	462	462
Other Liabilities			
- Monies Held in Trust	-	7	7
- Income in Advance	-	16,293	16,293
Total Financial Liabilities [(ii)]	**-**	**41,346**	**41,346**

(i) The total amount of financial assets disclosed here excludes statutory receivables (i.e. GST input tax credit recoverable)

(ii) The total amount of financial liabilities disclosed here excludes statutory payables (i.e. Taxes payables)

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

2017	Total Interest Income / (expense) 2017 $'000	Total Interest Income / (expense) 2016 $'000
Financial Assets		
Cash and cash equivalents [(i)]	1,075	918
Total Financial Assets	**1,075**	**918**
Financial Liabilities		
Borrowings [(ii)]	15	27
Total Financial Liabilities	**15**	**27**

(i) For cash and cash equivalents, loans or receivables, the net gain or loss is calculated by taking the movement in fair value of the assets, the interest revenue, plus or minus foreign exchange gains or losses arising from revaluation of the financial assets, and minus any impairment recognised in the net result.

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

Note 7.1: Financial Instruments (cont)

(c) Credit Risk

Credit risk arises from the contractual financial assets of Northern Health, which comprise cash and deposits and non-statutory receivables. Northern Health's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to Northern Health. Credit risk is measured at fair value and is monitored on a regular basis. Credit risk associated with Northern Health's contractual financial assets is minimal because the main debtor is the Victorian Government.

In addition, Northern Health 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. Northern Health's policy is to only deal with banks with Approved Deposit Institutions (ADIs).

Provision of impairment for contractual financial assets is recognised when there is objective evidence that Northern Health will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, 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 Northern 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 (A1+ Credit Rating) $'000	Other Financial Assets $'000	Total $'000
Financial Assets			
Cash and Cash Equivalents	32,659	2,497	35,156
Receivables (i)			
- Trade debtors	-	1,521	1,521
- Other receivables	-	4,864	4,864
Total Financial Assets	**32,659**	**8,882**	**41,541**
2016			
Financial Assets			
Cash and Cash Equivalents	19,631	29	19,660
Receivables (i)			
- Trade debtors	-	3,030	3,030
- Other receivables	-	4,750	4,750
Total Financial Assets	**19,631**	**7,809**	**27,440**

(i) The total amounts disclosed above excludes statutory amounts (e.g. amounts owing from Victorian Government and GST input tax credits recoverable).

It is impractical for Northern Health to disclose credit ratings in respect of receivables. Consequently receivables are disclosed under "Other" category.

Ageing analysis of financial assets as at 30 June

	Consol'd Carrying Amount	Not Past Due and Not Impaired	Past Due But Not Impaired				Impaired Financial Assets
			Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years	
2017	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial Assets							
Cash and Cash Equivalents	35,156	35,156	-	-	-	-	-
Receivables (i)							
- Trade debtors	1,521	826	581	81	28	5	-
- Other receivables	4,864	2,757	870	870	367	-	-
Total Financial Assets	**41,541**	**38,739**	**1,451**	**951**	**395**	**5**	**-**
2016							
Financial Assets							
Cash and Cash Equivalents	19,660	19,660	-	-	-	-	-
Receivables (i)							
- Trade debtors	3,030	2,163	739	79	49	-	-
- Other receivables	4,750	2,005	1,929	740	31	45	-
Total Financial Assets	**27,440**	**23,828**	**2,668**	**819**	**80**	**45**	**-**

(i) Ageing analysis of financial assets excludes statutory financial assets (i.e. GST input tax credit)

Contractual financial assets that are either past due or impaired

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

Note 7.1: Financial Instruments (continued)

(d) Liquidity Risk

Liquidity risk is the risk that Northern Health would be unable to meet its financial obligations as and when they fall due. Northern Health operates under the Government's fair payments policy of settling financial obligations within 45 days and in the event of a dispute, making payments within 45 days from the date of resolution.

