



# ANNUAL REPORT

2015



**redhs**

*More Than a Hospital*  
Rochester and Elmore District Health Service

# STRATEGIC INITIATIVES, GOALS AND OBJECTIVES 2013-2016

## VISION

Rochester and Elmore District Health Service (REDHS) is widely recognised for its excellence in responsive, sustainable rural health services and compassionate care.

## VALUES

**The Board, management and staff of REDHS value:**

- R**espect, dignity and understanding
- E**quity, access, participation and consultation
- D**iligence, responsibility and accountability
- H**onesty, trust and fairness
- S**ervice, professionalism, improvement and innovation



Initiative	Goal	Objectives
<b>Professional People &amp; Defining Culture</b>	REDHS people, culture and structure will provide a platform to:	<ul style="list-style-type: none"> <li>embed our vision, values, service philosophy and initiatives</li> <li>attract and retain high calibre, caring and enthusiastic staff, volunteers and students</li> <li>continue professional development of new or existing staff, volunteers and students that aligns with our workforce development plan</li> <li>enhance our organisation's operational structure, roles and responsibilities</li> </ul>
<b>Great Care &amp; Service Excellence</b>	REDHS consumers will have access to a range of integrated, high quality primary, home-based, acute and aged care health services that:	<ul style="list-style-type: none"> <li>embed the great care and service philosophy across the organisation for every consumer, every time, in all areas</li> <li>ensure existing and new services are consistent with current policy, are proactive and founded on reputable research and evidence based practice that has been undertaken by REDHS or independent third parties</li> <li>delay the impacts of ageing, promote health and wellbeing and build their capacity to live independently and self manage their health and daily activities</li> <li>link consumers and their carers or families to relevant primary, home based, acute and aged care information and services</li> </ul>
<b>Community Engagement &amp; Strategic Relationships</b>	REDHS will have meaningful engagement, partnerships and contributions to services from consumers, families, volunteers, communities and key external stakeholders in the achievement of our vision and strategic initiatives to:	<ul style="list-style-type: none"> <li>develop and implement specific engagement, partnership and education strategies with consumers, the community and service providers</li> <li>enable involvement of people and partners in, and to contribute to strategic initiatives, projects and activities</li> <li>increase donations, sponsorship, bequests and fundraising to benefit service delivery</li> </ul>
<b>Social, Economic &amp; Environmental Sustainability</b>	REDHS will ensure we are sustainable through social, economic and environmental strategies that:	<ul style="list-style-type: none"> <li>enable consumers to have access to high quality services that meet identified needs and improve the overall health of the community ensure</li> <li>each program area, and the health service overall, is economically viable and able to fund our vision and strategic direction</li> <li>contribute in a positive way to the management of the environment of our health service, our local area and broader region</li> </ul>
<b>Systems Enhancement &amp; Business Excellence</b>	The Board, management and staff of REDHS will have timely, accurate and informative data and knowledge to enable:	<ul style="list-style-type: none"> <li>the operation of a robust and secure Information and Communication Technology platform with contemporary and integrated organisational and service systems</li> <li>effective decision making and outcomes in primary, home based, acute and aged care services</li> <li>innovation and continuous improvement initiatives that enhance effectiveness and efficiency</li> <li>internal and external service providers and consultants to undertake specific projects and activities to enhance service delivery</li> </ul>

## WHO WE ARE

Rochester and Elmore District Health Service (REDHS) was established on 1 November 1993 following the amalgamation of the Rochester and District War Memorial Hospital and the Elmore District Hospital.

REDHS is an incorporated body under Section 31 of the Health Services Act 1988 providing a broad range of services including acute, residential aged and primary care services including home nursing to our catchment population of over 8,500 and has:

- 107.12 Full time equivalent staff
- 30 high care residential aged care beds
- 30 low care residential aged care beds (including respite and 10 dementia-specific beds)
- 12 inpatient beds including 1 palliative care bed, transition care program
- Urgent Care Centre
- Primary Care Services
- Day Procedure Unit

The responsible ministers are the Victorian Ministers for Health, the Honourable Jill Hennessey MLA (4 December 2014 to 30 June 2015) and the Honourable David Davis MLC (1 July 2014 to 3 December 2014).

## OUR LOCATION



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# YEAR IN BRIEF 2014-15

## Acute Ward:

Total Acute Ward Separations	403
Acute Bed Days	2,440
Average Length of Stay (Days)	9.3

## Day Procedure Unit (DPU)

Total DPU Separations	457
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## Aged Care

Nursing Home Bed Days	10,751
Nursing Home Separations	12
Hostel Bed Days	10,110
Hostel Separations	8

## Total Non-admitted Occasions of Service

District Nursing	5,782
Urgent Care Centre	867
Radiology	1,404
Planned Activity Group/NRCP Day Program	2,934
Meals on Wheels	3,166

## Primary Care:

Diabetes Education	306
Dietetics	818
Group Fitness	1,523
Occupational Therapy	690
Physiotherapy (IP)	711
Physiotherapy (OP)	944
Podiatry	3,025
Social Work/Counselling	449

## Services offered by REDHS

- Acute Ward
- Cardiac Rehabilitation
- Day Surgery
- Diabetes Education
- Dietetics
- District Nursing
- Exercise Physiology
- Health Promotion
- LIFE program (Diabetes Prevention)
- National Respite for Carers Program
- Occupational Therapy
- Palliative Care
- Pathology Collection
- Physiotherapy
- Planned Activity Group
- Podiatry
- Psychology
- Radiology (X-ray and Ultrasound)
- Residential Aged Care
- Rural Withdrawal Service
- Social Work
- Transition Care Program
- Type 2 Diabetes Program
- Urgent Care Centre
- Volunteer Program



# PRESIDENT & CEO REPORT

In accordance with the *Financial Management Act 1994*, we are pleased to present REDHS' Report of Operations for the year ending 30 June 2015.

There have been a number of achievements that are detailed in this annual report and we are truly proud of the dedication and care provided by our staff and volunteers in delivering services for the community.

There continues to be growth in our services, in particular within the primary and aged care areas, while many improvements in systems within our corporate services have been implemented throughout the year.

## Board of Management

We were delighted with the commencement of two new board members in July 2014. Dr Carol McKinstry and Michelle O'Sullivan were both appointed for three-year terms and bring extensive governance knowledge and expertise to complement our skills-based board.

We have had four re-elected board members: Keith Oberin, for a third three-year term and Tim Fulton, Ben Maw and Alan Darbyshire for a further 12 months. Tim, Ben and Alan comprise the REDHS Board Executive, with Tim continuing as chairman, Ben stepped up to the position of vice chair and Alan remained as treasurer. Due to a change of employment Rueben Johnson resigned and we thank him for his contribution and service.

Early in 2015, the board completed an extensive evaluation process, facilitated by the Australian Council of Healthcare Governance. The evaluation sought subjective director opinions on the effectiveness of our board in relation to key governance responsibilities. The evaluation assessed overall board effectiveness. Director opinions were sought both through a self-assessment questionnaire and individual interviews with each director in the following nine key areas of governance:

- strategic direction
- risk management and compliance
- finance
- service quality
- governance relations
- board composition
- board processes
- stakeholder communication
- ongoing assessment, review and improvement.

The results, along with the recommendation report, were presented to the board at an evaluation session in February 2015. A set of agreed recommendations have been incorporated into an action plan and will be implemented incrementally, based on our priorities, over the next 12 months.

## Executive Changes

Anne McEvoy was appointed as CEO in early July 2014, following a period in the acting role and worked cohesively with the board to implement the strategic plan.

The recruitment of a director of clinical services was finalised in October 2014 with the appointment of Mark Nally. In addition, a review of our corporate services area recommended the development of a corporate service manager role. Our information systems manager, Clare Ireland, was successfully appointed and now joins the executive team.

## Australian Council on Healthcare Standards

REDHS underwent an Organisation Wide Survey for continuing accreditation in April 2015 in the EQIP National program. This meant that REDHS was surveyed against the required ten National Safety and Quality Health Service Standards as well as an additional five standards. REDHS met all the requirements for accreditation with the exception of one action which related to the design of the nursing history, the nursing admission/assessment, nursing care and short stay forms in acute. To meet this final action, REDHS accreditation working



**Tim Fulton**  
Board President

**Anne McEvoy**  
Chief Executive  
Officer

## PRESIDENT & CEO REPORT

party drove the rectification process, with strong support from Lynn Wolfe, Meredith Hodder and Mark Nally. A Satisfactorily Met rating was achieved well ahead of the allocated time. REDHS was awarded four years accreditation from 6 July 2015 to 5 July 2019.

### Strategic Plan and Statement of Priorities

*REDHS Strategic Plan July 2013 – June 2016* provides the direction of focus for the board and executive.

These strategic initiatives were once again utilised to develop the annual *Statement of Priorities* process, a requirement led by the Department of Health and Human Services.

The following points summarise key achievements by REDHS during the year:

- Increase in primary care activity of 12.4%, being 1,306 additional occasions of services.
- Day procedure unit activity increased by 22.5%, equating to an additional 84 procedures.
- A new aged care manager, Michele Bibby was appointed. Occupancy rates for aged care were exceptional and required a review of the *Transition Care Program* base and hence necessitated this program's shift to acute to support our aged care demand.
- The implementation of the major Commonwealth aged care reform processes required dedicated focus and even with the challenges, REDHS has managed this efficiently and effectively without any impact to resident care.
- REDHS received advice from the Department of Health and Human Services that the *Rochester Community Ice Action Group* is one of 13 successful ice action groups in the first round of funding and will receive \$10,000.
- Leadership group professional development - inclusive of an enhanced budgeting process and the Studer program.
- Recruitment to a permanent Acute Services Manager with the DPU ANUM, Meredith Hodder successful and exemplifies the success of REDHS 'growing our own' strategy.
- Participation in a number of partnerships and collaborations such as REDHS being a partner in the cross regional *Strengthening Health Services and Aged Care Financial Modelling Tool* projects and the lead for the regional *Aged Care Funding Instrument (ACFI)* project.
- The research partnership with La Trobe University to develop a long-term, inclusive, community led process continued into its third year with the priorities supporting future service planning.
- Primary care growth - the introduction of team leaders for allied health and home and community care, an extra full time physiotherapist to support the implementation of an aged care pain management program and the opportunity to deliver a carer respite program.
- Implementation of the *Studer* program through the REDHS *People Excellence Program*.
- Major upgrade of the air-conditioning system in acute and administration areas.
- The completion of the management agreement with Dingee Bush Nursing Centre.

### Community Support

REDHS is truly grateful for the support of the community, local organisations and people through generous donations of time and money to support our vision to be widely recognised for excellence in responsive, sustainable rural health services and compassionate care. Numerous donations and bequests have been received and we would like to particularly acknowledge the support of the Rochester District Health Service Auxiliary which donated \$7,300 to support the replacement of two electric beds for the acute ward.

### Our Thanks and Congratulations

We would like to thank the REDHS Board of Management, our staff, volunteers, auxiliary members, our partner organisations and many others who support REDHS in a variety of ways. In addition we wish to thank our visiting medical officers, the Victorian Department of Health and Human Services and Commonwealth Department of Social Services. We are truly grateful for your assistance and services as we strive to improve the health and wellbeing of the communities in and around the Rochester and Elmore communities.

Finally, congratulations to our aged care residents' *Sing Out Loud Choir* on being awarded the Shire of Campaspe Australia Day Arts award in January 2015 for their innovative and inclusive entertainment. The award truly epitomises the importance of social inclusion and the board and executive were proud of the efforts of our residents, volunteers, staff and families in the *Sing Out Loud* program. We look forward to their talents being showcased in future concerts.



*Timothy Fulton*

**Tim Fulton**

**Board President**

Rochester and Elmore District  
Health Service

**31 July 2015**

*Anne McEvoy*

**Anne McEvoy**

**Chief Executive Officer**

Rochester and Elmore District  
Health Service

**31 July 2015**

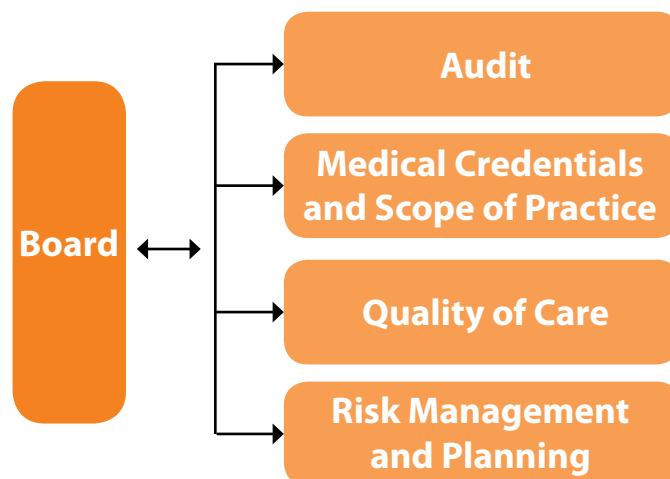
# CORPORATE GOVERNANCE

Rochester and Elmore District Health Service (REDHS) is an incorporated body listed under Schedule 1 of the Health Services Act 1988. Board members are recommended by the Minister and appointed by the Governor-In-Council for a term of up to three years and act in a voluntary capacity.

The strategic direction of REDHS is determined by the Board of Management, which meets regularly with the Chief Executive Officer and Executive staff to determine governance, compliance and policy. The Board is supported in its decision-making by a number of sub-committees.

Subject to the requirements of government and the Health Service By-Laws, the Board of Management exercises decisions including the control of funds, determining the range of services to be provided, and the appointment of visiting medical officers and other senior staff.

## Board Committee Structure



## Board Members

### Timothy Fulton

President (25.11.13 – 30.6.15):  
B.Bus (Accounting/ Economics), Diploma of  
Financial Planning, Financial  
Accountant Kagome  
Date appointed: 1.7.2009

### Keith Oberin

Vice President (25.11.13 – 24.11.14):  
Dip Ed  
Service Review Manager  
(Shire of Campaspe)  
Date appointed: 1.7.2008

### Ben Maw

Vice President (24.11.14 – 30.6.15):  
RN, B Hlth Sc (Nursing), GAICD  
Regional Business Manager (Benetas)  
Date appointed: 1.7.2011

### Alan Darbyshire

Treasurer (25.11.13 – 30.6.15):  
FCPA, Accountant, Registered Company  
Auditor and Tax Agent  
Date appointed: 1.7.2012

### Michelle O'Sullivan

Bachelor of Commerce/Laws (Hons)  
Solicitor, Principal, O'Sullivan Johanson Lawyers  
Date appointed: 1.7.2014

### Carol McKinstry

B App Sc (OT), MHIth Sc, PhD,  
Grad Cert Higher Ed.  
Senior Lecturer OT, College of Science Health  
and Engineering, La Trobe Rural Health School  
Registered occupational therapist  
Date appointed: 1.7.2014

### Kate Lee

Administration Coordinator  
Murray Goulburn Co-op  
Date appointed: 1.7.2011

### Graeme Hodgens

B Ed, Dip Ed (Primary)  
Principal, Rochester Primary School  
Date appointed: 1.7.2011

### Reuben Johnson

B Ed, M Ed Leadership  
Principal, St. Monicas Primary, Kangaroo Flat  
Date appointed: 1.7.2012  
Retired: 30.6.15



### L-R

Graeme Hodgens, Keith Oberin, Tim Fulton,  
Carol McKinstry and Ben Maw.

Alan Darbyshire, Kate Lee and Michelle O'Sullivan

## Meeting Attendance

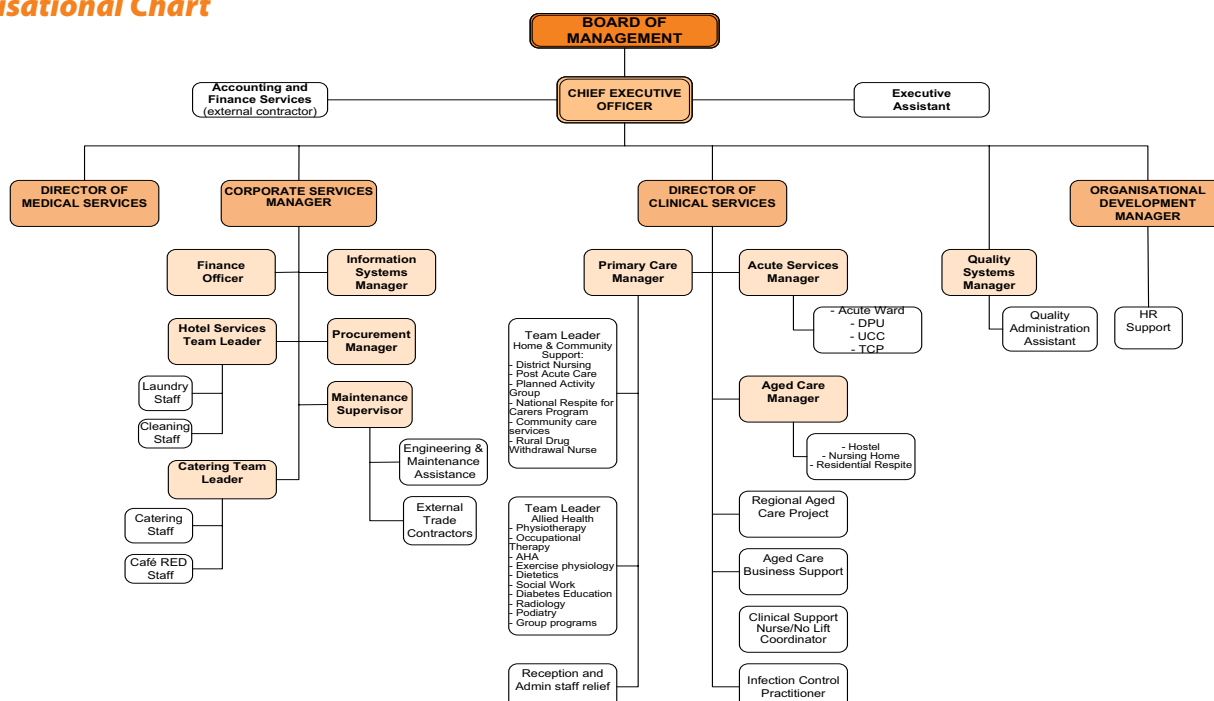
Board Meetings												Annual General Meeting	Total Attended
2014						2015							
	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
Timothy Fulton	✓	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓
Keith Oberin	✓	A	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓
Benjamin Maw	✓	✓	✓	A	✓	NA	A	A	✓	✓	✓	A	A
Alan Darbyshire	✓	A	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓
Graeme Hodgens	✓	✓	✓	✓	✓	NA	✓	✓	✓	✓	A	✓	✓
Reuben Johnson	A	✓	✓	✓	A	NA	A	A	A	A	A	A	A
Kate Lee	✓	✓	A	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓
Carol McKinstry	✓	✓	✓	A	✓	NA	✓	✓	✓	✓	A	✓	✓
Michelle O'Sullivan	✓	✓	✓	A	✓	NA	✓	✓	✓	A	✓	✓	✓

A = Apology, L = Leave of Absence, NA = no meeting held

## Committee Membership

	Risk Management & Planning Committee	Audit Committee	Credentials and Medical Appointments Advisory Committee	Quality of Care
Timothy Fulton	(4/4)	(4/4)		
Keith Oberin	(4/4)		(2/2)	
Carol McKinstry				(4/5)
Michelle O'Sullivan		(4/4)		
Graeme Hodgens			(2/2)	
Kate Lee	(4/4)		(2/2)	(3/5)
Alan Darbyshire		(3/4)		
Benjamin Maw	(3/4)			(3/5)
Reuben Johnson		(1/2)		
<b>Audit Committee (Independent) Members:</b>				
<b>Tracie Kyne</b> <i>Independent member of Audit Committee (retired 24.11.2014)</i>	N/A	(1/2)	N/A	N/A
<b>Rebecca Mitchell</b> <i>Independent member of Audit Committee (retired 24.11.2014)</i>	N/A	(1/2)	N/A	N/A
<b>Phillip Johnson</b> <i>Independent member of Audit Committee</i>	N/A	(4/4)	N/A	N/A
<b>Troy Holmberg</b> <i>Independent member of Audit Committee (appointed 3.3.2015)</i>	N/A	(2/2)	N/A	N/A

## Organisational Chart





# KEY PERSONNEL

## Executive

### Chief Executive Officer

Ms Anne McEvoy  
RN, B Hlth Sc (Nursing) Grad Dip  
Man, Grad Cert Gerontology,  
Grad Cert Diabetes Education

### Acting Director of Clinical Services

(to 19 October 2014)  
Mr Damian Holden  
RN, B.N. Post Graduate Diploma,  
PGD paediatrics

### Director of Clinical Services

(from 20 October 2014)  
Mr Mark Nally  
RN, B.Hlth Sc (Nursing), CCRN,  
M.Hlth Sc.