Northern Health's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed on the balance sheet.

The following table discloses the contractual maturity analysis for Northern 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

			Maturity Dates			
2017	**Carrying Amount $'000**	**Nominal Amount $'000**	**Less than 1 Month $'000**	**1-3 Months $'000**	**3 months - 1 Year $'000**	**1-5 Years $'000**
Financial Liabilities						
Payables	24,847	24,848	19,067	4,866	914	-
Borrowings	181	181	24	49	109	-
Other Financial Liabilities (i)	16,025	15,559	1,080	148	664	13,667
Total Financial Liabilities	**41,053**	**40,588**	**20,172**	**5,062**	**1,687**	**13,667**
2016						
Financial Liabilities						
Payables	24,584	24,584	18,198	5,975	411	-
Borrowings	462	462	23	47	210	181
Other Financial Liabilities (i)	16,300	16,300	838	189	714	14,559
Total Financial Liabilities	**41,346**	**41,346**	**19,059**	**6,212**	**1,335**	**14,740**

(i) Ageing analysis of financial liabilities excludes statutory financial liabilities (i.e. GST Payable)

(e) Market Risk

Northern 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

Northern 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 timeframe between commitment and settlement.

Interest Rate Risk

Exposure to interest rate risk might arise primarily through Northern Health's interest bearing liabilities. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial liabilities, Northern Health 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 market interest rates.

Northern Health has minimal exposure to cash flow interest rate risks through its cash and deposits that are at floating rate.

Northern Health 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 Northern Health to significant risk, management monitors movement in interest rates on a regular basis.

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

			Interest Rate Exposure		
2017	**Weighted Average Effective Interest Rate (%)**	**Carrying Amount**	**Fixed Interest Rate $'000**	**Variable Interest Rate $'000**	**Non-Interest Bearing $'000**
Financial Assets					
Cash and Cash Equivalents	2.01	35,156	-	35,125	31
Receivables[(i)]					
- Trade debtors	0.00	1,521	-	-	1,521
- Other receivables	0.00	4,864	-	-	4,864
		41,541	**-**	**35,125**	**6,416**
Financial Liabilities					
Payables[(i)]	0.00	24,847	-	-	24,847
Borrowings[(ii)]	4.39	181	181	-	-
Other financial liabilities	0.00	16,025	-	-	16,025
		41,053	**181**	**-**	**40,872**
2016					
Financial Assets					
Cash and Cash Equivalents	2.46	19,660	-	19,631	29
Receivables[(i)]					
- Trade Debtors	0.00	3,030	-	-	3,030
- Other Receivables	0.00	4,750	-	-	4,750
		27,440	**-**	**19,631**	**7,809**
Financial Liabilities					
Payables[(i)]	0.00	24,584	-	-	24,584
Borrowings[(ii)]	4.39	462	462	-	-
Other financial liabilities	0.00	16,300	-	-	16,300
		41,346	**462**	**-**	**40,884**

(i) The carrying amount excludes statutory financial assets and liabilities (i.e. GST input tax credit and GST payable)

(ii) Northern Health has entered into two borrowing arrangements via 2 providers (Metro Parking Borrowing arrangement at 6.5% and the Wilson Security Borrowing arrangement is at 2.27%).

Note 7.1: Financial Instruments (continued)

(e) Market Risk (cont)

Sensitivity Disclosure Analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, Northern 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 +0.25% and -0.25% in market interest rates (AUD) from year-end rates of 2.01%
- A parallel shift of +1% and 1% in inflation rate from year-end rates of 2.10%

The following table discloses the impact on net operating result and equity for each category of financial instrument held by Northern Health at year end as presented to key management personnel, if changes in the relevant risk occur.

	Carrying Amount	Interest Rate Risk			
		-0.25%		+0.25%	
2017		$'000	$'000	$'000	$'000
Financial Assets					
Cash and Cash Equivalents[(i)]	35,156	(88)	(88)	88	88
Receivables					
- Trade debtors	1,521	-	-	-	-
- Other receivables	4,864	-	-	-	-
Financial Liabilities					
Payables	24,847	-	-	-	-
Borrowings	181	-	-	-	-
Other Financial Liabilities	16,025	-	-	-	-
		(88)	**(88)**	**88**	**88**
2016					
Financial Assets					
Cash and Cash Equivalents[(i)]	19,660	(49)	(49)	49	49
Receivables					
- Trade debtors	3,030	-	-	-	-
- Other receivables	4,750	-	-	-	-
Financial Liabilities					
Payables	24,584	-	-	-	-
Borrowings	462	-	-	-	-
Other Financial Liabilities	16,300	-	-	-	-
		(49)	**(49)**	**49**	**49**

(i) e.g. Sensitivity of cash and cash equivalents to +0.25% movement in interest rates: [$35,156*0.0226]-[$35,156*0.201] = $88k
Similarly -0.25% movement in interest rate impact = ($88k)

(ii) The carrying amount excludes statutory financial assets and liabilities (i.e. GST input tax credit and GST payable).

(f) Fair Value

Northern Health considers that the carrying amount of financial assets and liabilities recorded in the financial statements to be a fair approximation of their fair values, given the short-term nature of the financial instruments and the expectation that they will be paid in full.

The aggregate net fair value of financial assets and liabilities, both recognised and unrecognised, at the balance date are equal to their carrying amount as per the balance sheet.

Note 7.2: Net Gain/(Loss) on Disposal of Non-financial Assets

	Consol'd 2017 $'000	Consol'd 2016 $'000
Proceeds from Disposals of Non-Current Assets		
Medical Equipment	2	2
Plant and Equipment	71	12
Total Proceeds from Disposal of Non-Current Assets	**73**	**14**
Less: Written Down Value of Non-Current Assets Sold		
Medical Equipment	19	54
Plant and Equipment	7	44
Total Written Down Value of Non Current Assets Sold	**26**	**98**
Net Gains/(Losses) on Disposal of Non-Current Assets	**47**	**(84)**

Disposal of non-financial assets

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement.

Impairment of non-financial assets

At the end of each reporting period Northern Health assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through profit of loss, are subject to annual review for impairment.

Receivables are assessed for bad and doubtful debts on a regular basis. Bad debts considered as written off and allowances for doubtful receivables are expensed.

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

In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

Note 7.3: Contingent assets and contingent liabilities

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

On the 5 June 2017, The Northern Health Research, Training and Equipment Foundation Ltd (a controlled entity of Northern Health) placed a successful bid for a house and land package for Lot 1345 Wiseman Walk, Wollert released by Nostra Homes. The agreed package price was $0.35m, and the property will be used for Emergency Patient Accommodation. The House and Land will be purchased outright using available cash reserves, however there is uncertainty about when the contracts for the Land and Building Development will be signed. A refundable deposit was paid as a gesture of good faith, to ensure the property was removed from further advertising.

Northern Health is not aware of any contingent assets (2016: Nil).

Northern Health is not aware of any contingent liabilities (2016: Nil).

Note 7.4: Fair Value determination

Asset Class	Types of assets	Fair Value Level	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	Level 3	Market approach	CSO adjustments
Specialised buildings [(i)]	Specialised buildings with limited alternative uses and/or substantial customisation e.g. prisons, hospitals, and schools	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and equipment [(i)]	Specialised items with limited alternative uses and/or substantial customisation	Level 3	Depreciated replacement cost approach	Cost per square metre Useful life
Cultural assets	Items for which there is an active market and there are operational uses for the item	Level 2	Market approach	N/A

[(i)] Newly built / acquired assets could be categorised as Level 2 assets as depreciation would not be a significant unobservable