### Corporate Services Manager

(from 13 April 2015)  
Ms Clare Ireland  
B.SC, Dip. Bus

### Organisational Development Manager

Ms Aileen Dobson  
Dip HR Mgmt/IR, B Business (HR  
Management)

### Director of Medical Services

Dr Glenn Howlett  
MB BS LLB; Grad Dip Hlth Serv  
Mt; FRACGP

## Department Heads

### Acting Acute Services Manager

(to 9 November 2014)  
Ms Meredith Hodder  
RN, B.Nursing, ost Graduate  
Diploma Perioperative Nursing

### Acute Services Manager

(from 10 November 2014)  
Ms Meredith Hodder  
RN, B.Nursing, Post Graduate  
Diploma Perioperative Nursing

### Day Procedure Unit – Acting Associate Nurse Unit Manager

(from 31 March 2014 to  
29 March 2015)  
Ms Rebecca East  
RN, B.Nursing, M.Nursing (Nurse  
Practitioner)

### Aged Care Manager

(until 26 October 2014)  
Ms Jodie Holmes  
RN, B Nursing

### Aged Care Manager

(from 9 February 2015)  
Ms Michele Bibby  
RN, B Nursing

### Primary Care Manager

Ms Alicia Cunningham  
B.Sc., MND, MPH

### Infection Control Practitioner

(until 12 March 2015)  
Ms Fleurette Hastings  
RN, B.N., Grad Dip Renal  
Nursing, Grad Dip Crit Care

### Infection Control Practitioner

(from 9 April 2015)  
Mrs Gayle Kerlin  
RN, Dip. Primary Care  
Coordination, Cert. Infection  
Control and Sterilisation, Cert. IV  
Cleaning Standards Auditing

### Quality Systems Manager

Ms Lynn Wolfe  
Adv Dip Bus Man, Adv. Dip Bus  
Man (HR Bridging) Dip App Sci  
(Hort)

### Information Systems Manager

(to 10 April 2015)  
Ms Clare Ireland  
B.SC, Dip. Bus

### Procurement & Hotel Services Manager

(to 10 August 2014)  
Procurement Manager  
(to 10 April 2015)  
Ms Gayle McConnell

### Catering Manager

(to 10 April 2015)  
Ms Darlene Weeks  
B Hlth Sc (Nutritional Medicine)

### Maintenance Supervisor

Mr Brett Shotton

## Visiting Medical Officers

### General Practitioners

Dr M Attalh, MBBS (Egypt),  
Dr AS Asaid, MBBS (Egypt),  
AMC, FRACGP, FACRRM  
Dr I Buadromo, MBBS, FRACGP  
Dr J Duggan, MBBS (Uni of WA),  
MPHC (Flinders)  
Dr ED Ekeanyanwu, MBBS  
(Nigeria), FRACGP  
Dr N Fang, MBBS, DRANZCOG,  
FRACGP  
Dr S Mansour, MBBS (Egypt),  
MSc (Canada)  
Dr P Nzegwu, MBBS (Nigeria),  
AMC  
Dr R Moiz, MBBS (Karachi), AMC

### General Surgeon

Ms J Arnold, MBBS, FRACS  
Dr J Azzopardi, MBBS DA (UK)  
DRACOG FRACGP  
Mr M Oliver, MBChB, FRCSEd,  
FRACS

### Urologist

Mr M McClatchey, MB ChB BAO  
FRCS FRACS  
Dr R Hall, B.Med, B.Sc, FRACS

### GP Anaesthetists

Dr C Hunt, MBBS DRACOG DA  
ACRRM  
Dr S Kennedy, MBBS, FRACGP,  
ARTP (Anaes)

Dr C Taverna, MB BS

### Specialist Anaesthetists

Dr P Buncle, MBBS, FANZCA  
Dr K Davenport, MBChB,  
FANZCA  
Dr S Dobell, MBBS, FANZCA

Dr L Hamond, MBBS, FANZCA,  
Dip RACOG

Dr S Hams, MBBS, FANZCA

Dr J Harding, MBBS, FANZCA

Dr G Hay, MBBS, DRACOG,  
FRACGP, FRACRRM

Dr B Hindson, MBBS, FANZCA

Dr P Mazur, MBBS FANZCA

Dr M Nerlekar, MBBS DA MD  
FANZCA

Dr D Noble, MBBS FANZCA

Dr A Purcell, MBBS DA (UK) Dip  
Obs RACOG FANZCA

Dr M Shapiro, MBChB, H DA  
FANZCA

### Visiting Cardiologist:

Dr A Jackson, MBBS, FRACP

### Visiting Radiology Service

Goulburn Valley Imaging

# PERFORMANCE AGAINST STRATEGIC PLAN AND STATEMENT OF PRIORITIES (Part A)

## Professional People and Defining Culture

Strategy	Deliverable	Outcome
1.1 Defining Our Vision, Values, Philosophy	Build workforce culture to sustain motivation, productivity, quality work and retention.	• evaluated the effectiveness of the workplace culture and excellence program and new format commenced
		• participated in the regional SRHS Studer program
		• develop and implement a set of key HR metrics including lead indicators HR KPIs agreed, developing methods for collection and presentation of data
		• review of workforce immunisation policy completed
1.2 Attracting and Retaining Staff, Volunteers and Students	Build workforce capability and sustainability by supporting formal and informal clinical education and training for staff.	• evaluated the effectiveness of retention and succession planning strategies and implemented identified improvements e.g. new after hours nurse managers and trainees recruited
		• implemented a management development program for the leadership group, specifically around providing feedback, managing performance and addressing behaviour that could be perceived as bullying and harassment
		• implemented an electronic recruitment software program
1.3 Continuing Professional Development	Optimise workforce productivity through identification and implementation of workforce models that enhance individual and team capacity and support flexibility.	• implemented the Rural and Isolated Practice Endorsed Registered Nurse model in urgent care with three staff
		• investigated the nurse led x ray initiative and decided not to proceed
		• evaluated the inter professional graduate mentoring program with 80% of program participants having positive outcomes
		• investigated options for collaborative shared employment models including graduates
1.4 Aligning Organisational Structure, Roles and Responsibilities	Build workforce capability and effectiveness by clearly defining structure, roles and accountabilities.	• progressing with business modelling for allied health for contract with St Anthony's medical practice
		• implement the actions from the aged care cultural audit
		• progressed through aged care working party and trial of additional PCA hours to be evaluated
		• implemented the new staffing structure in catering and hotel services
		• completed a review of non clinical services structure with implementation of recommendations, including recruitment of corporate services manager
		• developed a Code Grey Policy and delivered education with some infrastructure updates to be finalised

## Great Care and Service Excellence

Strategy	Deliverable	Outcome
2.1 Delivering Great Care and Service Excellence	Evaluate current advanced care planning processes and implement in acute and community based set.	<ul style="list-style-type: none"> <li>evaluated advanced care planning processes</li> <li>improved staff knowledge and skill in facilitation and supporting advanced care planning with clients</li> </ul>
	Respond to the specific needs of people with chronic and treatable conditions	<ul style="list-style-type: none"> <li>increased primary care occasions of service by 12.4% compared to 2013-14</li> <li>day procedure unit services increased by 22.5% compared to 2013/14</li> </ul>
	Develop and implement improvement strategies that optimise client access, client continuity of care and the quality and safety of the health services.	<ul style="list-style-type: none"> <li>incrementally implementing the Great Care and Services framework, quality of care subcommittee focus on future goals and directions</li> </ul>
		<ul style="list-style-type: none"> <li><i>Campaspe Primary Care Partnership</i> project complete regarding service coordination in primary care</li> </ul>
2.2 Strengthening Evidence Based Practice, Our Services	Improve 30-day unplanned readmission rates.	<ul style="list-style-type: none"> <li>clinical reviews (Trigger Tool framework) completed for all such occurrences to identify and implement improvements. Readmissions within 30 days reduced from 13 in 2013-14 to seven in 2014-15.</li> </ul>
2.3 Creating a New Service Model, Business Model	Consider new models of care and more coordinated services.	<ul style="list-style-type: none"> <li>implemented the primary care team leader roles in August 2014</li> </ul>
		<ul style="list-style-type: none"> <li>developed a <i>REDHS Home Care Service</i> model with first home care client services rolled out in June 2015</li> </ul>
		<ul style="list-style-type: none"> <li>review and update the <i>REDHS Service Plan</i> supported by priorities of the Latrobe University project - not completed - with plans to complete collaboratively with Echuca and Kyabram health services</li> </ul>
2.4 Promoting Health and Wellbeing Strategies	Improve capability for health promotion planning and wellbeing strategies.	<ul style="list-style-type: none"> <li><i>Healthy Aging Project</i> collaboration with <i>Campaspe PCP Integrated Health Promotion Plan</i></li> </ul>
2.5 Shaping Service Integration	Ensure service coordination, discharge planning and referral processes support person centred care and timely and appropriate service provision.	<ul style="list-style-type: none"> <li>continue to implement Victorian Service Coordination principles and practices across the health service (particularly primary care services) and ensure quality standards and KPIs are maintained</li> </ul>

## Community Engagement and Strategic Relationships

3.1 Strengthening Community Engagement	Improve health literacy and support informed choice by responding to the health information needs of consumers and consider new services.	<ul style="list-style-type: none"> <li>embed the priorities of the <i>Improving the Health of Communities Through Participation</i> partnership with La Trobe University. Implementation progress and engagement improved and committee developed to support outcomes of relevance to REDHS and the community</li> </ul>
	Enhance communication with REDHS' catchment community.	<ul style="list-style-type: none"> <li>new REDHS website now live, localising newspaper articles to REDHS catchment areas</li> </ul>
3.2 Building Community Contributions	Actively promote existing initiatives that have utilised community funds and support to be undertaken and secure additional donations to support future initiatives.	<ul style="list-style-type: none"> <li>event held to signify the completion of the hostel refurbishment</li> </ul>
		<ul style="list-style-type: none"> <li>support community groups and events including the Rochester Mural Festival, Rochester Chamber of Commerce</li> </ul>
3.3 Maximising Strategic Relationships	In partnership with other providers within the local area, develop area based planning initiatives that consider health care across the continuum and develop strategies that maximise the use of available resources across the local area.	<ul style="list-style-type: none"> <li>participate in shared service initiatives with other health services to improve productivity</li> </ul>
		<ul style="list-style-type: none"> <li>collaborating in multiple aged care related projects such as the <i>Strengthening Health Services</i> project</li> </ul>
		<ul style="list-style-type: none"> <li>identify joint strategic and service provision opportunities with Aboriginal services and CEO a part of Campaspe Aboriginal Partnership Group meetings</li> </ul>
		<ul style="list-style-type: none"> <li>completed the management service to Dingee Bush Nursing Centre</li> </ul>



## Social, Economic and Environmental Sustainability

Strategy	Deliverable	Outcome
4.1 Shaping Social Sustainability	Actively support the Committee 4 Rochester (C4R) and the Rochester Chamber of Commerce.	<ul style="list-style-type: none"> <li>Completed obligations as the employing agency for the C4R Project Officer and participated in Strategic Planning sessions.</li> </ul>
4.2 Enhancing Economic Sustainability	Reduce variation in health service administrative costs.	<ul style="list-style-type: none"> <li>Investigated the viability of employing own pharmacist to reduce contract costs. Not progressed.</li> </ul>
		<ul style="list-style-type: none"> <li>Provided leadership and support to small rural health services in the region providing residential aged care regarding documentation and business improvement processes via the ACFI project with further funding committed for stage 3.</li> </ul>
		<ul style="list-style-type: none"> <li>Monitor and analyse effects of private patient strategy in acute on a quarterly basis, favourable % of admissions to previous year, however unfavourable to budget YTD.</li> </ul>
	Prepare for, and respond to changes in policy and regulation as a result of new Aged Care legislation.	<ul style="list-style-type: none"> <li>Application for significant refurbishment to improve revenue completed however unsuccessful.</li> </ul>
4.3 Instituting Environmental Sustainability	Implement initiatives to enhance existing environmental strategies and secure funds for further initiatives.	<ul style="list-style-type: none"> <li>Participating in the SRHS financial modelling tool to support review of the business processes involved in implementing the aged care reforms.</li> </ul>
4.4 Securing Alternative Revenue Streams	Fully embed Primary Care service growth opportunities.	<ul style="list-style-type: none"> <li>Replaced the majority of high energy globes with low energy globes which has supported a reduction in electricity costs of \$2K/month.</li> </ul>
		<ul style="list-style-type: none"> <li>Analysis completed on impacts of aged care reform on revenue at 6 monthly intervals with no major issues identified with bed pricing strategy.</li> </ul>
		<ul style="list-style-type: none"> <li>Investigate and, where possible, establish mental health service opportunities, supported by a sustainable financial model. Recruitment of mental health trained staff has been difficult.</li> </ul>
		<ul style="list-style-type: none"> <li>Trialing REDHS home based services with appropriate clients.</li> </ul>
		<ul style="list-style-type: none"> <li>Establish paediatric and family focused allied health service opportunities, supported by a sustainable financial model. Cost benefit analysis showing service not sustainable as yet.</li> </ul>

## Systems Enhancement and Business Excellence

Strategy	Deliverable	Outcome
5.1 Reviewing and Enhancing Systems	Improve performance reporting suite provided to management and the Board.	<ul style="list-style-type: none"> <li>New model of financial reporting graphs presented to Board in September. Department Managers receiving fortnightly FTE reports.</li> </ul>
	Fully implement streamlined Information Management Systems to improve organizational efficiency.	<ul style="list-style-type: none"> <li>Health Legal legislative framework and Commonwealth government quality improvement systems. Framework became accessible December 2014. Implementation is now proceeding, following REDHS piloting system for LMRHA.</li> </ul>
		<ul style="list-style-type: none"> <li>Implementation progressing slowly for e credentialing system.</li> </ul>
5.2 Telehealth and Telecare Strategy	Maximise the use of health ICT infrastructure.	<ul style="list-style-type: none"> <li>Support the outreach orthopaedic clinic (visiting service) delivered in Primary Care.</li> </ul>
5.3 Facilitating Innovation in all areas	Implement identified improvements to systems.	<ul style="list-style-type: none"> <li>Extra physiotherapist employed January 2015 to support aged care pain management model.</li> </ul>
		<ul style="list-style-type: none"> <li>Business analysis for shared allied health services to support outreach requests progressing favourably.</li> </ul>
5.4 Advancing Service Excellence, Business Excellence	Prepare for the National Safety and Quality Health Service Standards.	Maintain accreditation: <ul style="list-style-type: none"> <li>NATA Diagnostic Imaging (Radiology Services) achieved January 2015</li> </ul>
		<ul style="list-style-type: none"> <li>National Safety and Quality Health Service Standards achieved in July 2015</li> </ul>
		<ul style="list-style-type: none"> <li>Aged care accreditation standards maintained. Two successful support visits</li> </ul>
	Undertake an annual review board assessment to identify and develop board capability to ensure all board members are well equipped to effectively discharge their responsibilities.	The Board completed an extensive evaluation process with an Action Plan developed and priorities to action identified.
	Implement systems that support streamlined approaches to clinical governance at all levels of the organisation.	Participated in VMIA clinical governance pilot with the Urgent Care Centre clinical audit completed in May 2015 and are awaiting final report.  Review for Quality of Care Committee governance systems progressing. Strategy session with committee held June 2015
5.5 Procurement Review	Health Purchasing Victoria Procurement Governance Review.	Reviews of health service non-salary expenditure, contracts and asset management systems progressing as part of the HPV reform with REDHS actively engaged.

# HUMAN RESOURCES AND STAFF DEVELOPMENT

One of REDHS' strategic initiatives is people and culture, which drives us to enhance our culture as a means of attracting and retaining the best caliber staff as well as delivering the best possible care to our clients, residents and patients. Our focus is the 1:1 correlation between highly engaged and skilled staff and better clinical outcomes. We work towards this in a number of ways:

## Staff Development Day

All staff employed by REDHS are required to attend the staff development day once each year. This provides us with an opportunity of not only delivering mandatory competencies, but also exploring our culture and undertaking activities to enhance it, involving staff at all levels of the organisation.

## Workforce Plan

The Workforce Plan identified areas for growth to meet the health needs of our community. In the last 12 months we have grown services in the areas of occupational therapy, physiotherapy, podiatry and social Work as a direct result of this strategy.

*The Workforce Plan* also identified a significant shortage of nursing and allied health staff in the labour market, therefore a need to "grow our own". In the last twelve months, we have had eight enrolled nurses complete their Diploma in Nursing and another two complete their Advanced Diploma in Nursing. We have also had one enrolled nurse complete a Bachelor in Nursing to become a registered nurse and two personal care workers are currently undertaking their Diploma in Nursing so they can work as enrolled nurses.

This year we also supported three nurses to undertake *Rural and Isolated Practice Endorsed Nurse (RIPERN)* program that will enable them to undertake advanced nursing tasks in our urgent care centre.

## Transition from Training to Work

We have continued our traineeship program in 2014/15, with two trainees, one in administration and another in allied health. In fact, Maddy Chapman successfully completed the administration traineeship in 2014 and was successful in gaining a further traineeship with us in 2015 as an allied health assistant.

We support our traineeship program by fostering a close relationship with the local high school. In 2014/15 we provided eight year 12 students from Rochester, Echuca and Bendigo with work experience, many through the VCAL and VET allied health subjects.

REDHS has once again been involved in the Rochester Secondary College Trade and Traineeships Night, where one of our trainees and former students Madeline Chapman presented to the students with the aim of encouraging local students to consider our traineeships as an opportunity once they finish Year 12.

Clinic Support Nurse Cheryl Petrini, explains the program is a wonderful opportunity for students to come and see, first-hand a busy rural health service and many students are surprised by the level of experience they gain and the outstanding guidance and learning opportunities shared by the staff at REDHS.

We have engaged seven graduate nurses through the Northern Rivers Graduate Program, a partnership with four other health services to increase the intake of graduate nurses within the region, who are shared between the four small rural health services for six-month placements.

We have continued our partnership with St. Anthony's whereby one of our graduates works half time in their GP Practice. Our GP graduate was again fortunate to be sponsored by Medicare Local to attend the Practice Nurse Association Conference in Queensland in May

We continue to support placement of nursing and allied health students during their studies. In 2014/15 we placed 93 students for a total of 983 placement days, including nursing, occupational therapy, physiotherapy, podiatry, social work and dietetics. These students are our potential workforce of the future as has been evidenced by the employment of some of these students, once they have completed their studies.

The feedback from all students has been favourable, which is mainly due to the efforts of our staff who go out of their way to make the 'placement' experience at REDHS a positive one.

There has also been a strong emphasis in personal development through our six-month Allied Health Nursing Graduate Program. An inter-professional graduate model where the main goal is to ensure all participants are educated about careers and planning around personal goals and the life skills required to work in the health industry. Graduates meet with the Clinical Support Nurse regularly to discuss any issues, concerns, observations and learnings. There is tutorial given at each meeting to further promote self-directed personal development.

The REDHS *Best Practice Clinical Learning Environment (BPCLE)* project was also introduced last year as an ongoing model designed to create a 'best practice learning environment' for both staff and students. An evaluation of the program has demonstrated a high level of achievement against 'best practice standards' as well as some opportunities for improvement that we will work to implement throughout 2015/16.

This year REDHS purchased a brand new life support mannequin doll and a new chest and arms mannequin, which provides the ideal training aid to practice clinical skills ensuring our staff maintain the most up-to-date and 'best practice' clinical competencies on an annual basis. These training aids allow all staff to practice in line with required competencies.

## People Excellence

REDHS has partnered with five other small rural health services to develop and implement a program that has been funded by the Department of Health, to utilise the *Studer Approach*



strategies and tactics to create an aligned culture accountable to achieving outcomes. Using these strategies and tactics, we will establish, accelerate, and hardwire the necessary changes to create a culture of excellence. This leads to better transparency, higher accountability, and the ability to target and execute specific, objective results that REDHS wants to achieve.

This program has already demonstrated results through the *People Matters Survey* conducted in May 2015, where staff's perceptions of equal employment opportunity, workplace wellbeing, responsiveness, integrity and impartiality all scored in the top quartile when compared to similar sized organisations. Overall, REDHS' staff satisfaction remained high at 85%.

### Workforce Data:

	Ongoing		Fixed Term		Casual		Total	
	Head Count	FTE	Head Count	FTE	Head Count	FTE	Head Count	FTE
June 2015	145	91.70	11	8.68	23	10.64	179	111.02
June 2014	128	81.17	34	25.23	25	9.34	187	115.74

Staff by Gender	Ongoing		Fixed Term		Casual		Total	
Male	13	9.00	0	0	0	0	13	9.00
Female	132	82.70	11	8.68	23	10.64	166	102.02

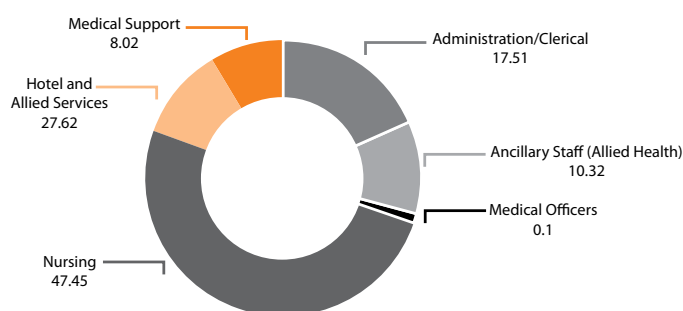
Staff by Age	Ongoing		Fixed Term & Casual		Total	
	Head Count	FTE	Head Count	FTE	Head Count	FTE
Under 25	8.00	5.68	3.00	1.85	11.00	7.53
25 – 34	15.00	8.87	5.00	2.39	20.00	11.26
35 – 44	25.00	14.66	8.00	4.58	33.00	19.24
45 – 54	51.00	32.58	11.00	6.17	63.00	38.86
55 – 64	42.00	27.25	5.00	3.39	47.00	30.64
65 +	4.00	2.66	1.00	0.84	5.00	3.50

**NOTES:** Note: All figures reflect active employees in the last full pay period of June 2014. Ongoing means people engaged in an open ended contract of employment. FTE = Full Time Equivalent.