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 Ex-gratia expenses
8.9 Events occurring after the balance sheet date
8.10 AASBs issued that are not yet effective
8.11 Economic dependency
8.12 Controlled entities
8.13 Alternative presentation of comprehensive operating statement
8.14 Glossary of terms and style conventions

Note 8.1: Equity

	Consol'd 2017 $'000	Consol'd 2016 $'000
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus [1]		
Balance at the beginning of the reporting period	200,146	200,146
Revaluation Increment/(Decrements) during the period		
- Land	10,962	-
Balance at the end of the reporting period*	**211,108**	**200,146**
- Land	49,966	39,004
- Buildings	161,142	161,142
	211,108	**200,146**
(b) Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	4,845	4,532
Transfer to and from Restricted Specific Purpose Surplus	228	313
Balance at the end of the reporting period	**5,073**	**4,845**
Total Surpluses	**216,181**	**204,991**
(c) Contributed Capital		
Balance at the beginning of the reporting period	161,634	161,634
Balance at the end of the reporting period	**161,634**	**161,634**
(d) Accumulated Deficits		
Balance at the beginning of the reporting period	(53,408)	(57,420)
Net Result for the Year	10,688	4,325
Transfer to and from Restricted Specific Purpose Surplus	(228)	(313)
Balance at the end of the reporting period	**(42,948)**	**(53,408)**
Total Equity at end of financial year	**334,867**	**313,217**

[1] The Property, Plant and Equipment Asset Revaluation Surplus arises on the revaluation of property, plant and equipment.

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.

Restricted Specific 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

	Consol'd 2017 $'000	Consol'd 2016 $'000
Net Result for the period	21,650	4,325
Non-cash movements		
Depreciation and Amortisation	23,819	22,924
Revaluation of Long Service Leave	(598)	-
Written Down Value of Assets Sold	26	98
Provision for Doubtful Debts	786	1,122
Amortisation of Prepaid Rent	(629)	(629)
Change in Inventories	(116)	(426)
Resources/Assets Provided/(Received) Free of Charge	-	(11)
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Plant and Equipment	(72)	(14)
Movements in assets and liabilities		
Change in Operating Assets and Liabilities		
Decrease in Current Receivables	217	(2,373)
(Increase) in Non Current Receivables	(3,714)	(2,410)
(Increase)/Decrease in Other Assets	(578)	(617)
(Decrease) / Increase in Payables	1,122	3,056
Increase in Employee Benefits	10,620	9,771
(Decrease) / Increase in Other Liabilities	(4,051)	216
NET CASH INFLOW FROM OPERATING ACTIVITIES	**48,482**	**35,032**

Note 8.3: Operating Segments

	Residential Aged Care		Other		Consol'd	
	2017 $'000	2016 $'000	2017 $'000	2016 $'000	2017 $'000	2016 $'000
REVENUE						
External Segment Revenue	3,704	3,310	501,223	452,969	504,147	456,279
Total Revenue	**3,704**	**3,310**	**501,223**	**452,969**	**504,147**	**456,279**
EXPENSES						
External Segment Expenses	(5,493)	(5,302)	(489,016)	(447,544)	(494,509)	(452,846)
Intersegment Expenses	-	-	-	-	-	-
Total Expenses	**(5,493)**	**(5,302)**	**(489,016)**	**(447,544)**	**(494,509)**	**(452,846)**
Net Result from Ordinary Activities	**(1,789)**	**(1,992)**	**12,207**	**5,425**	**9,638**	**3,433**
Interest Expense	-	-	(25)	(25)	(25)	(25)
Interest Income	-	-	1,075	918	1,075	918
Net Result for Year	**(1,789)**	**(1,992)**	**13,257**	**6,318**	**10,688**	**4,326**
OTHER INFORMATION						
Segment Assets	129	127	402,095	392,159	402,223	392,286
Unallocated Assets	-	-	62,707	40,764	62,707	40,764
Total Assets	**129**	**127**	**464,802**	**432,923**	**464,930**	**433,050**
Unallocated Liabilities	-	-	130,063	119,833	130,063	119,833
Total Liabilities	**-**	**-**	**130,063**	**119,833**	**130,063**	**119,833**
Acquisition of Property, Plant and Equipment and Intangible Assets	25	8	22,850	23,145	22,875	23,153
Depreciation and Amortisation expense	24	26	23,795	22,899	23,819	22,925

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

Business Segments	**Services**
Residential Aged Care Services (RACS)	Provider of residential aged care beds
Northern Health	Provider of acute and sub acute patient care

All inter-segment transactions are carried at cost.

Geographical Segment
Northern Health operates in the northern suburbs of Melbourne (Broadmeadows, Bundoora, Craigieburn, Epping and Preston) Victoria. All revenue, expenses and segment assets relate to operations in Melbourne, Victoria.

Note 8.4: Responsible Persons Disclosures

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

	Period
Responsible Ministers	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2016 - 30/06/2017
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2016 - 30/06/2017
Governing Board	
Ms Jennifer Williams (Chair)	01/07/2016 - 30/06/2017
Ms Melba Marginson	01/07/2016 - 30/06/2017
Ms Paula Shelton	01/07/2016 - 30/06/2017
Mr Peter McWilliam	01/07/2016 - 30/06/2017
Dr Alison Lilley	01/07/2016 - 30/06/2017
Mr James Bailey	01/07/2016 - 30/06/2017
Ms Juliann Byron	01/07/2016 - 30/06/2017
Mr John Watson	02/08/2016 - 30/06/2017
Mr Peter McDonald	29/11/2016 - 30/06/2017
Accountable Officers:	
Mr Siva Sivarajah	01/07/2016 - 30/06/2017

Remuneration of Responsible Persons

The number of Responsible Persons are shown in their relevant income bands;

	Consol'd	
Income Band	**2017 No.**	**2016 * No.**
$0 - $9,999	-	1
$10,000 - $19,999	1	2
$20,000 - $29,999	2	3
$30,000 - $39,999	5	4
$60,000 - $69,999	1	-
$180,000 - $189,999	-	1
$390,000 - $399,999	1	-
Total Numbers	10	11
Total remuneration comprising all money, consideration and benefits received or receivable by Responsible Persons from the reporting entity amounted to:	**$679,058**	**$419,504**

* During 2015/16 Northern Health had three Accountable Officers spanning the financial year. The above schedule is counting them as 3 people, whilst their remuneration has been pro-rated for comparative purposes.

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet. For information regarding register of member's interests in publicly available from www.parliament.vic.gov.au/publications/register of interests.

Note 8.5: Executive Officer Disclosures

Remuneration of executives

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

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

Short-term employee benefits include amounts such as wages, salaries, annual leave or sick lease 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 payment are cash or other assets paid or payable as agreed between Northern Health and the employee, provided specific vesting conditions, if any, are met.

Several factors affected total remuneration payable to executives over the year. All executives received an annual bonus as per the terms of their individual employment contracts. A number of executive officers resigned or were retrenched in the past year. This has had an impact on total remuneration figures due to the inclusion of annual leave, long service leave and retrenched payments.

Remuneration of Executive Officers (including Key Management Personnel disclosed in Note 8.6)	**Consol'd 2017 $**	**Consol'd 2016 $**
Short term employee benefits	2,430,363	
Post-employment benefits	170,916	
Other long-term benefits	208,926	
Termination benefits	4,955	
Share based payments	-	
Total Remuneration (i) (ii) (iii)	2,815,159	
Total Number of Executives	10	7
Total Annualised Employee Equivalent (AEE) (iv)	11	12

(i) No comparatives have been reported because remuneration in the prior year was determined in line with the basis and definition under FRD21B. Remuneration previously excluded non-monetary benefits and comprised any money, consideration or benefit received or receivable, excluding reimbursement of out-of-pocket expenses, including any amount received or receivable from a related party transaction. Refer to the prior year's financial statements for executive remuneration for the 2015-2016 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 required within the related parties (Note 8.6).