### Staff by Occupational Group

Labour Category	Current Month		YTD	
	Jun 15	Jun 14	Jun 15	June 14
Nursing	47.45	63.84	45.58	58.06
Administration & Clerical	17.51	17.20	16.07	14.46
Hotel & Allied Services	27.62	23.70	26.79	21.95
Medical Officers	0.10	0.10	0.10	0.10
Sessional Clinicians	0.00	0.00	0.00	0.00
Hospital Medical Officers	0.00	0.00	0.00	0.00
Ancillary Staff (Allied Health)	10.32	10.90	9.63	10.10
Medical Support	8.02	0.00	8.95	0.00
<b>Totals</b>	<b>111.02</b>	<b>115.74</b>	<b>107.12</b>	<b>104.67</b>

### Staff - Full Time Equivalent as at 30 June 2015



### Recognition of Staff Service

REDHS is fortunate to have many long-term staff with a relatively low turnover. This year, REDHS recognises the service of the following staff:

#### 10 years

Emma Brentnall  
Linda Costello  
Leanne Gledhill  
Mary Hayes  
Glenys Lampard  
Elizabeth Moulden

Rhonda Nalder  
Rebecca O'Sullivan  
Jasmin Powles  
Kim Powles  
Jennifer Ryan  
Debra Shreeve

#### 15 years

Jeannie Holmberg  
Heather Johnstone  
Pauline Jones  
Philippa Kirk  
Carol Little  
Susan Ludbey

Megan O'Brien  
Karen Tognolini

#### 20 Years

Wendy Kneebone  
Janet McArdle  
Dorothy Smith

#### 25 years

Heather Wickham

# CLINICAL SERVICES REPORT

Clinical services at REDHS have diversified and grown again throughout the past year with the introduction of new initiatives and further development of key services which align with our strategic direction.

This year we have focused on 'growing our own' staff and have been proud to witness the progress of many as they have risen to the challenge of promotion.

There have been significant achievements in our focus of maintaining high standards of care and ensuring they are person-centered across all program services. REDHS commends the efforts of our clinical department managers on their leadership and attention to the strategic direction of our organisation.

During the year we introduced the Studer program for our leaders - a sharing of goals and sound reporting of progress ensuring that our organisational plans are being carried out. The Studer program also helps in the understanding of organisational priorities and creates a spirit of unity and commitment across our various clinical services.

An example of the collaborative spirit of REDHS staff is the planning, provision and promotion of advance care planning process across the entire organisation. This in-turn ensures REDHS meets its goal of being a responsive, sustainable health service that is well known for compassionate care, which is a direct result of the care provided by our staff. Some of the area highlights for the year include:

## Primary Care

Our primary care services have continued to grow and diversify with the introduction of team leaders in home and community services and allied health.

This has promoted line-management, communication and detailed budgetary oversight for all components of primary care, improving governance and refining responsibilities.

The primary care team extends its support across many of the projects that REDHS undertakes, providing a valuable multidisciplinary perspective, that contributes to their success.

The success of the REDHS Trainees Program within primary care has also been a real achievement. This process of encouraging local youth into our workforce is an example of the progressive leadership provided by our primary care manager Alicia Cunningham and her team.

Our physiotherapy service has been an example of diversification; with our aged care physiotherapy program commencing and increased community services now resulting. Podiatry services continue to grow with provision of clinics across a variety of venues within our region, such as Rushworth, Echuca and Stanhope.

Primary care has also become increasingly active in regards to health promotion with lead roles taken in coordination of events such as *April Falls Day* and support for the local drug prevention education evening at the local high school. These health promotion activities are a form of invaluable preventative medicine for our community and will be a significant part of the future focus of our health service.

Our outpatient services, inclusive of group programs and home services, also continue to support people in our community. The recent addition of Home Care arose from the noted need within our community for this service. This fits the model of community support without the necessity for hospital admission and will be another area of strategic development for REDHS.

REDHS is also pleased to report excellent feedback from our clients as we provide services such as the *National Respite for Carers* program within the community.

## Aged Care

This year we have also witnessed further improvements and innovation within our aged care department. The hostel refurbishment has been completed with the works refreshing the buildings and improving functionality. These works will continue in the coming year with ongoing repainting and minor carpentry.

Michele Bibby is the new aged care manager and brings a wealth of aged care experience to the role. Her person-centered approach is in line with the REDHS values and she has introduced many new programs and initiatives to ensure we maintain our high level of care at REDHS.

Our aged care *working party* has been engaged to provide input into the work practices and routines within the department to ensure we are always striving for the best level of care for all residents. Our REDHS activities staff members have been engaged in innovative programs, including the incredibly successful *Sing Out Loud choir*. The benefits of these programs include the sharing of the positive experience with residents and staff.

Our attractive facility and our quality of care have resulted in high demand for our beds throughout the year.

## Projects

REDHS has been the lead agency for the project *Aged Care Funding Instrument (ACFI)* for many small rural health services. This change, affecting all aged care services, involves the assessment of residents and ensuring appropriate interventions and support are being provided. The initiatives overseen by our project have ensured organisations providing aged care services in our region are funded correctly. This in-turn benefits residents of the health services.

## Education and Innovation

Central to our theme of 'growing our own' is education. Our clinical placement program that involves the majority of health-based careers has continued to broaden. I must acknowledge the support given by our education team throughout these programs. The commitment of our staff has been integral to the success of this program, who act as preceptors and mentors through the clinical placements. They also play an important role in giving feedback to students for which they should be congratulated.

Our *Northern Rivers Graduate Nursing* program has developed and our graduates have progressed with diverse clinical knowledge and experience and an increased chance of flourishing careers. During the last year the program saw the introduction of a ground-breaking partnership with one of our local general

practice clinics which resulted in a broad experience gained by one of our graduate nurses, through shared support and education across both hospital and GP settings.

### **Infection Control**

REDHS would like to acknowledge the extensive body of work done by Fleur Hastings over the last few years in infection control. Fleur's resignation to focus on her career in Castlemaine left quite a gap, however we were fortunate to be able to recruit Gayle Kerlin who brings a wealth of experience to our team.

Issues managed by infection control this year include planning and training for potential infectious diseases such as Ebola, and local issues including maximising immunisations for Influenza for our staff and client groups.

### **Day Procedure Unit**

Day procedures continue to grow in number throughout 2014-2015. Dr Rohan Hall (urologist) commenced operating with us during this time, filling the void left after the departure of Dr Angelika Borozdina.

During the early part of 2015 our steriliser ceased to function and our Board approved replacement of this expensive, but essential item. The steriliser will be commissioned in mid-July 2015. The DPU staff worked collaboratively with Echuca Regional Health (ERH) to ensure minimal disruption to services. We acknowledge the efforts of all staff through this time, particularly REDHS Associate Nurse Unit Manager Rebecca East and the CSSD staff here and at ERH.

### **Acute Ward**

Meredith Hodder was appointed as nurse unit manager of acute in November 2014. Meredith brings a variety of skills to this position and a positive attitude that is shared by her staff group. Examples of progress in this department include the introduction of the *Rural and Isolated Practice Endorsed Nurses (RIPERN)* program to REDHS, where nurses are able to independently review certain patients presenting to urgent care. This, in turn, reduced the burden on our hardworking medical colleagues.

A recent review of our urgent care facilities is an example of utilising external resources to ensure that 'best practice' is employed by our facilities.

Our after hours managers make significant contributions to the smooth running of the organisation out-of-hours which requires independent decision making and confidence in their understanding of REDHS vision and values.

Acute ward has progressed person-centered care via the introduction of 'bedside hand-over', which includes patient involvement in the decision making of their care.

Members of the REDHS Medication Advisory Group have worked closely with our acute nurses to introduce antimicrobial stewardship. This ensures the best practice use of antibiotics across our organisation to minimise the risk of resistant infections.

### **Mark Nally**

**Director of Clinical Services**

## ACUTE SERVICES

Acute services staff have continued to provide high quality health care to inpatients, day procedure patients and people presenting to the urgent care centre (UCC).

The retirement of some long-standing senior staff required some adjustment for remaining staff however successful recruiting has filled positions, both with new staff members and existing staff members who have been able to further their careers through promotion. Meredith Hodder, former associate nurse unit manager, was appointed as the acute services manager in November 2014 to lead all three areas.

### **Acute Ward**

There were 403 acute ward separations compared to 452 last year. Patients stayed an average of 9.3 days, an increase from the 7.4 days last year. For a small number of patients who had very long stays this year a different methodology was also used in order to facilitate future benchmarking opportunities, both contributing to the significant variation to previous years.

Under the leadership of Meredith Hodder, staff were involved in the preparation of evidence for the EQIP National accreditation survey in April 2015. The survey involved the ten *National Safety and Quality Health Service Standards* with REDHS also opting to be surveyed against an additional five standards. The new standards focus heavily on frontline care, so the staff were more directly involved than previously. They developed and embraced some new processes, forms and policies. (REDHS was awarded full accreditation in July 2015).

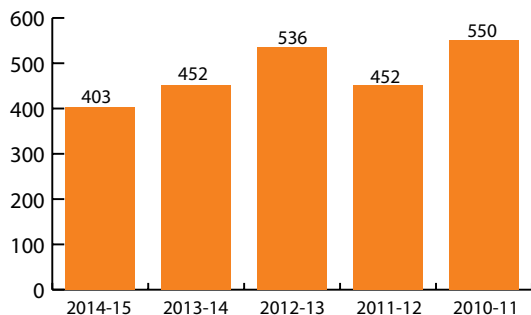
This year REDHS launched the Rural and Isolated Practice Endorsed Nurse (RIPERN) model of care in the REDHS UCC. This model has been introduced to improve access to safe and timely care, and to reduce the burden on the GPs related to after hours and on-call requirements. The Department of Health and Human Services (Victoria) has been working with rural health services in implementing this model which allows a RIPERN nurse to obtain, supply and administer specified medications for nursing practice in a rural area when a doctor or nurse practitioner is not available. Our four RIPERN nurses have undergone specific training to equip them with advanced skills in assessing and treating patients who present to the UCC. REDHS is encouraging more nurses to become RIPERN endorsed by undertaking the required training and currently has two staff members studying for the qualification.

Bedside handover and bedside discharge planning were both introduced this year to facilitate increased patient (and carer) involvement in their care. These bedside gatherings have proven to be a great opportunity for information exchange that builds team relationships between patients, family members and care givers.

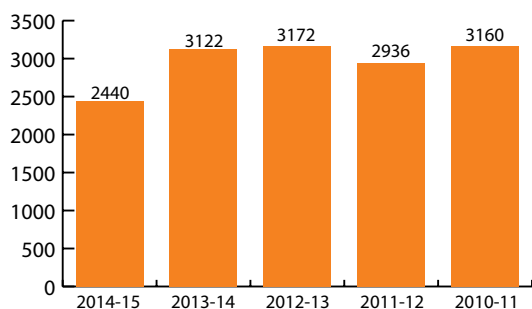
Acute staff have enjoyed working with the graduate nurses and appreciate their enthusiasm and professionalism. The acute ward also continued to host student nurses throughout the year. Education within the day-to-day activities in acute continues to build our workforce for the future.



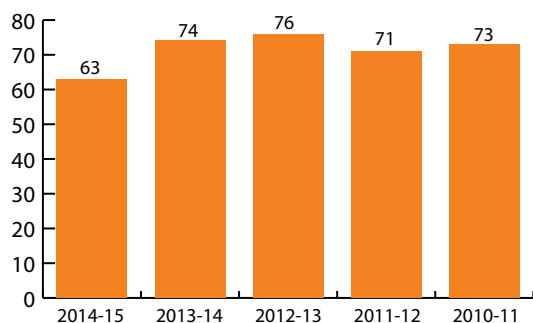
**Acute Ward Separations**



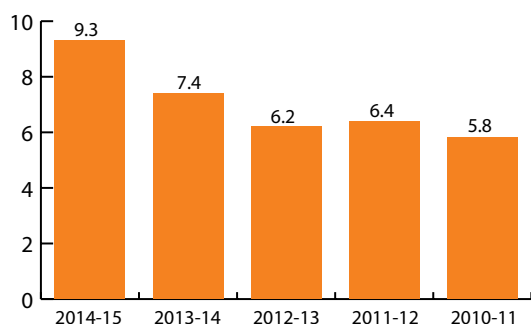
**Acute Ward Bed Days**



**Acute Ward Occupancy (Average %)**



**Acute Ward - Average length of stay (Days)**



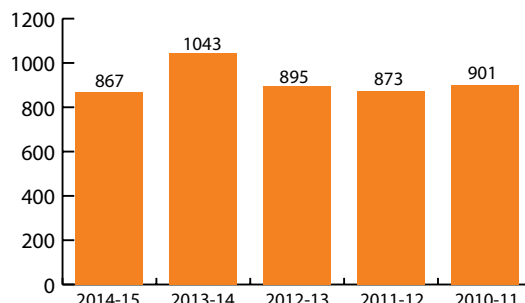
### Urgent Care Centre

The REDHS urgent care centre (UCC) recorded 867 people presenting for care, down from 1,043 last year but back in line with previous years (see graph).

The UCC was also included in the accreditation survey and met the required standards. Accreditation is only one method of determining the level of quality and safety; audits are another method. REDHS is very pleased to be one of the pilot sites for the *External Audit of Clinical Areas – emergency departments and Urgent Care Centres* project through VMIA, VHA and East Grampians Health Service. This audit, focusing on the high-

risk presentations to UCC, was carried out by independent health professionals in May 2015. Initial results are pleasing with a high standard of care noted by the auditors. Detailed refinements suggested were welcomed and will allow continued improvements in care to be benchmarked against 'best practice'.

**Urgent Care Centre Presentations**



## DAY PROCEDURE UNIT

DPU has continued to provide high quality service throughout the year with many compliments regarding the service being received. One patient commented, *"I commend the staff, they were amazing, very cheery and polite. I didn't want to go home, it was like a hotel. I was apprehensive before the procedure but I felt like I was treated like family."*

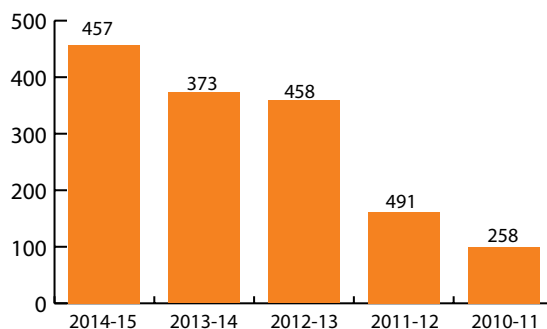
Acting DPU associate nurse unit manager, Rebecca East, continued in the role until her resignation in March 2015. Acute services manager, Meredith Hodder, is covering this role until a replacement is recruited.

Activity in the DPU has continued to grow, with a 22.5% increase in separations from last year (see graph). REDHS' DPU undertook minor procedures including gastroscopies, colonoscopies, cystoscopies, excision of lesions, vasectomies and carpal tunnel release.

Day procedure unit staff were also involved in the April 2015 accreditation survey and were able to provide evidence to the surveyors of the continuing safe, high quality care in-line with the required standards.

DPU staff were also pleased to work with Echuca Regional Health staff during the steriliser replacement process to ensure that procedures could safely continue during this time.

**Day Procedure Unit Separations**



## TRANSITION CARE PROGRAM

The Transition Care Program is managed by Aged Care Manager, Michele Bibby, with two residential beds and one community bed (in the client's home) available through a brokerage arrangement with Bendigo Health. The target for the program is 95% occupancy, which was exceeded with a result of 98.4%. REDHS was one of the few health providers in regional Victoria to achieve the target. This was partly due to REDHS picking up additional places when offered by Bendigo Health throughout the year. Clients can participate in the program for up to 12 weeks.

Occupational therapy has also evolved into a case management role to centralise the process, with the overall responsibility coming under the aged care department.

Until recently, the residential beds were located in the hostel but the demand for permanent residential aged care beds increased. This necessitated transferring the program to REDHS Acute ward on a trial basis for three months. This was communicated to the Department of Health and Human Services. REDHS was required to make some minor alterations in the furnishings of the designated rooms to create an enhanced home-like environment, but with consideration to OHS and Infection Control requirements. During the trial, Acute ward beds were monitored to make sure that they had not been compromised with minimal impact recorded. The trial has been very successful so the program will continue to be delivered in this location.

To facilitate the move, TCP allied health assistant, Jacinta McWhinney, relocated her office to the Acute ward and occupational therapist, Nerae Anstee, was allocated case management time to support the transition and centralise processes. Acute ward staff were provided with education to enhance their knowledge of the program including the importance of promoting independence to TCP clients and the philosophy of slow stream rehabilitation programs. We acknowledge the work of staff during the change – their efforts have led to the continued success of the program.

Throughout their participation, TCP clients are increasingly involved in *Activities of Daily Living* such as a Breakfast Club, aged care activities with residents and community return. During this time they also progress through a range of physiotherapy activities and, on an "as needs basis", other allied health input such as occupational therapy and social work is provided.

Clients, in consultation with TCP staff, set the goals they would like to achieve by the end of the program. Some have the aim to maintain their independence at home and others are transitioning to aged care.

For one client this year who was in hospital, it looked as though residential aged care was going to be the best option. However, the client was undecided. The client was referred to REDHS TCP staff, who worked with him to achieve a goal of maximising the client's independence. By the end of the 12 weeks, the client was able to successfully return home with some support services put in place.

## RESIDENTIAL AGED CARE

The major highlight of the year in the REDHS Aged Care Unit was the completion of the major refurbishment in the hostel. A celebration was held in October with residents and their families, friends and staff. A locally based harpist entertained the guests who enjoyed lunch in the courtyard, which had also received a revamp in time for the celebration. Board member, Kate Lee, spoke about the generous bequest that had contributed so much to the refurbishment. Chief Executive Officer, Anne McEvoy, spoke about the great efforts and teamwork required by staff to minimise disruption and the involvement and cooperation of residents and families throughout the many months of activity.

Residents, their families and staff provided feedback regarding the courtyard revamp to include plants and flowers popular with the residents, additional room to play bowls and more space for tables and chairs.

From an operational perspective, there had been a restructure of staff with one aged care manager having the responsibility for both aged care facilities since last year. Michele Bibby was appointed as aged care manager in January 2015 following the departure of Jodie Holmes (who resigned in September 2014) and Damian Holden in an acting role. An associate nurse unit manager (ANUM registered nurse) is now rostered to every shift, there is an additional staff member on night shift extended shift lengths and additional administration hours. These changes were instigated to provide more direct resident care hours and ensure REDHS aged care sustainability into the future.

The ANUMS have been trained and guided to take on enhanced leadership roles and responsibilities including care planning, consultation processes and clinical staff support.

There has been a redefining of roles and a tightening of processes ensuring all aged care staff are aware expectations of them in order for REDHS to deliver the highest quality care.

There have been many events and celebrations during the year, which have included:

- Commonwealth Games event in August
- Aged Care Staff Celebration Day in October
- Book Week celebrations with local primary school students
- annual footy tipping contest throughout the winter months
- visit by the local Salvation Army brass band
- annual Hat Day in October to highlight mental health
- Easter craft activities with local primary school children
- visit to the Rochester Mural Festival
- Couples Day to celebrate Valentine's Day in February
- Mothers' Day High Tea
- Australia Day BBQ
- April 'Falls' Day on April 1st to highlight falls prevention
- ANZAC Day memorial service

Another major highlight for the year was the much-enjoyed public performance by REDHS *Sing Out Loud* choir, as featured on the cover of the report. The group put on a wonderful performance for family, friends and staff after eight weeks of rehearsal. The fun and enjoyment that choir members had was very evident and planning for another program for next year is underway.

The choir consisted of residents, family members and volunteers who were supported by REDHS Activities Coordinators, a volunteer pianist and a maestro from the Arts Health Institute in Melbourne. In addition, the choir was not only named the Australia Day Arts Group of the Year for Rochester but was also named the 2014 Campaspe Shire Arts Group of the Year at the annual Australia Day awards. This was a fabulous achievement and one of which the entire organisation is very proud.

The aged care area received two unannounced visits this year. The first was in November 2014, at which we were found to be compliant. The feedback given did result in an internal review being brought forward to ascertain the effectiveness of the staff restructure.

One of the outcomes of this review was the rostering of additional care hours during busy times (morning and afternoon shifts) in the high level unit, which allows the registered nurse more time in the low care unit.

The second visit was in April 2015, at which we were also found to be continuing to meet the required standards. Staff are currently working towards a full accreditation survey in July 2015.

Achievements for the year have included additional staff training in the computer software on which resident health information including care plans is kept, and the carrying out of comprehensive self-auditing. These measures ensure we are on the right track and identify what we are doing well and any areas for improvement to the care we provide.

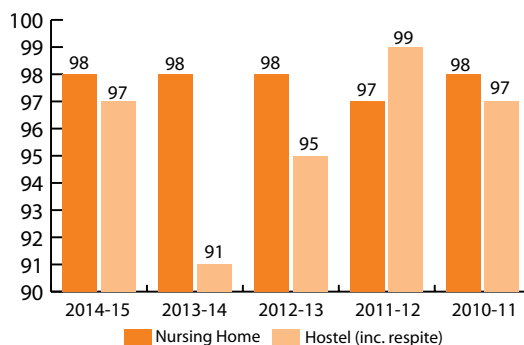
A major outcome of this auditing process is the revamping of the *Resident of the Day* process. This has introduced another opportunity to formally review all residents and is conducted each month to consult with families to track any changes or concerns with residents and update care plans. A formal annual review still exists and families are welcome to touch base anytime, however this additional, formalised, and more contemporary process is another way of monitoring whether all resident's needs are being met.

The REDHS Pain Management Project began in February 2015 and has seen the introduction of a dedicated physiotherapist four days a week to provide specialised treatments to aged care unit residents. The feedback from residents has been extremely positive with many commenting how the treatments have allowed them to get more enjoyment from life as they have less pain and are able to take part in activities again. Many of these residents are now participating in activities such as gardening and other planned activities, which is a great result for everyone involved.

In the coming year, the aged care department is looking forward to the introduction of an electronic medication system to help reduce the potential for medication errors.

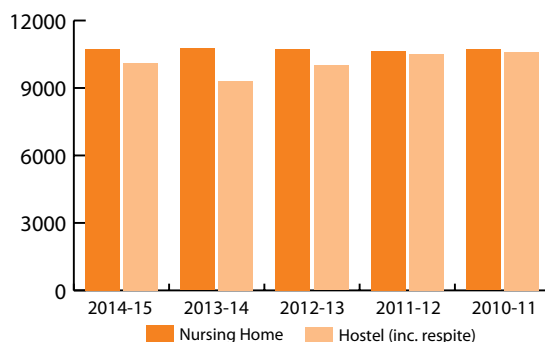
REDHS aged care management and staff would like to thank the many volunteers who give so freely of their time to spend with residents. They enable REDHS to offer a wider range of activities than would otherwise be possible and brighten residents' days in so many ways.

**Aged Care Occupancy (%)**



***Demand for Nursing Home (High Care) occupancy remains consistently high. An increase in demand for Hostel (Low Care) places has been recorded with occupancy returning to match the rates of three and four years ago.***

**Aged Care Bed Days**



***In 2014-15, there were 10,751 Nursing Home bed days (including respite) compared to 10,757 last year. Hostel bed days (including respite) increased from 9,322 last year to 10,110 in 2014-15 and reflects the increased demand as illustrated in the above occupancy rates.***



# PRIMARY CARE SERVICES

## **Primary Care – Overview – Alicia Cunningham**

In the past 12 months the primary care team has continued to introduce new programs and services to support people to enhance or maintain their health and wellbeing, their independence living in Rochester, Elmore and surrounding districts, and to access services locally.

There have been a number of key highlights across the department during the 2014-15 financial year including a restructure, the introduction of a new health coaching style - the Studer Approach, new initiatives and programs, staff education and training, and a move towards an enhanced collective accreditation method.

In August 2014 primary care underwent a restructure to amalgamate primary care services into one team. Previously 3 program areas were managed as separate teams including district nursing, Transition Care Program (TCP) and primary care. As part of the restructure, primary care and district nursing amalgamated, and TCP moved to aged care.

Alicia Cunningham continues as primary care manager, assisted by Meaghan Sully and Andrea Howarth, who were appointed in team leader roles. The restructure has increased the department's capacity to meet the strategic goals of the organisation, further investigate opportunities to grow the primary care services, and support staff to provide high quality and best practice care for clients. Despite an initial transition phase, team cohesiveness and communication has improved significantly and the restructured service area is functioning smoothly and effectively. As a management team, Alicia, Meaghan and Andrea work together exceptionally well – their combined management, strategic and clinical experience adds great depth, strength and stability across primary care services.

The Studer Approach has been implemented across REDHS this financial year and has already received favorable endorsement from within the primary care department.

Since October 2014, Alicia, Meaghan and Andrea have been engaged in monthly meetings with a coach from the Studer Group, to train in the new approach.

As part of the process, the management group has introduced a new rounding technique, which has had a markedly positive impact on the team.

Rounding with staff is an approach where managers meet with individual staff members in their own work space, and engage staff members in a conversation centred around what is working well, what is not working well, how they can improve areas that are not working well, and how the management team can support them to make improvements.

Another new Studer initiative has been the introduction of huddles to replace traditional meetings at a leadership and

departmental level. The approach requires participants to meet outside in a huddle to discuss what is happening across the organisation and within the department. Huddles must be concluded within 15 minutes and are already proving to be a much more effective use of staff time.

Throughout 2014-15, primary care staff have completed a variety of training courses and professional development, and the department has again placed a strong emphasis on supporting student placements, including allied health, paramedicine, nursing, pharmacy and work experience students.

Group programs in primary care have expanded this year in response to community demand and have received overwhelmingly positive feedback from participants:

- The Fitness for Older Adults Program (FOAP) reached 61 individuals in the 2014-15 financial year. FOAP operates as two separate groups averaging 25-30 participants over the winter months and 30-35+ over the summer months.
- Cardiac Rehabilitation saw growth in numbers to 13 participants by the end of the year with an average of eight participants per session.
- Strength & Balance Level 1 recorded steady growth to 14 participants this year. This group will continue to grow due to the implementation of the Falls Prevention Program, which has encouraged participants to seek out further exercise programs to support their ongoing health and fitness goals.
- Participant results in the lifestyle program Life! this year were excellent. The six participants who completed the entire course lost a total of 35.5cm from their waist measurements and 8.3kg in body weight.
- The Type 2 Diabetes Education (T2DM) program commenced in March 2015 aimed at improving general fitness, encouraging healthy eating and developing diabetes self-management skills. The program received excellent feedback from participants who experienced improvements in a range of areas including sleep patterns, exercise routines, dietary knowledge and social interaction.

Another new program implemented in 2014-15 year was the Falls Prevention Program supported by a grant received by Loddon Mallee Murray Medicare Local (LMMML) and led by a multi-disciplinary team. Seven community members were recruited via media advertising, or referrals from general practitioners and allied health professionals. Results showed that participants had increased their confidence in daily activities, made positive changes to reduce the risk of falls, and experienced increased mobility, endurance and balance.

## PRIMARY CARE SERVICES

### Allied Health Assistants

An allied health assistant (AHA) traineeship was once again made available at REDHS during the 2014-15 year. Maddy Chapman commenced this role in January, working five days per week at REDHS, and studying her Certificate IV in AHA at Bendigo TAFE. Maddy works alongside allied health assistant Kellyann Clarke, supporting allied health professionals with their treatment plans for clients in acute, aged care and the community. Allied health assistant Jacinta McWhinney, supports the Transition Care Program.

A major highlight for the AHA team was the commencement of the pilot Falls Prevention Program which consisted of seven group members and provided both education and exercise components. The education was provided by various health professionals and the exercise sessions were delivered by Maddy and physiotherapist Keely Trew. The six week program recently concluded with excellent results and is likely to run again next year.

Another highlight for the AHA staff was the development of the Food Service Reference Group, consisting of staff members from various departments including dietetics, aged care, catering, quality systems and a consumer representative. The group focuses on improving nutrition for all residents/patients and ensuring the choices offered are understood and readily available. Through its multi-department involvement, the group aims to ensure the consistent delivery of appealing and nutritious meals.

The AHA team held its first April Falls Day on April 1st – an interactive and educational display on falls prevention that included fun games, show bags and advice and information from health professionals. The event was well received by the community and within the organisation, and will be held again in 2016.

A challenge that invited new and innovative solutions for the AHA team was the introduction of a new discharge planning process in February 2015.

Allied health collaborated with nursing staff in changing the way discharge occurs on the acute ward. In the past, discharge took place 'behind closed doors', with less patient engagement. To improve patient outcomes, allied health were involved with the introduction of a new Bedside Discharge Planning system whereby discharge planning occurs at the patient's bedside, allowing the patient to be engaged in discharge discussions. The new approach assisted REDHS to align with national standards through its accreditation process, but also fostered strong relationships between clinicians and patients. There were challenges related to the change in location and involvement of the patient in this discussion, however the huge gains for patient outcomes in Bedside Discharge Planning has made the change worthwhile. Patients themselves have provided positive endorsement - importantly patients who have had previous admissions note the positive aspects of being involved in their own discharge discussion.

The primary care department has identified opportunities to expand staff knowledge and skills around supervising and delegating appropriate tasks to allied health assistants, and building AHA competency across a range of allied health practice. There is potential to branch out into many new areas, including podiatry and social work. Maddy, Kellyann and Jacinta will continue working with allied health professionals to determine what expanded support they can provide to allow clinicians to focus on higher-level clinical tasks.

### Community Care Program

REDHS has recently commenced a *Community Care Program* as part of its strategic goal to grow primary care services. The program supports people in the home through the provision of personal care and home care services.

The program responds to a need in the community for the provision of locally based services, and complements existing REDHS primary care services by supporting people to remain at home.

Clients of this program are often people who come to REDHS for respite in aged care, and this new service is about providing them with a further choice of provider and a continuum of care whereby the staff they see in the community will be the same staff they see in the aged care setting.

Andrea Howarth and Alicia Cunningham have been working to develop a sustainable model of service delivery for the program since August 2014. The new program is based upon a full cost recovery model, which is achieved through offering the service to people in receipt of home care packages or post acute care services. Where a client requires personal care, the REDHS *Community Care Program* becomes an option.

In future, there is potential for the service to be expanded to offer some maintenance around the home and assistance with client travel needs.

### Diabetes Educator

The REDHS diabetes educator Leanne Rankin continues to provide a valuable service to the acute and aged care departments, and the wider community.

In addition to working directly with clients to educate and support self-management of diabetes care, this year Leanne has focused on the delivery of the *Type 2 Diabetes Education (T2DM)* program and the *Life!* program.

The *T2DM* program commenced in March 2015 and was a six week exercise and education program aimed at improving general fitness, encouraging healthy eating and developing diabetes self-management skills.

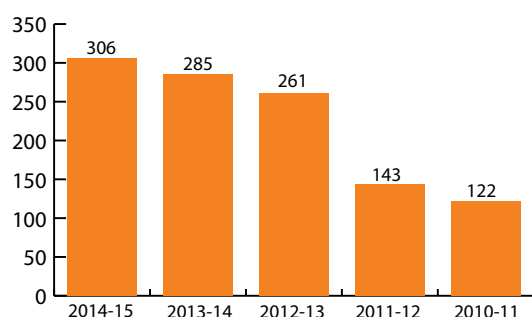
The program was developed and delivered by the REDHS primary care team through Leanne, Katherine Watson (dietitian) and Ash Watson (exercise physiologist).

The program received excellent feedback from participants who experienced improvements in a range of areas including sleep patterns, exercise routines, dietary knowledge and social interaction.

*Life!* is a lifestyle program aimed at the prevention of type 2 diabetes, heart disease and stroke and is open to participants at risk of diabetes (>45 years old) or over 18 years of age with a family history of gestational diabetes or Ischaemic heart disease and who do not have a diagnosis of diabetes.

The program runs over six sessions and involves education about the disease process, dietary changes and exercise.

**Diabetes Education - Occasions of Service**



## Dietetic Services

Katherine Watson continues in her dietetic role at REDHS working closely with the food services staff to ensure patients and residents are well nourished and have food choices for optimal health and wellbeing.

She has been motivated to see the establishment of the Food Services Reference Group (FSRG) which was initiated 12 months ago to monitor and evaluate food services at REDHS and to develop appropriate policies. The group meets bi-monthly and includes REDHS staff and a consumer representative. Given the growing emphasis placed on nutrition and hydration within the accreditation process, it is anticipated that the FSRG will be a permanent meeting group moving into the future.

The Community Kitchen program continues to be held at REDHS on a fortnightly basis and is highly valued by participants. This program, initially facilitated by Katherine, is now participant-led and involves a group of people coming together to socialise and cook affordable and nutritious meals.

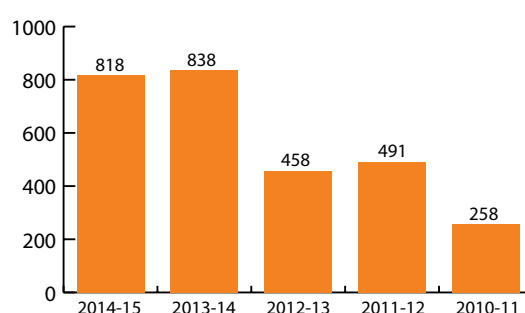
REDHS dietetics services have also been contracted to provide nutrition expertise and management to clients residing at Wharparilla Lodge, an aged care residential service provided by Echuca Community for the Aged. As testament to the success of that partnership, Wharparilla Lodge will use Katherine's expertise next financial year to assist with a menu review to support Best Practice processes.

Katherine also provides an outreach service to Dingee Bush Nursing Centre on a fortnightly basis, which is funded through the Rural Workforce Agency Victoria.

In early 2014, the dietetics service reviewed and changed the malnutrition screening form used in the acute ward. All new patients are required to complete the screen for malnutrition.

The dietetics department hosted a group of final year dietetic students from LaTrobe University Bundoora during 2014-15, and has been involved in a number of the primary care group initiatives and health promotion activities throughout the year including the Falls Prevention Program, the Type 2 Diabetes Education (T2DM) program and Healthy Weight Week activities.

**Dietetics - Occasions of Service**



## District Nursing

The district nursing team provides a wide range of nursing services to meet the in-home nursing care needs of the Rochester and Elmore district community.

These services include post acute care, domiciliary midwifery services, hospital in the home, Department of Veteran Affairs community nursing services, palliative care and *Home and Community Care (HACC)* nursing. The key care areas continue to be in wound management and infection control.

This year the REDHS district nursing staff made 5,782 visits and delivered close to 2,600 hours of service to the community.

The members of the district nursing service operate as a team and consistently support one another's work. The recent transition into a bigger team under the primary care umbrella has created a period of adjustment, which has been embraced by all parties.

The service has a reputation for high quality care, and is considered an excellent placement destination for nursing students. District nursing has hosted many students this year, including those studying nursing, pharmacy and podiatry, as well as those undertaking work-experience.

Highlights for the service this year have been the review of assessment and care planning processes to improve person-centred care.

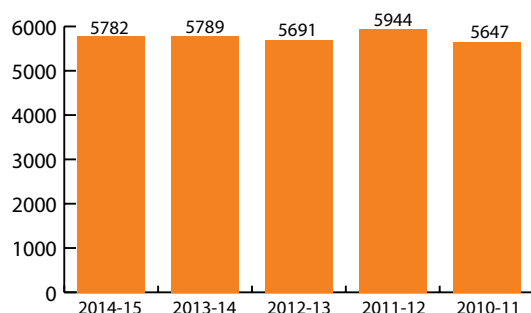
The service has made some changes to the storage of items in cars this year, in line with infection control and Occupational Health and Safety guidelines and has established a wound consumables fund to assist clients with the payment of consumables for chronic wounds.

## PRIMARY CARE SERVICES

A key strength of the team is that each nursing staff member plays a lead role in their area of expertise. As an example, this year Ali Walsh has accessed education in palliative care which is being incorporated into care plans for palliative care patients and is achieving better outcomes for clients in terms of pain management and general support and access to services they might need.

All staff members are committed to *Advanced Care Planning (ACP)* and are weaving that into the acute and aged care settings. The next area for growth is to introduce ACP into the community and the district nurses will be at the forefront of facilitating that process.

District Nursing - Occasions of Service



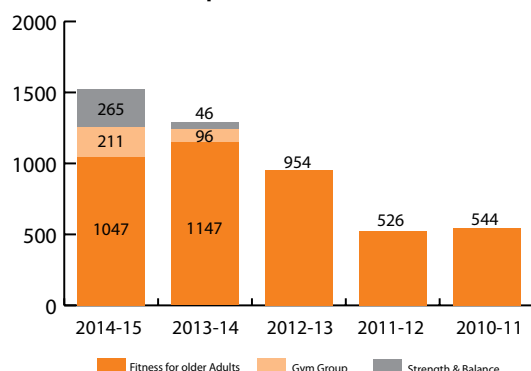
### Exercise Physiology

Our exercise physiologist Ash Watson specialises in clinical exercise prescription, health education and the delivery of exercise-based lifestyle and behavior modification programs for the prevention and management of chronic disease and injury.

Ash works one day per week in the exercise physiologist role at REDHS. He recently completed his Graduate Certificate in Diabetes Education through Deakin University and provided a backfill support role one day per week whilst the diabetes educator has taken long service leave. This opportunity has allowed Ash to strengthen his skills and experience in diabetes education.

In addition to conducting individual sessions, he also oversees group exercise sessions i.e. the *Fitness for Older Adults* program and a gym group on a weekly basis and this year has been a co-facilitator in the *Type 2 Diabetes* group program.

Group Fitness Attendances



### Occupational Therapy

REDHS occupational therapists Casey James and Nerae Anstee continue to provide a valuable service across our primary care, acute and aged care departments.

A key highlight this year has been the continuation of HACC funding to enable Casey to continue her work with Echuca Regional Health and Campaspe Shire to provide opportunities for coordinated assessment and care planning to improve client independence. The program provides opportunities for occupational therapists to build the capacity of, and support personal care attendants in the home with strategies that improve client independence with personal and community activities of daily living. Casey has worked diligently to progress the program and build the partnership for the benefit of all clients, and initiatives include joint home visits, shared client review meetings, and shared goals for client outcomes.

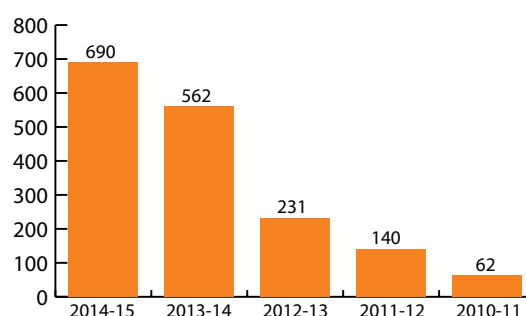
As a way of celebrating *Occupational Therapy (OT) Week* this year, REDHS staff participated in the inaugural *OT Olympics*. This involved a circuit of activities placing staff 'in the shoes' of others who experience conditions such as visual impairment, reduced mobility and loss of senses. The event also aimed to promote the OT profession and assist other departments and members of the community to better understand the scope of the practice. The initiative achieved its aim of increasing awareness of what occupational therapists do, and the conditions they work with. It is hoped the improved understanding will assist other clinicians to expand their referrals to the department, to ultimately ensure clients receive the best possible service.

This year Casey was awarded a scholarship under the VHA Rural Allied Health Post Graduate Scholarship 2015 to assist with completing a graduate certificate in Clinical Teaching at the University of Melbourne.

Nerae was awarded a scholarship through the VHA Continuing Professional Development for Rural Allied Health Practitioners Subsidy Program 2014-15 to attend a home modifications workshop. In addition to her OT role at REDHS, Nerae also provided some coordination support for the *Transition Care Program* clients and was the project worker for the *Falls Prevention Program*.

Both Nerae and Casey are active in their supervision of OT undergraduate students with three students hosted by REDHS this year.

Occupational Therapy - Occasions of Service





## Physiotherapy

REDHS physiotherapists Judy Lee, Keely Trew and Sherein Henry offer a service focusing on the assessment, diagnosis, treatment and education of clients to enhance movement disorders. This may include exercise programs to improve mobility and strengthen muscles, joint manipulation and mobilisation to reduce pain and stiffness. They also provide muscle re-education to improve control, airway clearance techniques and breathing exercises and massage therapy.

This year REDHS increased its physiotherapy staffing from one to two full-time clinicians. New graduate Keely Trew commenced with REDHS in January 2015 after completing her Bachelor of Applied Science and Master of Physiotherapy Practice. Keely was well known to REDHS prior to commencing employment as she had completed her final year placement at REDHS in October 2014.

Demand for a second physiotherapist grew following a major service development in the 2014-15 year, which saw the commencement of a *Pain Management Program* in aged care. The clinic operates four days a week and aims to reduce pain and improve overall wellbeing and quality of life of REDHS aged care residents. It also aims to reduce the dependence on pain medication, by providing a physiotherapy-led therapeutic massage approach to pain management. Twenty aged care residents are registered in the program and results to date are very positive.

Keely and Judy were drivers of the new clinic and have played a lead role in embedding the practice.

Another highlight this year was the trial of the *Falls Prevention Program* - an initiative which the physiotherapy service played a key role in developing and delivering.

The physiotherapy department also hosted three final year students in 2014-15 and will look to develop this beneficial practice moving forward to build future workforce potential.