(iii) The remuneration of Executive Officers disclosed includes pro-rata remuneration of employees whilst acting in the Executive's roles

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

Note 8.6: Related Parties

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

- all key management personnel 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 health service include the Portfolio Ministers and Cabinet Ministers and KMP as determined by the health service. The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the *Parliament Salaries and Superannuation Act 1968,* and is reported within the Department of Parliamentary Services' Financial Report.

Compensation	**Consol'd 2017 $'000**
Short term employee benefits	2,968
Post-employment benefits	305
Other long-term benefits	221
Termination benefits	-
Share based payments	-
Total	**3,494**

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

Northern Health received funding from DHHS of $429 million (2016: $391 million).

Note 8.7: Remuneration of Auditors

	Consol'd 2017 $'000	**Consol'd 2016 $'000**
Victorian Auditor-General's Office		
Audit of financial statement	77	77
Total Remuneration of Auditors	**77**	**77**

Note 8.8: Ex-gratia Expenses

	Consol'd 2017 $'000	**Consol'd 2016 $'000**
Northern Health has made the following ex-gratia expenses :		
Payments associated with employee departure separation arrangements	27	162
Total ex-gratia expenses	**27**	**162**

Includes ex-gratia for both individual items and in aggregate that are greater than or equal to $5,000.
The total for ex-gratia expenses in also presented in Note 3.1 Analysis of expenses by source

Note 8.9: Events occurring after the balance sheet date

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

Note 8.10: AASBs issued that are not yet effective

Summary of New and Revised Accounting Pronouncements

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

Topic	Key requirements	Effective date
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 ▪ the 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 January 18
AASB 9 Financial Instruments	The key changes introduced by AASB 9 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 January 18
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 January 18
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	1 January 19
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 January 2017, except amendments to AASB 9 (December 2009) and AASB 9 (December 2010) apply 1 January 2018.
AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9	Amends various AASs to incorporate the consequential amendments arising from the issuance of AASB 9.	1 January 18
AASB 2016-7 Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities	This standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	1 January 19
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 January 17
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 not-for-profit entities to further their objectives.	1 January 19
AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities	This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events. The amendments: ▪ require non-contractual receivables arising from statutory requirements (i.e. taxes, rates, and fines) to be initially measured with AASB 9 as if those receivables are financial instruments; and ▪ clarifies circumstances when a contract with a customer is within the scope of AASB 15.	1 January 19

Note 8.11: Economic Dependance

The financial performance and position of Northern Health has improved since the prior year. Northern Health has reported a net surplus before capital and specific items of $2.16 million (2016: net deficit of $0.54 million), a current asset ratio of 0.49 (2016: 0.34) and net cash flow operations of $37.69 million (2016: $35.03 million).

While there has been improvement across all three indicators Northern Health's financial sustainability is still materially below the level that would enable management and the Board to form a view that the health service has adequate cash flow to meets its obligations. As a consequence Northern Health has obtained a Letter of Comfort from the State Government, namely DHHS, confirming that they will continue to provide Northern Health adequate cash flow to meet its current and future obligations up to September 2018. A letter was also obtained for the previous financial year. On this basis, the financial statements have been prepared on a going concern basis.

Northern Health is committed to the continued review of its financial and operating performance with a view to identifying further efficiencies and revenue generating opportunities and providing the most effective and efficient service delivery model without compromising patient care and quality of service delivery. Northern Health management will continue to identify and implement a number of business initiatives to better manage available financial resources.