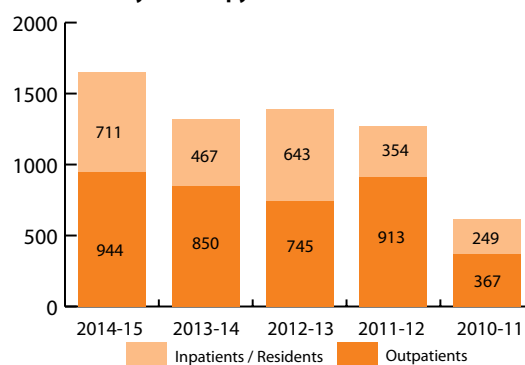
REDHS continues to host Bendigo Health Rural Health Team physiotherapy services once a fortnight, providing further physiotherapy services to those eligible under the Home and Community Care (HACC) program.

REDHS also continues to provide a physiotherapy outreach service at Lockington Bush Nursing Centre and is investigating opportunities to provide an outreach service to other surrounding areas in the next year.

A challenge for the department is in managing the large numbers in group exercise programs and the expanding case load for appointments.

Future plans for the service are to investigate new opportunities for treating patients with private health cover, and to treat clients with acute sports injuries.

Physiotherapy - Occasions of Service



## Planned Activity Group and National Respite for Carers Program

The planned activity group (PAG) and *National Respite for Carers Program (NRCP)*, staffed by Ann-Maree Hewlett, Anne Shaw and Deb Leed, provide opportunities for community members to interact in a setting that accommodates those people who live independently, but require social supports due to health conditions, frailty or advancing age.

The day program includes clients from the *National Respite for Carers Program (NRCP)* and offers friendship, activities, excursions and support.

NRCP day program and in-home respite services provided in Rochester and surrounding areas are entering a third year of service, in partnership with Uniting Age Well.

This year 25 clients have participated in the group and seven clients have accessed the service through NCRP.

The planned activity group receives strong support from a band of volunteers who assist staff members to deliver an appropriate and fulfilling service to participants.

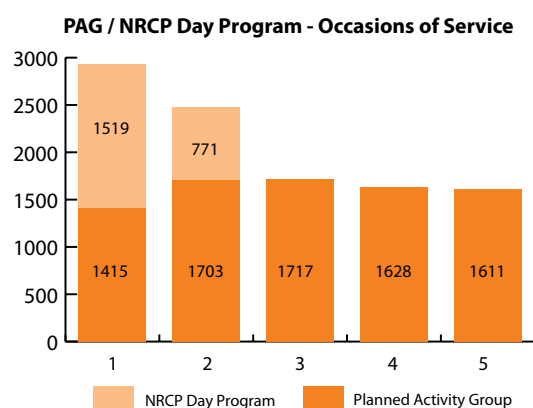
A highlight for PAG and NRCP in 2014-15 was the securement of funding through Bendigo Health Carer Support Service to run a further eight days of day program for clients in June. The service and funding provided by Bendigo Health Carer Support Services complemented our existing PAG and NRCP programs, and enabled the staff to take clients on day trips to Tatura, Shepparton, Torrumbarry Weir, Pyramid Hill and Bendigo. The excursions have been very well received by participants, and by their carers who have welcomed the opportunity for respite.

This year REDHS has invested in supporting PAG and NRCP staff in training and education across a range of areas including in *Advanced Care Planning*, *Code Grey training*, dementia specific and virtual dementia training. A growing trend across the organisation is that an increasing number of high care clients are accessing support programs like PAG and NRCP, therefore this training is vital in ensuring staff are resourced to deal with the level of support required.

PAG clients have participated in a number of community events this year including the Christmas Tree display at the Rochester Shire Hall in which the group received a special achievement award.

## PRIMARY CARE SERVICES

As part of the 5000 poppies project, clients also produced a beautiful wreath, which was used at the REDHS Anzac service. Plans are currently underway to make decorations for the debutante ball in October – a fundraiser for REDHS with which the PAG group takes great delight in being involved.



**PAG Occasions of Service have decreased this year owing to some former PAG clients transferring to the NRCP Day Program. The program provides increased assistance to attend and join in activities.**

### Podiatry

The REDHS podiatry service continues to experience high demand and has expanded this year with five staff providing care across the Shire of Campaspe areas of Echuca, Rushworth, Stanhope and Rochester.

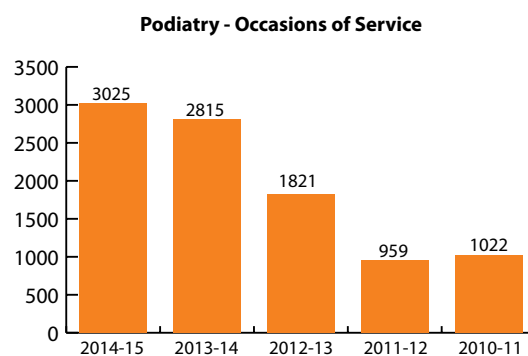
The podiatry team consists of Emily Gallagher, Kelsie MacDonald, Sally Deed, Rose Gallagher and Denise Fox. Denise, in her part-time capacity, and Rose as a casual employee both provide valuable support to the team as the senior podiatrists.

Both Emily and Kelsie were awarded scholarships under the VHA Continuing Professional Development for Rural Allied Health Practitioners Subsidy Program 2014-15 to attend podiatry-related professional development workshops.

The team continues to provide a range of podiatry services through a number of program areas including HACC, Department of Veteran Affairs (DVA), Medicare Chronic Disease initiatives, private health insurance, aged care and outreach clinics to Stanhope and Rushworth. This financial year there has been a significant increase in access to the outreach clinics, placing the service at capacity. There are plans to increase the service by at least one day per month next year.

The podiatry team also provides HACC services to Echuca Regional Health through a contract and remains committed to regular professional development to enhance clinical podiatry skills and enhance client centred care. Each of the podiatrists support student learning and have provided supervision to two podiatry students in the past 12 months.

Looking ahead, there will be a focus on developing an allied health assistant (AHA) model of care in the podiatry department. Much of the service is provided around basic foot care that can potentially be provided by an AHA, allowing the podiatrists to focus their clinical skills at a higher level.

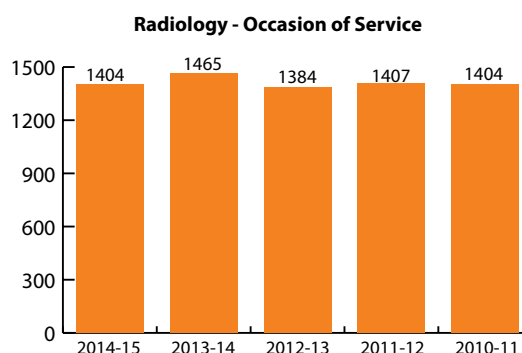


### Radiology

The REDHS radiology department continues to operate services for the community four days per week.

The REDHS medical imagist provides x-ray services on two of those days, and REDHS in partnership with Goulburn Valley Imaging Group (GVIG) provides an ultrasound and x-ray service out of the department on two days.

The radiology department achieved NATA Diagnostic Imaging Accreditation in January 2015 and is accredited until 2019.



### Rural Drug Withdrawal Service

The REDHS Rural Drug Withdrawal Service is in its third year, servicing the Campaspe Shire in partnership with Northern District Community Health Service.

The position has been serviced by Paul Hughes for much of 2014-15, who was replaced by Anne Phillips in a locum capacity for the final eight weeks of the year.

The service is working closely with clients and their families to facilitate withdrawal from drugs or alcohol in a supported and safe environment. The service also has a role in health promotion, working with community groups to promote drug

and alcohol services and to allay some of the commonly held fears and misconceptions around the issue.

The bigger picture is that drug and alcohol issues are a concern for this community, and the health services and GPs in Rochester, Echuca and Kyabram are working closely together to determine how best to strategically service community needs and work in partnership around a drug and alcohol approach.

A top level priority for the shire is to develop a partnership model to improve drug and alcohol services across the municipality.

A major highlight for the *Rural Drug Withdrawal Service* was the delivery of a *Drug and Alcohol Information Night* held in conjunction with the Rochester Lions Club in February 2015. Approximately two hundred community members attended the event, which saw key drug and alcohol professionals, a Victoria Police representative and a Rochester parent share their knowledge and perspectives on illicit drug use in the community. The aim of the information night was to increase public awareness, knowledge and understanding of substance abuse and addiction, its effect on users and the wider community, and local options to seek treatment and support.

The event successfully achieved its aim, and a key learning was the need to provide regular education to the public on this topic.

Across the catchment this year, the withdrawal service has successfully managed 10 hospital based and 43 home based withdrawals referred 11 clients to appropriate specialised detoxification services and provided counseling services to an additional 28 clients.

The service has delivered valuable in-service education across the shire, performed group work with clients and worked closely with GPs in the area.

The service is also involved in the *Rochester Ice Action Group* - a community consultation group involving representatives from the chamber of commerce, ambulance, police and secondary college, local football club, community house and the Bendigo Bank, working to secure a grant through the Victorian Government's recently announced *Ice Action Strategy* to provide a local community approach to Ice including community mobilisation and action around safety and to prevent the uptake of Ice in young adults.

The major challenge for the rural drug withdrawal position is to provide a seamless service and continuity of care for clients through assessment, withdrawal, and long-term behavior change. Our aim is to support and enhance the collaboration of services in the future.

## Social Work

REDHS social workers Helen Larmour, Meaghan Sully and Emily Noske-Turner have been actively working on the REDHS *Advance Care Planning* program and will continue to develop and enhance the program roll-out across all services including

acute and primary care. Advance Care Planning allows patients and residents the opportunity to document their care wishes for the future should they not be able to communicate this for themselves. If consumers so wish, the process can help in ensuring appropriate decision makers are in place through the creation of Enduring Powers of Attorney medical and financial. *Advance Care Planning* is available to all members of the community.

Together, Meaghan and Helen manage the social work services and counseling services of clients across the acute, aged care and primary care.

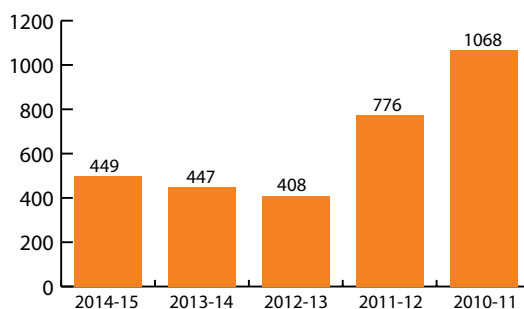
The social work department held a health promotion *Tobacco Day* this year to support participants wishing to quit smoking. The team has also been involved in the new *Bedside Discharge Planning* process.

In terms of service delivery and client engagement the social work service holds multi-disciplinary case conferencing meetings each month which provide all members of the primary care team an opportunity to discuss a particular client's case and collectively determine the best approach to take.

Strategic plans for the future include investigating the potential delivery of a contracted outreach service by an accredited mental health social worker. Such a service would be supported by the Medicare rebate model of care.

The social work team is looking forward to assisting in the development of an organisation-wide health expo to be held at REDHS in late 2015. The expo will provide an opportunity for team members to engage with other case managers in the community and to network and promote their services.

Social Work - Occasions of Service



**The higher occasions of service from 2009 to 2012 reflect the additional social worker hours available as part of the Flood Recovery program.**

## SUPPORT SERVICES

The Support Services department has been undergoing a process of restructuring throughout the year to with the aim of increasing efficiencies by forming separate specialist teams for catering and cleaning. This resulted in a new structure with three team leaders with leadership support from the new position of Corporate Services Manager.

### Catering

The catering department continued to provide high quality meals throughout the year to residents, patients, clients and Café Red and staff were delighted with the purchase of a new oven to assist them in their work.

The restructuring of the department led to the creation of a team leader role who reports to the reinstated position of corporate services manager.

Rebecca O'Sullivan is currently the acting catering team leader until the permanent role is filled. Rebecca first commenced her employment as a trainee at REDHS, moving on to complete her apprenticeship to become a trade qualified chef, and completing a frontline management course. Rebecca's commitment to REDHS and to ensuring great outcomes for REDHS residents and clients is demonstrated in participation in the REDHS Food Services Reference Group, participating in the resident food forums, and the development of a close working relationship with our dietitian. Her involvement in these areas has been extremely beneficial as she also brings experience and knowledge through a recent frontline management course.

The multidisciplinary REDHS Food Services Reference Group was formed in 2014 to oversee actions taken to address recommendations in menu reviews. REDHS dietitian, chef, aged care manager and allied health assistant run the group with the support of the Allied Health Team Leader and Quality Systems Manager. The group has widened its scope to include an aged care resident representative and is holding forums where aged care residents have gathered to provide feedback around meals and drinks. The group was originally formed to manage progress against recommendations received from menu reviews but has expanded its scope to incorporate additional consumer input.

REDHS dietitian and catering staff supported La Trobe University dietetic students on placement. The students spent three weeks reviewing policies and providing information to catering staff members regarding nutrition, meal sizes, preparation and catering for individual requirements. Further work has been planned on education for all catering staff on special diet requests, ensuring that staff are confident to cater for any requirements.

REDHS is hoping to continue this review process in the future, as it was clear the dietetic students were able to offer some very useful advice and sound knowledge around food nutrition.

In addition, REDHS hosted a catering work experience student from Rochester Secondary College for the first time, helping out in the kitchen and café during her time.

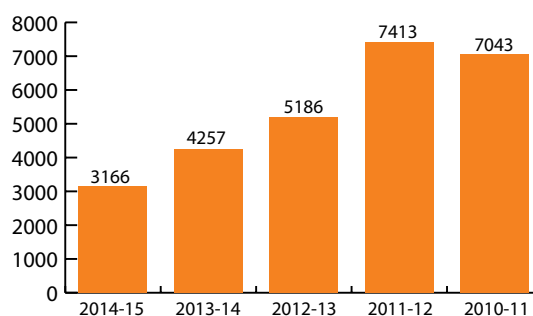
On the catering front, REDHS provided 65 birthday cakes for residents to share with family, friends, volunteers and fellow residents as well as thousands of meals and snacks throughout the year as per the table below:

Meals on Wheels – Elmore	657
Meals on Wheels – Lockington	330
Meals on Wheels - Rochester	2,179
Planned Activity Group - Elmore	1,982
Planned Activity Group – Rochester	3,010
Patients – Acute ward	15,988
Residents – Hostel	64,214
Residents – Nursing Home	64,338
Senior Citizens Club – Rochester	641
Functions	2,988
Other	50

**Total meals\*** 156,377

*\*Includes morning and afternoon teas*

Meals on Wheels



**The reduction in the number of Meals on Wheels is consistent with state-wide trends.**

REDHS supports the surrounding community through its catering capabilities including the Elmore Summer Ball, Ladies Auxiliary AGM and meetings and other significant groups.

The catering team continues to supply the Café RED and strives to provide healthy meals and snacks for staff and visitors. Café staff regularly receive very positive feedback regarding the food offered and the very accommodating and friendly staff.

Plans for the following year include replacing the flooring in the kitchen area, which will be a significant project.



There are also plans to implement a menu planning system and a full menu review, in which all aged care residents will be closely engaged.

After many years of service, catering manager Darlene Weeks left REDHS following the restructure implementation. We thank her for her contributions to REDHS and wish her well in her future endeavours.

### **Hotel Services**

Like many other areas at REDHS, the hotel service department has also undergone organisational change with the introduction of two Support Services team leaders, these being Kerri McEllister and David Watson – both long-term staff members with great experience within the unit.

Both have been instrumental in working together to roll out the new organisational structure. It is the first time two team leaders have worked this way and it has been a position change, along with changes to routines and shifts which have improved the level of cleaning and services throughout.

Over the past 12 months a new clothing labeller was purchased for the laundry, which has improved the process of clothing identification and helped reduce the number of misplaced garments and subsequent and unnecessary stress for residents.

Work has also been done, in conjunction with the REDHS Infection Control Team, to achieve all national standards and staff are working towards an external cleaning audit in July, 2015.

There are also daily internal audits carried out on all rooms at REDHS, which helps maintain all cleaning standards across the organisation.

The introduction of LED lighting into the REDHS theatre has also been a positive move, eliminating unnecessary cleaning and lighting that previously attracted dust and insects.

Challenges throughout the year have included changes to shifts and routines as a result of organisational changes; however, staff have adapted well and are now settled into new routines.

Plans for the upcoming 12 months will include refining the training process for all new staff and there is currently a recruitment process to increase the number of casual 'bank' staff to take pressure off existing staff.

Plans also include the introduction of an audit software system, overseen by Clare Ireland who has an extensive background in ICT systems, which will move away from the current system of paper audits. Clare explains the current system is very time consuming and a new tablet based, online system will improve efficiency and see the department become less reliant on paper-based records.

The department is also currently implementing *Code Grey* (duress code) training for staff, which is a department response to an occurrence of a non-armed personal threat within the organisation. Staff will be trained to handle a situation where they are required to manage an individual in a non-armed situation (as opposed to a serious threat where police would be called).

Staff trained in this area will then pass on what they've learned to other staff across the organisation.

In addition, two hostel staff members are also taking on dementia training, which is extremely relevant to their workplace (although not mandatory) and pleasing for the organisation as they took it upon themselves to take part in the training.

### **Vale Terri Windridge**

The REDHS Board of Management, executive and staff were saddened by the sudden passing of Support Services team member, Terri Windridge in December 2014. Terri had been working at REDHS in various departments and, during her time with us, made many contributions and connections with staff. She is sadly missed.

### **Procurement**

The REDHS procurement department has undergone both an internal and external audit throughout the past 12 months.

The department led by Gayle McConnell, is halfway through a Hospital Purchasing Victoria (HPV) two-year compliancy review – as mandated by government – a five-policy review, which was a very large project to undertake. The benefits of this review will ensure better pricing for health services (where services and products are procured in 'bulk') and also transparency in government spend. The results of this review will see REDHS obtain better value for money in many of their contracts. The HPV review will ensure that REDHS continually evaluate contracts ultimately resulting in better service for our residents and clients.

Compliance with the government tendering process, supporting health service reform, best value outcome and probity.

REDHS Procurement Manager has commenced working on a two-year HPV.

In line with the HPV review, a greater focus in the broader community has been on government expenditure. For health services this has resulted in a larger number of audits and more complex requirements being sought from the supply department.

Mandy Dockery very capably took on the role of supply manager for three months to cover long service leave.

The ordering and accounting practices are continually being refined and improved; ensuring that managers can improve on efficiencies within their own departments, leading to a better outcome for REDHS. This year, in line with works completed at the Loddon Mallee Rural Health Alliance, a bar coding system will be rolled out to REDHS. This will facilitate the ordering of stock from departments and should streamline this process, while ensuring stock orders comply with HPV requirements. This will be a major project which supply will lead all departments through.

Highlights have included the additional training staff have undertaken to improve *Excel* skills assisting in the analysis of expenditure data and the contracts management training currently undertaken by the supply manager.

### Information and Communication Technology (ICT)

Over the past 12 months the introduction of virtual desktop stations across the aged care area has been extremely positive and has enhanced shared workspaces and a 'moving' workplaces across the organisation.

There has also been a review of all REDHS network security to address the ever-present issue of online security – this is an ongoing process at the organisation to stay abreast of all technology and appropriate systems.

In addition, all PCs running the *Window XP* program have been replaced which brings the REDHS hardware fleet relatively up-to-date and there is a current investigation into a capital replacement program around all IT hardware to reduce costs and ensure technology efficiency. The result will be a formal process to replace or update all REDHS computer hardware and a clear starting point for all equipment.

Staff have also undergone a thorough training regime involving all *Microsoft* programs include *Excel* and *Word* and aged care staff have been trained in the *Management Advantage* software to improve use in this area. This program allows the aged care department to utilise electronic notes which has become the standard and been fully embraced by staff.

Embracing technological advances can be challenging for some staff, however the benefits for processes and procedures are undeniable.

Other special achievements throughout the year have included developing some strategic relationships with other local health organisations around disaster management and recovery.

Changes have also been made to ICT support, which is now being outsourced and is proving very positive for all project outcomes and access for staff on a regular basis.

Plans for the following year include the introduction of ICT into areas that might not have previously involved technology systems, including hotel services and catering.

ICT will also oversee the introduction of a medication management software program throughout the aged care department and an upgrade of all LAN/wireless systems to strengthen the network.

Other programs to be introduced over the next 12 months include smaller projects based around the eventual introduction of electronic medical records.

There are background infrastructure works occurring in the region to prepare for electronic medical records in the future and REDHS continues to prepare for the time when a shared online medical records system becomes a reality.

The aim is for REDHS to be prepared for whatever form of e-health records system is introduced into the health system within the next five years when medical records can be shared online and accessed via the 'cloud'. This will be an incredible tool for all health organisations and REDHS is ensuring they will be ready to come on board when the time comes.

### Maintenance

The Maintenance team has had a very busy year with maintaining REDHS buildings and grounds as well as coordinating capital works and room refurbishments.

Maintenance Supervisor, Brett Shotton, recruited maintenance worker, Luke Kohn, following the completion of Jamie Nalder's maintenance traineeship. Support Services team member Judy Olney showed great versatility by assisting with grounds maintenance during the recruitment process and her hard work in the grounds during this period was appreciated by staff and residents alike.

Maintenance requests and preventative maintenance continue to be managed through the Building Equipment and Inventory Maintenance System (BEIMS). In 2014-15, the Maintenance team completed 742 maintenance requests on top of the scheduled major works and the total refurbishment of six aged care bedrooms. BEIMS has been shared with Echuca Regional Health but REDHS now has increased administrative access which will allow additional reporting and monitoring to occur. Administration support is provided one day per week to assist with the data entry process.