Note 8.12: Controlled Entities

Name of entity	Country of incorporation	Equity Holding
Northern Health Research, Training and Equipment Foundation Ltd	Australia	Limited by Guarantee
Northern Health Research, Training and Equipment Trust	Australia	n/a

Note 8.13: Alternative Presentation of Comprehensive Operating Statement

	Note	Consol'd 2017 $'000	Consol'd 2016 $'000
Grants			
Operating	2.1	431,781	389,894
Capital	2.1	29,401	25,732
Interest	2.1	1,075	918
Sales of goods and services	2.1	36,187	35,285
Other Income			
Other Income	2.1	3,744	4,406
Other capital income	2.1	2,959	934
Revenue from Transactions		**505,147**	**457,169**
Employee expenses	3.1	(331,889)	(298,093)
Operating expenses			
Supplies and consumables	3.1	(84,595)	(78,209)
Non salary labour costs	3.1	(6,782)	(9,663)
Finance costs	3.1	(15)	(27)
Other	3.1	(47,033)	(42,712)
Non-Operating Expenses			
Specific Expenses	3.1	(163)	(803)
Expenditure for Capital Purpose	3.1	(808)	(339)
Assets provided free of charge	2.2	-	11
Depreciation		(23,819)	(22,925)
Expenses from Transactions		**(495,104)**	**(452,760)**
Net Result from transactions		**10,043**	**4,409**
Other economic flows included in net result			
Net gain/(loss) on non-financial assets	7.2	47	(84)
Revaluation of Long Service Leave	3.5	598	-
Total other economic flows included in net result		**645**	**(84)**
Net result		**10,688**	**4,325**

Note 8.14: Glossary of terms and style conventions

Actuarial gains or losses on superannuation defined benefit plans

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

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

(b) the effects of changes in actuarial assumptions.

Amortisation

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

Comprehensive result

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

Commitments

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

Current grants

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

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 asset

A financial asset is any asset that is:

(a) cash;

(b) an equity instrument of another entity;

(c) a contractual or statutory right:

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

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

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

Financial instrument

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

Note 8.14: Glossary of terms and style conventions (cont)

Financial liability

A financial liability is any liability that is:

(a) A contractual obligation:

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

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

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

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

(ii) a derivative that will or may be settled other than by the exchange of a fixed amount of cash or another financial asset for a fixed number of the entity's own equity instruments.

For this purpose the entity's own equity instruments do not include instruments that are themselves contracts for the future receipt or delivery of the entity's own equity instruments.

Financial statements

A complete set of financial statements comprises:

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

(b) Comprehensive operating statement for the period;

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

(d) Cash flow statement for the period;

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

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

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

Grants and other transfers

Transactions in which one unit provides goods, services, assets (or extinguishes a liability) or labour to another unit without receiving approximately equal value in return. Grants can either be operating or capital in nature.

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

General government sector

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

Intangible produced assets

Refer to produced assets in this glossary.

Intangible non-produced assets

Refer to non-produced asset in this glossary.

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.

Note 8.14: Glossary of terms and style conventions (continued)

Liabilities

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

Net acquisition of non-financial assets (from transactions)

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

Net result

Net result is a measure of financial performance of the operations for the period. It is the net result of items of income, gains and expenses (including losses) recognised for the period, excluding those that are classified as 'other comprehensive income'. Net result from transactions/net operating balance Net result from transactions or net operating balance is a key fiscal aggregate and is income from transactions minus expenses from transactions. It is a summary measure of the ongoing sustainability of operations. It excludes gains and losses resulting from changes in price levels and other changes in the volume of assets.

Net worth

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

Non-financial assets

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

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 startup costs associated with capital projects).

Public financial corporation sector

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

Public non-financial corporation sector

The public non-financial corporation (PNFC) sector comprises bodies mainly engaged in the production of goods and services (of a non-financial nature) for sale in the market place at prices that aim to recover most of the costs involved (e.g. water and port authorities). In general, PNFCs are legally distinguishable from the governments 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 8.14: 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.

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Northern Health