The filter system in the Day Procedure Unit has been upgraded to cater for appropriate bacterial levels and a new instrument steriliser will arrive in mid-July. Other maintenance works across the organisation have included the replacement of heating and cooling units in acute, primary care, and parts of the nursing home and staff area.

In addition, REDHS has applied for funding through a government bush fire management scheme to fund a new generator to replace the current 20-year-old backup generator equipment. *The Local Infrastructure Assistance Fund (LIAF)* scheme aims to support generator equipment for aged care facilities in regards to bush fire management and has been running since 2013.

Maintenance is also working on an overall building management system to have all systems working coherently together (see Environment and Sustainability section).

Plans for the coming year include being up-to-date with all aged care facility maintenance and continue to refurbish all rooms, hallways, doorways and skirting boards as per schedule. New sprinkler systems will also be established in the garden areas.

## Environment and Sustainability

REDHS is committed to meeting its strategic objective of maintaining a culture of accountability and diligence in the use of its resources.

We currently have Heath Purchasing Victoria (HPV) agreements in place for waste, gas and electricity that provides a benchmarking opportunity for comparison with other health services across Victoria.

Chemical usage is monitored by the Support Services Team Leaders but REDHS continues to use minimal amounts of hazardous chemicals. Neutral detergents are most commonly used for cleaning, in combination with microfibre cloths, steam cleaning equipment and hard surface cleaning machines.

REDHS grounds and community garden have been maintained with the use of rainwater harvested from roofs and roadways that is stored in an underground tank. This year a new underground watering system has been installed that can automatically run at night, reducing the amount of moisture lost to evaporation. Garden waste is mulched and redistributed onto garden beds.

Where possible, staff attending training outside Rochester carpool or catch public transport to Melbourne or join a meeting via the onsite videoconferencing system. REDHS has purchased two MYKI cards for staff to use on public transport. Many competencies are able to be done online, further reducing the need for travel.

Energy and water usage is reported to the Department of Health and Human Services and regular reports are provided to help REDHS with monitoring. Conventional lighting is being progressively replaced throughout the buildings with energy efficient LED lighting. This initiative is already providing substantial energy savings and helping to reduce REDHS' carbon footprint as are ongoing adjustments to the Building Management System (BMS).

REDHS Environment Week was held in November 2014. Whilst recycling is well-entrenched at REDHS, this week reminded staff what can and can't be recycled and staff were encouraged to provide ideas on how REDHS could reduce its environmental impact. Some of the suggestions were: clearer signage for recycling locations and/or colour-coded waste bins, turn off electrical switches when equipment not in use, energy-efficient lighting and use of electronic meeting agendas and minutes and staff newsletters to save paper. Some of the ideas have been taken up, as you will read in this report. The fortnightly staff newsletter is distributed via email with only one paper copy available to each department. This has saved approximately 600 sheets of paper per month in addition to that saved through the increased use of I-pads for meetings and auditing purposes.

The Maintenance department has been working with contractors to upgrade the BMS access control hardware. The upgrade will facilitate automatic shutting down of air conditioning and lighting after department lockdown across all departments with a trial currently underway in the Administration area. Computer isolation switches have also been installed to reduce the amount of electricity being used when the computers are switched off after hours but still in "standby" mode. The installation of energy-efficient LED lights is also an energy and money saving initiative.

The savings are also associated with time to replace lighting as well as costs associated with cleaning non-LED lighting.

The air-conditioning system in most departments was decommissioned and is being replaced from May 2015. The new system allows for individual climate control in all rooms and can be turned off when no one is using a room, leading to further energy savings and improving the environment for health service consumers and staff.

REDHS staff continue to segregate waste and recycle as much as possible. A new waste contractor has been engaged and REDHS now receive reports by weight rather than volume, providing a far more accurate record of the waste generated. The new service also uses larger bins so pickups have reduced from three times to twice a week. There are plans to provide larger, colour coded recycling signage and easily identified bins to further improve recycling across all departments.

REDHS will continue to investigate ways to reduce its environmental impact into the future.

## Occupational Health and Safety

REDHS engaged the services of an external consultant to conduct a full audit of our essential services infrastructure (fire management system) and as a result we have implemented a number of improvements to ensure we are compliant with Australian Standards and that we can maintain the safety of our residents, patients, clients, staff and visitors during an emergency.

REDHS also implemented *Code Grey* to our emergency management system, ensuring the safety of staff, volunteers, patients and visitors, should any incidents of aggression arise. *Code Black*, previously used for personal duress has also been changed so that safety systems are in place should we be presented with an armed aggressor. Our policies, procedures and staff training have all been upgraded to ensure risks associated with aggression are minimised.

Our occupational health and safety systems have also been audited and opportunities for improvement implemented. A visit from *Work Safe* also demonstrated our safe systems of work associated with manual handling meet the *Australian Standards*.

REDHS commits significant resources to ensure the safety of our staff, residents, patients and volunteers is maintained to a high standard. This includes providing staff health and safety representatives with a full day, bi-monthly to conduct workplace and risk assessments to maintain safety throughout the organisation.

This year, the workplace health and safety representatives introduced an innovation by using iPads to complete workplace audits, halving the amount of time this task takes to complete. Our workplace health and safety representatives have also used technology to register and monitor known health and safety risks and to track the incidence of these to ensure our focus is where it is most needed.

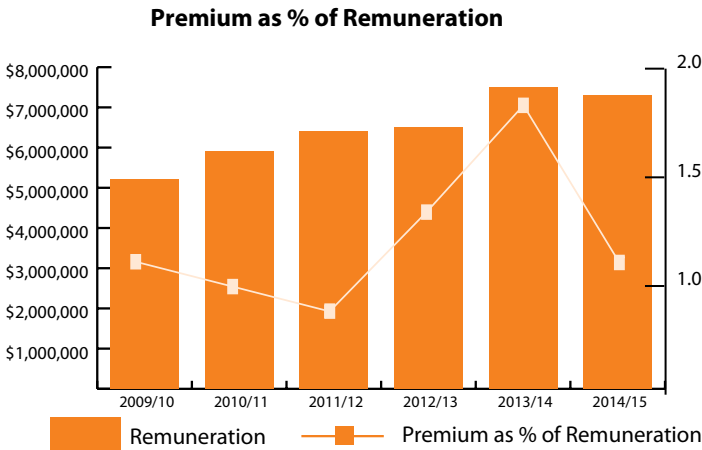
In 2014-15, there were 93 occupational health and safety incidents, near misses and hazards recorded which equates to 86.8 reports per 100 FTE. By comparison, there were 56 reported in 2013-14 equating to 49.6 reports per 100 FTE. It is pleasing

to see that the considerable education and promotion around incident and risk reporting is yielding results as evidenced by the significant increase in reporting rate. Initiatives to improve reporting included *Report a Risk Week* promotion, specific risk education session at our REDHS staff development day and a particular focus on reporting through *Occupational Health and Safety Week*.

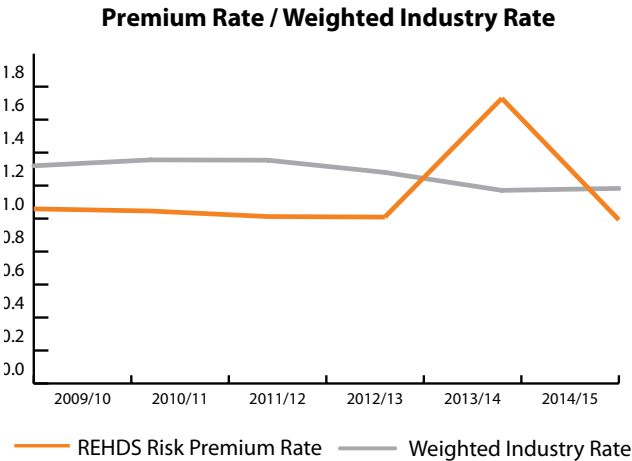
REDHS purchased five standing desks for staff in various service areas. The desks are height adjustable so that staff can choose to sit or stand throughout the day. Staff who regularly use the desks claim to be spending more time standing and have reported improvements in physical issues such as back and hip pain. We will consider purchasing more standing desks in the future.

Workplace inspections are now undertaken on a consistent basis, which is also raising staff awareness and resulting in hazards being more readily identified and reported.

REDHS continues to participate in *Safety Week* in October each year, running events and competitions to raise safety awareness. This year's winner of the *Safety* trophy was our primary care team for achieving the most activities throughout the week.



*REDHS' Workers Compensation premium has dropped significantly this year due to two long-term claims, that occurred 4 years ago, no longer being included in our premium calculation.*



*REDHS' Risk Premium Rate reflects our better than average performance when compared to the industry as a whole.*

# FINANCE

Operational highlights for the REDHS financial department include attaining a surplus for the year and receiving a grant for the continuation of the REDHS *Drug and Alcohol Program*. Continued funding was also gained for a staff member to work on the *Aged Care Funding Instrument Regional Project*. This funding is shared between six regional health services, with a staff member based at REDHS.

REDHS has also been recognised as a lead agency through the *Sustainable Hospitals Project* - an initiative for hospitals to work together in determining projects where significant efficiencies would be achieved through clusters of hospitals working collaboratively.

A newly appointed finance officer, Sharon Chapman, started in the role in November 2014 handling all accounts payable and financial spreadsheets and quickly settled into the role.

Special achievements throughout the past financial year include further improvement around transparency of funds spent, streamlining of invoice approval processes, the developing and imbedding policies for all financial operations, and involvement in internal and external audits.

There has also been important training for all REDHS area managers to develop their skills and build confidence around financial reporting. This will allow managers to take on greater financial responsibility for their budget preparation utilising power budget.

Sharon has also been involved in training to further her development and help assist managers in their budget preparations. For some managers this was the first time they have had this level of involvement with budget preparations.

Plans for the future in the finance department include developing financial modeling tools to better utilised in REDHS' contract processes.



# COMMUNITY INVOLVEMENT AND **SUPPORT**

## Volunteers

The REDHS volunteer workforce currently consists of 120 people who volunteer their time in areas as diverse as gardening, activities, assisting at meal times, church services, singing, reading, walking and planned activity group.

In November 2014, a report proposed that the organisation employ a volunteer coordinator at one day a week as a trial to support our volunteer workforce. In recognition of the value the organisation places on its volunteers and the need to support and grow the workforce, the board approved funding for the trial position for a six month period. During the trial, the coordinator worked on formalising volunteer orientation processes, developing a rostering system and clarifying volunteer roles and responsibilities - the results of which are now under review.

A highlight for the organisation this year was in recognising REDHS volunteers during *Volunteers Week*. In May 2015 the organisation hosted a volunteers morning tea and presented all volunteers with a lapel pin and certificate in recognition of service.

REDHS has created a number of education and training opportunities for volunteers this year to assist them in carrying out their duties. These workshops have mainly focused on caring for patients with dementia.

In a first for the organisation, REDHS will distribute a survey to all volunteers to obtain a benchmark of their satisfaction. The survey will establish whether volunteers think their skills and knowledge is being appropriately utilised, what other activities they might like to be involved in, whether they feel supported, and whether their working environment is as it should be. The survey will be conducted every 12 months and measured against the benchmark set this year.

## Rochester and District Hospital Auxiliary

During the past 12 months the Auxiliary continued to support the organisation with fundraising and social events for the benefit of people accessing REDHS' services.

The auxiliary aims to hold a fundraising event for each month of the year and during the last year raised an estimated \$7,000. During the past 12 months fundraising efforts have been channeled towards electric beds.

Events held throughout the year included trips to the cinema in Echuca, raffles at Easter, Christmas and for the Melbourne Cup – held in conjunction with a luncheon.

The auxiliary was established in 1958 from what began as a branch of the Nanneella group and currently has a hard working group of around 16 members.

The group also organises morning tea events for cancer research and celebrates occasions such as St Patrick's Day and

has coordinated the local children's Christmas letters from Santa for 15 years (with the support of the local Lions Club).

They also coordinate the generous private donation of chocolate eggs for the children each year for the Easter raffle and support various events in the form of catering including the local art show and annual *Elmore Summer Send-off Ball*.

The group also has a strong presence at many regular events in the community with displays at the Great Northern Show - Rochester, St John's Church Fair and Anglican Church Christmas Tree event.

Committee members have especially enjoyed the movie events in Echuca as well as the garden walks in three local gardens each October.

There is no doubt REDHS would be lost without the presence of such a hardworking, dedicated group who thoroughly enjoy what they do.

It's groups such as the Auxiliary who help make the organisation able to continue the provision of high quality care for its community.

## Donations and Bequests (\$100 and over)

Donations in memory of Anthony Schofield	\$20,000.00
Donations in memory of Filippo Cappellano	\$6,885.46
Rochester Hospital Auxiliary	\$5,400.00
Elmore Charity Ball	\$2,000.00
Murray Goulburn Co-operative	\$1,760.00
Heartbeat Victoria Campaspe Branch	\$1,087.78
Unknown cash deposits	\$839.65
Donations in memory of Michael Hynes	\$325.00
Donations in memory of Maurice Tamburini	\$120.00
"Lolly Trolley"	\$200.00
Donations in memory of Dorothy Neilson	\$150.00
Donations in memory of Peter Joyce	\$180.00
Donations under \$100 (total)	\$85.00
<b>Total Donations for 2014-15</b>	<b>\$39,032.89</b>

*The ongoing support of community groups is always gratefully accepted. Group members work hard to make regular donations of handmade goods and other items for use by our Aged Care residents, which is always appreciated.*

# STATUTORY INFORMATION

The Rochester and Elmore District Health Service Annual Report has been prepared in compliance with the requirements of the Financial Management Act 1994 (the Act), Section 4.2 of the Standing Directions of the Minister for Finance under the Act and Financial Reporting Directions.

## Attestations

### 1. Data Integrity

I, Anne McEvoy, certify that Rochester and Elmore District Health Service has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. Rochester and Elmore District Health Service has critically reviewed these controls and processes during the year.



**Anne McEvoy,**  
**Accountable Officer**  
**Rochester and Elmore District Health Service**  
**31 July 2015**

### 2. Compliance with Ministerial Standing Direction 4.5.5.1 - Insurance

I, Anne McEvoy, certify that Rochester and Elmore District Health Service has complied with Ministerial Standing Direction 4.5.5.1 – Insurance.



**Anne McEvoy,**  
**Accountable Officer**  
**Rochester and Elmore District Health Service**  
**31 July 2015**

### 3. Compliance with Australian/New Zealand Risk Management Standard

I, Anne McEvoy, certify that Rochester and Elmore District Health Service has risk management processes in place consistent with the AS/NZS ISO 31000:2009 (*or an equivalent designated standard*) and an internal control system is in place that enables the executive to understand, manage and satisfactorily control risk exposures. The Risk Management and Planning Committee verifies this assurance and that the risk profile of Rochester and Elmore District Health Service has been critically reviewed within the last twelve months.



**Anne McEvoy,**  
**Accountable Officer**  
**Rochester and Elmore District Health Service**  
**31 July 2015**

## Availability of Additional Information

In compliance with the requirements of the Standing Directions of the Minister for Finance, details in respect of the items listed below have been retained by Rochester and Elmore District Health Service and are available to the relevant Ministers, Members of Parliament and the public in request (subject to the freedom of information requirements, if applicable):

- (a) A statement of pecuniary interests has been duly completed by all relevant officers;
- (b) Details of shares held by a senior officer as nominee or held beneficially in a statutory authority or subsidiary;
- (c) Details of publications produced by the Health Service about its activities, 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;
- (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;
- (k) A list of major committees sponsored by the Health Service, the purposes of each committee and the extent to which the purposes have been achieved; and
- (l) Details of all consultancies and contractors including consultants/ contractors engaged, services provided and expenditure committed to for each engagement.

## Building Compliance

Rochester and Elmore District Health Service ensures that all buildings, plant and equipment in its control are maintained and operated according to the statutory requirements of the Building Act 1993 and the Minister for Finance Guideline Building Act 1993/ Standards for Publicly Owned Buildings November 1994.

## National Competition Policy

Rochester and Elmore District Health Service continues to comply with the National competition Policy. In addition, the Victorian Government's Competitive Neutrality Policy principles have been applied to all relevant business activities.

### **Carer's Recognition**

In accordance with the Carer's Recognition Act 2012, Rochester and Elmore District Health Service is taking all practicable measures to ensure that:

- management and employees have an awareness and understanding of the Statement for Australia's Carers; and
- persons who are in care relationships and who are receiving services in relation to the care relationship from REDHS, have an awareness and understanding of the care relationship principles; and
- REDHS' management and employees reflect the care relationship principles in developing, providing or evaluating support and assistance for persons in care relationships implementing, providing or evaluating care supports.

### **Consumer feedback**

We welcome feedback in regard to the quality of our service and assists the health service with the development of strategies for continuous improvement. Feedback forms are available throughout the health service. Alternatively, feedback can be emailed directly to the address below or via [www.redhs.com.au](http://www.redhs.com.au)

Compliments, suggestions and complaints should be directed to:

**Chief Executive Officer, REDHS,**  
**PO Box 202, Rochester Vic 3561**  
**ph: (03) 5484 4451**  
**Email: [rochhosp@redhs.com.au](mailto:rochhosp@redhs.com.au)**  
**Web: [www.redhs.com.au](http://www.redhs.com.au)**

### **Equal Opportunity, Merit and Equity**

Recruitment, selection and employment at REDHS comply with employment conditions as specified in relevant Health Awards and Enterprise Bargaining Agreements. The employment of staff satisfies equal employment opportunity requirements, legislative and moral obligations and terms and conditions of the Fair Work Act 2009, Public Sector Management Act 1992 and Victorian Charter of Human Rights and Responsibilities 2008.

### **Freedom of Information**

The Freedom of Information Act 1982 provides the public with a means to obtain information held by the Rochester and Elmore District Health Service. During the 2014-15 financial year, 13 requests for information were received, with 11 requests granted in full and two requests not proceeded with. Freedom of information requests can be made by contacting the health service Freedom of Information Officer on (03) 5484 4451.

### **National Competition Policy**

Rochester and Elmore District Health Service continues to comply with the National Competition Policy. In addition, the Victorian Government's Competitive Neutrality Policy principles have been applied to all relevant business activities.

### **National Police Record (NPR) Checks**

Rochester and Elmore District Health Service requires all staff, volunteers and contractors to have a current, satisfactory national police register (NPR) check (also known as National Criminal History Checks). Employment or volunteering with Rochester and Elmore District Health Service does not commence until this requirement is met. NPR checks are deemed valid for three years. Some staff are also required to hold a satisfactory "Working with Children" check.

### **Protected Disclosure**

The Protected Disclosure Act 2012 (Vic) (the Act) provides for the protection of persons who make a protected disclosure under the Act from detrimental action by officers, members, employees and contractors of Rochester and Elmore District Health Service. During the 2014-15 financial year, no applicable disclosures were made.

### **Victorian Industry Participation Policy (VIPP) Disclosures**

Rochester and Elmore District Health Service's procurement practices and purchasing policies comply with the Victorian Industry Participation Policy Act 2003 as applicable. During 2014-15, REDHS did not complete any contracts to which VIPP applied.

## **YOUR COMMUNITY – YOUR HEALTH SERVICE**

### **You Can Help In Many Ways**

Donations and bequests play a vital part in the provision of services to residents in our community. REDHS relies on the generosity of individuals and organisations within our community.

You can help by:

- Making a donation towards a specific item
- Defraying the cost of much needed equipment
- Remembering the Health Service in your will
- Joining the Hospital Auxiliary

Donations in memory of loved ones or in lieu of flowers are also appreciated. Envelopes are available for this purpose from the Health Service. Receipts are issued, acknowledgement letters are written, and when totals are known, summary letters are mailed to the decedent's next of kin.

### **Your Help Is Needed – And Will Be Appreciated**

If you would like to make a donation or bequest, please contact the executive assistant, Linda Charles (03) 5484 4451

# OPERATIONAL PERFORMANCE SUMMARY

## Statement of Priorities

### Part B Service Performance Priorities

	Target	2014-15 Actuals
<b>Patient Experience and Outcomes</b>		
Victorian Health Care Experience Survey	Full compliance	Achieved
<b>Governance, leadership and culture</b>		
Patient Safety Culture	80	89
<b>Safety and Quality Performance</b>		
Health Service Accreditation	Full compliance	Achieved
Residential Aged Care Accreditation	Full compliance	Achieved
Cleaning Standards(Overall)	Full compliance	Achieved
Cleaning standards (AQL-A)	90	Achieved
Cleaning standards (AQL-B)	85	Achieved
Cleaning standards (AQL-C)	85	Achieved
Health care worker immunisation – influenza	75	72
Submission of data to VICNISS	Full compliance	Achieved
Hand hygiene (rate) – quarter 2	75	79
Hand hygiene (rate) – quarter 3	77	90
Hand hygiene (rate) – quarter 4	75	84

**Note:** Performance against Statement of Priorities Part B (Financial Performance) and Part C can be found as an appendix in the financial report.

## Financial Report

The Financial Report which forms part of this annual Report of Operations can be found stapled at the rear of this report. If the Financial Report is not attached, a copy can be obtained from [www.redhs.com.au](http://www.redhs.com.au)



# DISCLOSURE INDEX

The Annual Report of Rochester and Elmore District Health Service is prepared in accordance with all relevant Victorian legislation. This index is prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

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<b>Report of Operations – FRD Guidance</b>		
<b>Charter and Purpose</b>		
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FRD 22F	Purpose, functions, powers and duties	1
FRD 22F	Initiatives and key achievements	4
FRD 22F	Nature and range of services provided	2
<b>Management and structure</b>		
FRD 22F	Organisational structure	6
<b>Financial and other information</b>		
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FRD 11A	Disclosure of ex gratia expenses	FR
FRD 12A	Disclosure of major contracts	FR
FRD 21B	Responsible person and executive officer disclosures	FR
FRD 22F	Application and operation of <i>Protected Disclosure 2012</i>	33
FRD 22F	Application and operation of <i>Carers Recognition Act 2012</i>	33
FRD 22F	Application and operation of <i>Freedom of Information Act 1982</i>	33
FRD 22F	Compliance with building and maintenance provisions of <i>Building Act 1993</i>	32
FRD 22F	Details of consultancies over \$10,000	FR
FRD 22F	Details of consultancies under \$10,000	FR
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	<i>Financial Management Act 1994</i>	3,32

\* FR - Financial Report

# GLOSSARY

<b>ACHS</b>	Australian Council on Healthcare Standards
<b>ACFI</b>	Aged Care Funding Instrument
<b>Acuity</b>	The measurement of the intensity of care required for a patient/resident
<b>AHA</b>	Allied Health Assistant
<b>ALOS</b>	Average Length of Stay
<b>CEO</b>	Chief Executive Officer
<b>CCCS</b>	Community Care Common Standards
<b>CMBS</b>	Commonwealth Medical Benefits Scheme
<b>CSN</b>	Clinical Support Nurse
<b>CSSD</b>	Central Sterile Supply Department
<b>DHHS</b>	Department of Health and Human Services
<b>DNS</b>	District Nursing Service
<b>DPU</b>	Day Procedure Unit
<b>DVA</b>	Department of Veterans' Affairs
<b>EQulPNational</b>	ACHS accreditation program including NSQHSS
<b>FOAP</b>	Fitness for Older Adults
<b>FR</b>	Financial Report
<b>FTE</b>	Full Time Equivalent
<b>GP</b>	General Practitioner
<b>HACC</b>	Home and Community Care
<b>HPV</b>	Health Purchasing Victoria
<b>HR</b>	Human Resources
<b>HSR</b>	Health and Safety Representative
<b>ICT</b>	Information & Communication Technology
<b>IP</b>	Inpatient
<b>LMRHA</b>	Loddon Mallee Rural Health Alliance
<b>NRCP</b>	National Respite for Carers Program
<b>NSQHSS</b>	National Safety & Quality Health Service Standards
<b>Occupancy</b>	Percentage of Beds filled per nominated period
<b>OHS</b>	Occupational Health and Safety
<b>OP</b>	Outpatient
<b>OT</b>	Occupational Therapy
<b>PAG</b>	Planned Activity Group
<b>PCP</b>	Primary Care Partnership
<b>PP</b>	Private Patient
<b>REDHS</b>	Rochester and Elmore District Health Service
<b>RIPERN</b>	Rural Isolated Practice Endorsed Registered Nurse
<b>Separation/Discharge</b>	The completion of an episode of care and the patient/ client leaves the organisation
<b>Statement of Priorities</b>	The formal funding and monitoring agreement between the Victorian Secretary for Health and REDHS
<b>TCP</b>	Transition Care Program
<b>UCC</b>	Urgent Care Centre
<b>VHES</b>	Victorian Health Experience Survey
<b>VHIMS</b>	Victorian Health Information Management System
<b>VICNISS</b>	Victorian Nosocomial Infection Surveillance System
<b>VMIA</b>	Victorian Managed Insurance Authority
<b>VMO</b>	Visiting Medical Officer
<b>YTD</b>	Year to date

**The Financial Report which forms part of this Annual Report is attached here.**

If the Financial Report is not attached, a copy can be obtained by phoning 03 5484 4400 or from **[www.redhs.com.au](http://www.redhs.com.au)**



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Email: rochhosp@redhs.com.au  
**www.redhs.com.au**







# FINANCIAL REPORT

2015



**redhs**

*More Than a Hospital*  
Rochester and Elmore District Health Service

## PERFORMANCE AGAINST STATEMENT OF PRIORITIES

The Statement of Priorities is the key accountability agreement between Rochester and Elmore District Health Service and the Victorian Minister for Health.

### PART A: Strategic Priorities

See Report of Operations pages 8-11 for details

### PART B: Performance Priorities

**Service performance:** See Report of Operations page 34 for details

#### Financial performance

Operating Result	Target	2014-15 Actual
Annual Operating result (\$m)	0.14	0.117
<b>Cash Management</b>		
Creditors	< 60 days	42 days
Debtors	< 60 days	6 days
Basic asset management plan	Full compliance	Compliant

### PART C: Activity and Funding

<b>Funding type:</b>	
<i>Small Rural</i>	<i>2014-15 Activity Achievement</i>
Small Rural Residential Care	20,861
Small Rural HACC	13,990

### Financials in Brief

A summary of the financial results for the year, from Annual Financial Reports, with comparative results from the preceding four financial years

	2014-15 \$000s	2013-14 \$000s	2012-13 \$000s	2011-12 \$000s	2010-11 \$000s
<b>Total Revenue</b>	13,053	12,789	12,723	12,275	11,875
<b>Total Expenses</b>	14,252	13,888	13,321	12,840	12,048
<b>Operating Surplus (Deficit)</b>	(1,199)	(1,099)	(597)	(566)	(173)
<b>Retained Surplus/ (Accumulated Deficit)</b>	12,458	13,703	14,586	15,245	16,606
<b>Total Assets</b>	46,007	45,715	36,190	33,431	33,657
<b>Total Liabilities</b>	7,258	5,767	6,761	5,747	5,407
<b>Net Assets</b>	38,749	39,948	29,429	27,684	28,250
<b>Net Cash Result</b>	(1,950)	1,236	671	(1,977)	701
<b>Total Equity</b>	38,749	39,948	29,429	27,684	28,250

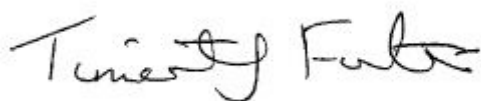
ROCHESTER AND ELMORE DISTRICT HEALTH SERVICE  
BOARD MEMBER'S, ACCOUNTABLE OFFICER'S AND  
CHIEF FINANCE & ACCOUNTING OFFICER'S DECLARATION

The attached financial statements for Rochester and Elmore District Health Service have been prepared in accordance with Standing Directions 4.2 of the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2015 and the financial position of Rochester and Elmore District Health Service at 30 June 2015.

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

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



.....  
Mr Timothy Fulton  
Chairperson

.....  
Mrs Ann McEvoy  
Accountable Officer  
Chief Finance and Accounting Officer

Rochester

Rochester

28 August 2015

28 August 2015

## Comprehensive Operating Statement for the financial year ended 30 June 2015

	NOTE	2015 \$	2014 \$
Revenue from Operating Activities	2	12,532,615	12,000,581
Revenue from Non-operating Activities	2	320,142	561,452
Employee Expenses	3	(9,536,646)	(9,411,193)
Non Salary Labour Costs	3	(494,975)	(445,975)
Supplies & Consumables	3	(1,131,083)	(696,739)
Other Expenses	3	(1,573,033)	(1,815,168)
<b>Net Result Before Capital and Specific Items</b>		<b>117,020</b>	<b>192,958</b>
Capital Purpose Income	2	200,618	226,976
Depreciation	4	(1,512,153)	(1,509,611)
Finance Costs	5	(4,285)	(9,691)
<b>NET RESULT FOR THE YEAR</b>		<b>(1,198,800)</b>	<b>(1,099,368)</b>
<b>OTHER COMPREHENSIVE INCOME</b>			
<b>Items that will not be reclassified to net result</b>			
Changes in physical asset revaluation surplus		-	11,618,455
<b>TOTAL OTHER COMPREHENSIVE INCOME</b>		<b>-</b>	<b>11,618,455</b>
<b>COMPREHENSIVE RESULT</b>		<b>(1,198,800)</b>	<b>10,519,087</b>

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



## Balance Sheet as at 30 June 2015

	NOTE	2015 \$	2014 \$
<b>Current Assets</b>			
Cash and Cash Equivalents	6	925,386	2,811,514
Receivables	7	385,875	667,477
Investments and other financial assets	8	7,176,032	3,475,237
Inventories	9	61,259	62,516
Other Assets	10	109,158	105,264
<b>Total Current Assets</b>		<b>8,657,710</b>	<b>7,122,008</b>
<b>Non-Current Assets</b>			
Receivables	7	258,877	296,676
Property, Plant & Equipment	12	37,090,767	38,296,796
<b>Total Non-Current Assets</b>		<b>37,349,644</b>	<b>38,593,472</b>
<b>TOTAL ASSETS</b>		<b>46,007,354</b>	<b>45,715,480</b>
<b>Current Liabilities</b>			
Payables	13	548,896	712,400
Borrowings	14	-	132,679
Provisions	15	2,085,522	2,065,816
Other Current Liabilities	17	4,337,514	2,450,112
<b>Total Current Liabilities</b>		<b>6,971,932</b>	<b>5,361,007</b>
<b>Non-Current Liabilities</b>			
Provisions	15	286,067	406,318
<b>Total Non-Current Liabilities</b>		<b>286,067</b>	<b>406,318</b>
<b>TOTAL LIABILITIES</b>		<b>7,257,999</b>	<b>5,767,325</b>
<b>NET ASSETS</b>		<b>38,749,355</b>	<b>39,948,155</b>
<b>EQUITY</b>			
Property, Plant and Equipment Revaluation Surplus	18a	18,053,026	18,053,026
Restricted Specific Purpose Surplus	18a	868,005	822,050
Contributed Capital	18b	7,369,839	7,369,839
Accumulated Surpluses	18c	12,458,485	13,703,240
<b>TOTAL EQUITY</b>		<b>38,749,355</b>	<b>39,948,155</b>
Contingent Assets and Contingent Liabilities	22		
Commitments	21		

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

# Statement of Changes in Equity for the financial year ended 30 June 2015

2015

		Equity at 1 July 2014	Net Result for the year	Equity at 30 June 2015
	Note	\$	\$	\$
<b>Accumulated Surplus/(Deficit)</b>	18c	14,343,357	(1,198,800)	13,144,557
Transfer to/(from) accumulated surplus	18c	(640,117)	(45,955)	(686,072)
		<b>13,703,240</b>	<b>(1,244,755)</b>	<b>12,458,485</b>
<b>Contributed Capital</b>	18b	7,369,839	-	7,369,839
		<b>7,369,839</b>	<b>-</b>	<b>7,369,839</b>
<b>Reserves</b>				
Property Plant and Equipment Revaluation Surplus	18a	18,053,026	-	18,053,026
Restricted Specific Purpose Surplus	18a	822,050	45,955	868,005
		<b>18,875,076</b>	<b>45,955</b>	<b>18,921,031</b>
<b>Balance as at 30 June 2015</b>		<b>39,948,155</b>	<b>(1,198,800)</b>	<b>38,749,355</b>

2014

		Equity at 1 July 2013	Net Result for the year	Equity at 30 June 2014
	Note	\$	\$	\$
<b>Accumulated Surplus/(Deficit)</b>	18c	15,442,725	(1,099,368)	14,343,357
Transfer to/(from) accumulated surplus	18c	(856,698)	216,581	(640,117)
		<b>14,586,027</b>	<b>(882,787)</b>	<b>13,703,240</b>
<b>Contributed Capital</b>	18b	7,369,839	-	7,369,839
		<b>7,369,839</b>	<b>-</b>	<b>7,369,839</b>
<b>Reserves</b>				
Property Plant and Equipment Revaluation Surplus	18a	6,434,571	11,618,455	18,053,026
Restricted Specific Purpose Surplus	18a	1,038,631	(216,581)	822,050
		<b>7,473,202</b>	<b>11,401,874</b>	<b>18,875,076</b>
<b>Balance as at 30 June 2014</b>		<b>29,429,068</b>	<b>10,519,087</b>	<b>39,948,155</b>

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

## Cash Flow Statement for the financial year ended 30 June 2015

	NOTE	2015 \$	2014 \$
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>			
Operating Grants from Government		9,244,992	8,594,374
Patient and Resident Fees Received		1,862,678	2,101,425
Donations and Bequests Received		38,818	5,381
GST Received from/(paid to) ATO		147,999	239,114
Interest Received		162,359	158,694
Other Receipts		1,719,418	1,395,186
<b>Total Receipts</b>		<b>13,176,265</b>	<b>12,494,174</b>
Employee Expenses Paid		(9,713,733)	(9,281,687)
Fee for Service Medical Officers		(380,635)	(313,337)
Payments for Supplies & Consumables		(1,129,826)	(1,161,282)
Finance Costs		(4,285)	(9,691)
Other Payments		(1,683,712)	(1,758,216)
<b>Total Payments</b>		<b>(12,912,191)</b>	<b>(12,524,213)</b>
<b>Cash Generated from Operations</b>		<b>264,074</b>	<b>(30,039)</b>
Capital Grants from Government		41,069	45,285
<b>NET CASH FLOW FROM OPERATING ACTIVITIES</b>	19	<b>305,143</b>	<b>15,246</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>			
Payments for Non-Financial Assets		(350,331)	(902,044)
Proceeds from sale of Non-Financial Assets		55,834	106,974
Purchase of Investments		(1,828,053)	2,059,939
<b>NET CASH FLOW FROM INVESTING ACTIVITIES</b>		<b>(2,122,550)</b>	<b>1,264,869</b>
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>			
Repayments of Borrowings		(132,679)	(44,390)
<b>NET CASH FLOW USED IN FINANCING ACTIVITIES</b>		<b>(132,679)</b>	<b>(44,390)</b>
<b>NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD</b>		<b>(1,950,086)</b>	<b>1,235,725</b>
Cash and Cash Equivalents at beginning of financial year		2,569,087	1,333,362
<b>CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR</b>	6	<b>619,001</b>	<b>2,569,087</b>

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

## **Note 1: Summary of significant accounting policies**

These annual financial statements represent the audited general purpose financial statements for Rochester and Elmore District Health Service for the period ending 30 June 2015. The purpose of the report is to provide users with information about the Health Services' stewardship of resources entrusted to it.

### **(a) Statement of compliance**

These financial statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act 1994* and applicable 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.

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

The annual financial statements were authorised for issue by the Board of Rochester and Elmore District Health Service on the 24<sup>th</sup> August 2015.

### **(b) Basis of accounting preparation and measurement**

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2015, and the comparative information presented in these financial statements for the year ended 30 June 2014.

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

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

The financial statements, except for cash flow information, have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

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

- non-current physical assets, which subsequent to acquisition, are measured at a revalued amount being their fair value at the date of the revaluation less any



subsequent accumulated depreciation and subsequent impairment losses. Revaluations are made and are re-assessed with sufficient regularity to ensure that the carrying amounts do not materially differ from their fair values;

- derivative financial instruments, managed investment schemes, certain debt securities, and investment properties after initial recognition, which are measured at fair value with changes reflected in the comprehensive operating statement (fair value through profit and loss); and
- available-for-sale investments which are measured at fair value with movements reflected in equity until the asset is derecognised (i.e. other comprehensive income – items that may be reclassified subsequent to net result);
- 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.

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

- the fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 1(k));
- superannuation expense (refer to Note 1(h)); 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 1(l)).
- Equities and management investment schemes classified at level 3 of the fair value hierarchy

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

All assets and liabilities for which fair value is measured or disclosed in the financial statements are categorised within the fair value hierarchy, 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, Rochester and Elmore District Health Service has determined classes of assets and liabilities on the basis of the nature, characteristics and risks of the asset or liability and the level of the fair value hierarchy as explained above.

In addition, Rochester and Elmore District Health Service 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 Rochester and Elmore District Health Service's independent valuation agency.

Rochester and Elmore District Health Service, 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.

### **(c) Reporting entity**

The financial statements include all the controlled activities of the *Rochester and Elmore District Health Service*.

Its principal address is:

1 Pascoe Street  
Rochester VIC 3551.

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

### **Objectives and funding**

*Rochester and Elmore District Health Service's* overall objective is to provide quality health care service, as well as improve the quality of life to Victorians.

*Rochester and Elmore District Health Service* is predominantly funded by accrual based grant funding for the provision of outputs.

### **(d) Principles of consolidation**

#### **Joint Controlled Assets or Operations**

Interests in jointly controlled assets or operations are not consolidated by Rochester and Elmore District Health Service, but are accounted for in accordance with the policy outlined in Note 1(k) Financial Asset.

Details of joint operations are set out in Note 11.

## **(e) Scope and presentation of financial statements**

### **Fund Accounting**

The *Rochester and Elmore District Health Service* operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds. The *Rochester and Elmore District Health Service's* Capital and Specific Purpose Funds include unspent capital donations and receipts from fund-raising activities conducted solely in respect of these funds.

### **Services Supported By Health Services Agreement and Services Supported By Hospital and Community Initiatives**

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

### **Residential Aged Care Service**

The *Residential Aged Care Service* operations are an integral part of the *Rochester and Elmore District Health Service* 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 Notes 2 and 3 to the financial statements.

The *Residential Aged Care Service* is substantially funded from Commonwealth bed-day subsidies.

### **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 *Rochester and Elmore District Health Service*. This subtotal reports the result excluding items such as capital grants, assets received or provided free of charge, depreciation, expenditure using capital purpose income and items of an unusual nature and amount such as specific income and expenses. The exclusion of these items is made to enhance matching of income and expenses so as to facilitate the comparability and consistency of results between years and Victorian Public Health Services. The 'net result before capital & specific items' is used by the management of *Rochester and Elmore District Health Service*, the Department of Health and Human Services 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 1 (g)). Consequently the recognition of revenue as capital purpose income is based on the intention of the provider of the revenue at the time the revenue is provided.

- ❖ specific income/expense, comprises the following items, where material:
  - Write-down of inventories
  - Non-current asset revaluation increments/decrements
  - Restructuring of operations (disaggregation/aggregation of Health Services)
  - Litigation settlements
  - Reversals of provisions
- ❖ impairment of financial and non-financial assets, includes all impairment losses (and reversal of previous impairment losses), which have been recognised in accordance with Notes 1 (j)
- ❖ depreciation and amortisation, as described in Note 1 (h);
- ❖ assets provided or received free of charge (refer to Notes 1 (g) and (h)); 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.

## **Balance sheet**

Assets and liabilities are categorised either as current or non-current (non-current being those assets or liabilities expected to be recovered/settled more than 12 months after reporting period), 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 bank overdrafts, which are included as current borrowings in the balance sheet.

## **Rounding**

All amounts shown in the financial statements are expressed to the nearest dollar unless otherwise stated.

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



## **(f) Change in Accounting Policies**

Subsequent to the 2013-2014 reporting period, the following new and revised standards have been adopted for the first time in the current period with their financial impacts disclosed.

### **AASB 11 Joint Arrangements**

In accordance with AASB 11, there are two types of joint arrangements, i.e. joint operations and joint ventures. Joint operations arise where the investors have rights to the assets and obligations for the liabilities of an arrangement. A joint operator accounts for its share of the assets, liabilities, revenue and expenses. Joint ventures arise where the investors have rights to the new assets of the arrangement; joint ventures are accounted for under the equity method. Proportionate consolidation of joint ventures is no longer permitted.

Rochester and Elmore District Health Service has reviewed its existing contractual arrangements with other entities to ensure they are aligned with the new classifications under AASB 11.

Rochester and Elmore District Health Service has applied the requirements of AASB 11 to account for its share of its joint operation, the Loddon Mallee Rural Health Alliance.

### **AASB 2015-7 Amendments to Australian Accounting Standards**

The Australian Accounting Standards Board issued an amending accounting standard AASB 2015-7 Amendments to Australian Accounting Standards - Fair Value disclosures of Not-for-Profit Public Sector Entities on 13 July 2015. In accordance with FRD 7A Early adoption of authoritative accounting pronouncements, the Minister for Finance has approved the option for Victorian not-for-profit public sector entities to early adopt the amending accounting standard to enable them to benefit from some limited exemption in relation to fair value disclosures for the 2014-15 reporting period. The limited exemption is available to those entities whose assets are held primarily for their current service potential rather than to generate net cash inflows.

Rochester and Elmore District Health Service meets the criteria specified in AASB 2015-7 to benefit from the reduced disclosure requirements, so it has chosen to early adopt the amendments to Fair Value disclosure of Not-for-profit-public sector entities.

## **(g) Income from transactions**

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

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

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

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

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

## **Indirect Contributions from the Department of Health and Human Services**

- Insurance is recognised as revenue following advice from the Department of Health and Human Services.
- Long Service Leave (LSL) – Revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular 05/2013 (update for 2013-14).

## **Patient and Resident Fees**

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

## **Private Practice Fees**

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

## **Revenue from commercial activities**

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

## **Donations and Other Bequests**

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

## **Dividend Revenue**

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

## **Interest Revenue**

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

## **Sale of investments**

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

## **Fair value of assets and services received free of charge or for nominal consideration**

Resources received free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another Health Service or agency as a consequence of a restructuring of

administrative arrangements. In the latter case, such transfer will be recognised at carrying value. Contributions in the form of services are only recognised when a fair value can be reliably determined and the service would have been purchased if not received as a donation.

## **(h) Expense recognition**

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

### **Cost of goods sold**

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

### **Employee expenses**

Employee expenses include:

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

### ***Defined contribution superannuation plans***

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

### ***Defined benefit superannuation plans***

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

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

The name and details of the major employee superannuation funds and contributions made by the *Rochester and Elmore District Health Service* are disclosed in Note 16: *Superannuation*.

## 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.

Intangible produced assets with finite lives are depreciated as an expense from transactions on a systematic basis over the asset's useful life. Depreciation is generally calculated on a straight line basis, at a rate that allocates the asset value, less any estimated residual value over its estimated useful life. Estimates of the remaining useful lives, residual value and depreciation method for all assets are reviewed at least annually, and adjustments made where appropriate. This depreciation charge is not funded by the Department of Health and Human Services. Assets with a cost in excess of \$1000 are capitalised and depreciation has been provided on depreciable assets so as to allocate their cost or valuation over their estimated useful lives.

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

	2015	2014
Buildings		
- Structure Shell Building Fabric	45 to 60 years	45 to 60 years
- Site Engineering Services and Central Plant	20 to 30 years	20 to 30 years
Central Plant		
- Fit Out	20 to 30 years	20 to 30 years
- Trunk Reticulated Building Systems	30 to 40 years	30 to 40 years
Plant & Equipment	3 to 10 years	3 to 7 years
Medical Equipment	7 to 10 years	7 to 10 years
Computers and Communication	3 years	3 years
Furniture and Fitting	9 years	13 years
Motor Vehicles	2 years	2 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.

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

## Finance costs

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

Finance costs include:

- interest on bank overdrafts and short-term and long-term borrowings (Interest expense is recognised in the period in which it is incurred);
- 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*.



## **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 1 (k) *Impairment of financial assets*.

### **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 value.

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

### **Borrowing costs of qualifying assets**

In accordance with the paragraphs of AASB 123 *Borrowing Costs* applicable to not-for-profit public sector entities, the Health Services continues to recognise borrowing costs immediately as an expense, to the extent that they are directly attributable to the acquisition, construction or production of a qualifying asset.

## **(i) Other comprehensive income**

Other comprehensive income measures the change 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 1(k) *Revaluations of non-financial physical assets*.

#### **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.

#### **Net gain/ (loss) on financial instruments**

Net gain/ (loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments at fair value;
- impairment and reversal of impairment for financial instruments at amortised cost (refer to Note 1 (k)); and
- disposals of financial assets and derecognition of financial liabilities

**Share of net profits/ (losses) of associates and joint entities, excluding dividends.**

Refer to Note 1 (d) *Principles of consolidation*.

**Other gains/ (losses) from other comprehensive income**

Other gains/ (losses) include:

- a. the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- b. transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

## **(j) Financial instruments**

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of the Rochester and Elmore District Health Service's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*. For example, statutory receivables arising from taxes, fines and penalties do not meet the definition of financial instruments as they do not arise under contract.

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

The following refers to financial instruments unless otherwise stated.

***Categories of non-derivative financial instruments***

**Financial assets and liabilities at fair value through profit or loss**

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

Financial instruments at fair value through profit or loss are initially measured at fair value and attributable transaction costs are expensed as incurred. Subsequently, any changes in fair value are recognised in the net result as other comprehensive income. Any dividend or interest on a financial asset is recognised in the net result for the year.

## **Loans and receivables**

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

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

## **Available-for-sale financial assets**

Available-for-sale financial instrument assets are those designated as available-for-sale or not classified in any other category of financial instrument asset. Such assets are initially recognised at fair value. Subsequent to initial recognition, gains and losses arising from changes in fair value are recognised in 'other comprehensive income' until the investment is disposed of or is determined to be impaired, at which time the cumulative gain or loss previously recognised in equity is included in net result for the period. Fair value is determined in the manner described in Note 20.

## **Financial liabilities at amortised cost**

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

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

## **(k) Assets**

### **Cash and Cash Equivalents**

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.

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

### **Receivables**

Receivables consist of:

- contractual receivables, which includes mainly debtors in relation to goods and services, loans to third parties, accrued investment income, and finance lease receivables; and

- statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax ("GST") input tax credits recoverable.

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

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.

### **Investments and other financial assets**

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

Investments are classified in the following categories:

- financial assets at fair value through profit or loss;
- held-to-maturity;
- loans and receivables; and
- available-for-sale financial assets.

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

*Rochester and Elmore District Health Service* assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

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

### **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.

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

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

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



obsolescence occurs when an item no longer functions the way it did when it was first acquired.

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

### **Property, plant and equipment**

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

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 12 *Property, plant and equipment*.

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 impairment.

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

### **Revaluations of non-current physical assets**

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

### **Prepayments**

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.

### **Disposal of non-financial assets**

Any gain or loss on the sale of non-financial assets is recognised in the comprehensive operating statement. Refer to note 1(i) – 'other comprehensive income'.

### **Impairment of non-financial assets**

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

- inventories;
- investment properties that are measured at fair value;
- non-current physical assets held for sale; and
- assets arising from construction contracts.

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

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

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

## **Investments in jointly controlled assets and operations**

In respect of any interest in jointly controlled assets, Rochester and Elmore District Health Service recognises in the financial statements:

- its share of jointly controlled assets;
- any liabilities that it had incurred;
- its share of liabilities incurred jointly by the joint venture;
- any income earned from the selling or using of its share of the output from the joint venture; and
- any expenses incurred in relation to being an investor in the joint venture.

For jointly controlled operations Rochester and Elmore District Health Service recognises:

- the assets that it controls;
- the liabilities that it incurs;
- expenses that it incurs; and
- the share of income that it earns from selling outputs of the joint venture

## **Derecognition of financial assets**

A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is derecognised when:

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

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

## **Impairment of financial assets**

At the end of each reporting period Rochester and Elmore District Health Service assesses whether there is objective evidence that a financial asset or group of financial asset is impaired. All financial instrument assets, except those measured at fair value through profit or 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. Bad debt written off by mutual consent and the allowance for doubtful debts are classified as 'other comprehensive income' in the net result.

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.

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

In order to determine an appropriate fair value as at 30 June 2015 for its portfolio of financial assets, Rochester and Elmore District Health Service obtained a valuation based on the best available advice using an estimated market value through a reputable financial institution. This value was compared against valuation methodologies provided by the issuer as at 30 June 2014. These methodologies were critiqued and considered to be consistent with standard market valuation techniques.

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*.

### **Net gain/(loss) on financial instruments**

Net gain/(loss) on financial instruments includes:

- realised and unrealised gains and losses from revaluations of financial instruments that are designated at fair value through profit or loss or held-for-trading;
- impairment and reversal of impairment for financial instruments at amortised cost; and
- disposals of financial assets and derecognition of financial liabilities.

### ***Revaluations of financial instruments at fair value***

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

## **(I) Liabilities**

### **Payables**

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the Health Service prior to the end of the financial year that are unpaid, and arise when the Health Service becomes obliged to make future payments in respect of the purchase of those goods and services. The normal credit terms for accounts payable are usually Nett 30 days.
- statutory payables, such as goods and services tax and fringe benefits tax payables.

Contractual payables are 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.

## **Borrowings**

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs (refer also to note 1(m) Leases) The measurement basis subsequent to initial recognition depends on whether the Health Service has categorised its borrowings as either, financial liabilities designated at fair value through profit or loss, or financial liabilities at amortised cost. Any difference between the initial recognised amount and the redemption value is recognised in net result over the period of the borrowings using the effective interest method.

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

## **Provisions**

Provisions are recognised when the Health Service has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

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

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

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

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

### ***Long service leave (LSL)***

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

Unconditional LSL is disclosed in the notes to the financial statements as a current liability, even where the health service does not expect to settle the liability within 12



months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months.

The components of this current LSL liability are measured at:

- Undiscounted value – if the health service expects to wholly settle within 12 months; and
- Present value – if the health service 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 bond interest rates for which it is 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.

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

### **Employee Benefit On-costs**

Employee benefit on-costs, such as payroll tax, workers compensation and superannuation are recognised together with provisions for employee benefits.

### **Superannuation liabilities**

The Rochester and Elmore District Health Service does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the Health Service has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due.

### **(m) Leases**

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

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

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

All other leases are classified as operating leases.

## **Finance leases**

### ***Entity as lessee***

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

## **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.

### ***Lease Incentives***

All incentives for the agreement of a new or renewed operating lease are recognised as an integral part of the net consideration agreed for the use of the leased asset, irrespective of the incentive's nature or form or the timing of payments.

In the event that lease incentives are received by the lessee to enter into operating leases, such incentives are recognised as a liability. The aggregate benefits of incentives are recognised as a reduction of rental expense on a straight-line basis, except where another systematic basis is more representative of the time pattern in which economic benefits from the leased asset is diminished.

## **(n) Equity**

### **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.

### **Specific restricted purpose surplus**

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

## **(o) Commitments**

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note (refer to note 21) 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.

## **(p) Contingent assets and contingent liabilities**

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

## **(q) Goods and Services Tax ("GST")**

Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the taxation authority. In this case, the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.

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

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

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

## **(r) AASs issued that are not yet effective**

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2015 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 2015, 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. Rochester and Elmore District Health Service has not and does not intend to adopt these standards early.

<i>Standard/Interpretation</i>	<i>Summary</i>	<i>Applicable for annual reporting periods beginning on</i>	<i>Impact on public sector entity financial statements</i>
<i>AASB 9 Financial Instruments</i>	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1 Jan 2018	<p>The assessment has identified that the financial impact of available for sale (AFS) assets will now be reported through other comprehensive income (OCI) and no longer recycled to the profit and loss.</p> <p>While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.</p>
<i>AASB 15 Revenue from Contracts with Customers</i>	The core principal of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1 Jan 2017 (Exposure Draft 263 – potential deferral to 1 Jan 2018)	<p>The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The standard will also require additional disclosures on service revenue and contract modifications.</p> <p>A potential impact will be the upfront recognition of revenue from licenses that cover multiple reporting periods. Revenue that was deferred and amortised over a period may now need to be recognised immediately as a transitional adjustment immediately as a transitional adjustment against the opening returned earnings if there are no former performance obligations outstanding.</p>

<i>Standard/Interpretation</i>	<i>Summary</i>	<i>Applicable for annual reporting periods beginning on</i>	<i>Impact on public sector entity financial statements</i>
AASB 2014-1 <i>Amendments to Australian Accounting Standards [Part E Financial Instruments]</i>	Amends various AAS's 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 2108 as a consequence of Chapter 6 Hedge Accounting, and to amend reduced disclosure requirements.	1 Jan 2018	The amending standard will defer the application period of AASB 9 to 2018-19 reporting period in accordance with the transition requirements.
AASB 2014-4 <i>Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 &amp; AASB 138]</i>	Amends AASB 116 <i>Property, Plant and Equipment</i> and AASB 138 <i>Intangible Assets</i> to: <ul style="list-style-type: none"> <li>• <i>Establish the principle for the basis of depreciation and amortisation as being the expected pattern of consumption of the future economic benefits of an asset;</i></li> <li>• <i>Prohibit the use of revenue-based methods to calculate the depreciation or amortisation of an asset, tangible or intangible, because revenue generally reflects the pattern of economic benefits that are generated from operating the business, rather than the consumption through the use of the asset.</i></li> </ul>	1 Jan 2016	The assessment has indicated that there is no expected impact as the revenue-based method is not used for depreciation and amortisation.
AASB 2014-9 <i>Amendments to Australian Accounting Standards – Equity Method in Separate Financial Statements [AASB 1, 127 &amp; 128]</i>	Amends AASB 127 <i>Separate Financial Statements</i> to allow entities to use the equity method of accounting for investments in subsidiaries, joint ventures and associates in their separate financial statements.	1 Jan 2016	The assessment indicates that there is no expected impact as the entity will continue to account for the investments in subsidiaries, joint ventures and associates using the cost method as mandated if separate financial statements are presented in accordance with FRD 113A.
AASB 2014-10 <i>Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an investor and its Associate or</i>	AASB 2014-10 amends AASB 10 <i>Consolidate Financial Statements</i> and AASB 128 <i>Investments in Associates</i> to ensure consistent treatment in dealing with the sale or contribution of assets between an investor and its associate or joint venture. The amendments require	1 Jan 2016	The assessment has indicated that there is limited impact, as the revisions to AASB 10 and AASB 128 are guidance in nature.



<i>Standard/Interpretation</i>	<i>Summary</i>	<i>Applicable for annual reporting periods beginning on</i>	<i>Impact on public sector entity financial statements</i>
<i>Joint Venture [AASB 10 &amp; 128]</i>	that: <ul style="list-style-type: none"> <li>• A full gain or loss to be recognised by the investor when a transaction involves a business (whether it is housed in a subsidiary or not); and</li> <li>• A partial gain or loss to be recognised by the parent when a transaction involves assets that do not constitute a business, even if these assets are housed in a subsidiary.</li> </ul>		
<i>AASB 2015-6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, AASB 124 &amp; AASB 1049]</i>	The amendments extend the scope of <i>AASB 124 Related Party Disclosures</i> to not-for-profit public sector entities. A guidance has been included to assist the application of the Standard by not-for-profit public sector entities.	1 Jan 2016	The amending standard will result in extended disclosures on the entity's key management personnel (KMP), and the related party transactions.

In addition to the new standards and amendments above, the AASB has issued a list of other amending standards that are not effective for the 2014-15 reporting period (as listed below). In general, these amending standards include editorial and references changes that are expected to have insignificant impacts on public sector reporting.

- AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)
- AASB 2014-3 Amendments to Australian Accounting Standards – Accounting for Acquisitions of Interests in Joint Operations [AASB 1 & AASB 11]
- AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15
- AASB 2014-6 Amendments to Australian Accounting Standards – Agriculture: Bearer Plants [AASB 101, AASB 116, AASB 117, AASB 123, AASB 136, AASB 140 & AASB 1049]
- AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)
- AASB 2014-8 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) – Application of AASB 9 (December 9) and AASB 9 (December 2010) [AASB 9 (2009 & 2010)]
- AASB 2015-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]
- AASB 2015-3 Amendments to Australian Accounting Standards arising from the Withdrawal of AASB 1031 Materiality.

## **(s) Category groups**

The *Rochester and Elmore District Health Service* 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.

**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 with a disability, and their carers.

**Primary, Community and Dental Health** comprises a range of home based, community based, community, primary health and dental services including health promotion and counselling, physiotherapy, speech therapy, podiatry and occupational therapy and a range of dental health services.

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

**Other Services not reported elsewhere – (Other)** comprises services not separately classified above, including: Public Health Services including laboratory testing, blood borne viruses/sexually transmitted infections clinical services, Kooris liaison officers, immunisation and screening services, drug 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: Analysis of Revenue by Source**

	Admitted Patients 2015 \$	Residential Aged Care 2015 \$	Aged Care 2015 \$	Primary Health 2015 \$	Other 2015 \$	Total 2015 \$
Government Grants	4,416,278	4,076,399	550,656	167,700	71,758	9,282,791
Indirect contributions by Department of Health and Human Services	6,816	-	-	-	(28,243)	(21,427)
Patient and Resident Fees	374,350	1,284,214	36,224	69,508	-	1,764,296
Commercial Activities	79,838	-	-	-	115,189	195,027
Other Revenue from Operating Activities	342,076	62,850	10,475	639,935	256,592	1,311,928
<b>Total Revenue from Operating Activities</b>	<b>5,219,358</b>	<b>5,423,463</b>	<b>597,355</b>	<b>877,143</b>	<b>415,296</b>	<b>12,532,615</b>
Interest and Dividends	-	-	-	-	159,567	159,567
Other Revenue from Non-Operating Activities	-	-	-	-	160,575	160,575
<b>Total Revenue from Non-Operating Activities</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>320,142</b>	<b>320,142</b>
Capital Purpose Income (excluding Interest)	-	-	-	-	104,513	104,513
Capital Interest	-	94,085	-	-	215	94,300
Proceeds from Sale of Assets (refer Note 2a)	-	-	-	-	1,805	1,805
<b>Total Capital Purpose Income</b>	<b>-</b>	<b>94,085</b>	<b>-</b>	<b>-</b>	<b>106,533</b>	<b>200,618</b>
<b>Total Revenue</b>	<b>5,219,358</b>	<b>5,517,548</b>	<b>597,355</b>	<b>877,143</b>	<b>841,971</b>	<b>13,053,375</b>

Indirect contributions by Department of Health (1 July 2014 - 31 Dec 2014)/ Department of Health and Human Services (1 Jan 2015 - 30 June 2015).  
Department of Health/Department of Health and Human Services makes certain payments on behalf of Rochester and Elmore District Health Service. These amounts have brought to account in determining the operating result for the year by recording them as revenue and expenses.

**Note 2: Analysis of Revenue by Source**

	Admitted Patients 2014 \$	Residential Aged Care 2014 \$	Aged Care 2014 \$	Primary Health 2014 \$	Other 2014 \$	Total 2014 \$
Government Grants	4,730,777	3,054,525	566,296	208,767	34,010	8,594,375
Indirect contributions by Department of Health and Human Services	111,258	-	-	-	-	111,258
Patient and Resident Fees	300,087	1,566,014	57,246	58,778	-	1,982,125
Commercial Activities	61,305	-	-	-	118,495	179,800
Other Revenue from Operating Activities	341,440	145,175	9,983	450,844	185,581	1,133,023
<b>Total Revenue from Operating Activities</b>	<b>5,544,867</b>	<b>4,765,714</b>	<b>633,525</b>	<b>718,389</b>	<b>338,086</b>	<b>12,000,581</b>
Interest and Dividends	-	-	-	-	124,120	124,120
Other revenue from Non - Operating Activities	-	-	-	-	437,332	437,332
<b>Total Revenue from Non - Operating Activities</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>561,452</b>	<b>561,452</b>
Capital Purpose Income (excluding Interest)	-	-	-	-	77,408	77,408
Bank & Investment Income	-	130,709	-	-	16,651	147,360
Proceeds from Sale of Assets (refer Note 2a)	-	-	-	-	2,208	2,208
<b>Total Capital Purpose Income</b>	<b>-</b>	<b>130,709</b>	<b>-</b>	<b>-</b>	<b>96,267</b>	<b>226,976</b>
<b>Total Revenue</b>	<b>5,544,867</b>	<b>4,896,423</b>	<b>633,525</b>	<b>718,389</b>	<b>995,805</b>	<b>12,789,009</b>

Indirect contributions by Department of Health (1 July 2014 - 31 Dec 2014)/ Department of Health and Human Services (1 Jan 2015 - 30 June 2015).

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

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

	2015 \$	2014 \$
<b>Proceeds from Disposals of Non-Current Assets</b>		
Motor Vehicles	57,616	107,110
Plant and Equipment	23	2,072
<b>Total Proceeds from Disposal of Non-Current Assets</b>	<b>57,639</b>	<b>109,182</b>
<b>Less: Written Down Value of Non-Current Assets Sold</b>		
Motor Vehicles	(55,834)	(102,153)
Plant and Equipment	-	(4,821)
<b>Total Written Down Value of Non-Current Assets Sold</b>	<b>(55,834)</b>	<b>(106,974)</b>
<b>NET GAIN/(LOSS) ON DISPOSAL OF NON-FINANCIAL ASSETS</b>	<b>1,805</b>	<b>2,208</b>

**Note 3: Analysis of Expenses by Source**

	Admitted Patients 2015 \$	Residential Aged Care 2015 \$	Aged Care 2015 \$	Primary Health 2015 \$	Other 2015 \$	Total 2015 \$
Employee Expenses	1,686,124	3,525,772	402,744	1,236,274	2,685,732	9,536,646
Non Salary Labour Costs	378,902	100,542	-	12,744	2,787	494,975
Supplies & Consumables	324,578	195,165	4,060	27,835	579,445	1,131,083
Other Expenses	188,455	135,638	18,224	74,140	1,156,576	1,573,033
<b>Total Expenditure from Operating Activities</b>	<b>2,578,059</b>	<b>3,957,117</b>	<b>425,028</b>	<b>1,350,993</b>	<b>4,424,540</b>	<b>12,735,737</b>
Depreciation (refer Note 4)	-	-	-	-	1,512,153	1,512,153
Finance Costs (refer Note 5)	-	-	-	-	4,285	4,285
<b>Total Other Expenses</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1,516,438</b>	<b>1,516,438</b>
<b>Total Expenses</b>	<b>2,578,059</b>	<b>3,957,117</b>	<b>425,028</b>	<b>1,350,993</b>	<b>5,940,978</b>	<b>14,252,175</b>

	Admitted Patients 2014 \$	Residential Aged Care 2014 \$	Aged Care 2014 \$	Primary Health 2014 \$	Other 2014 \$	Total 2014 \$
Employee Expenses	1,732,940	3,500,633	404,374	1,100,225	2,673,021	9,411,193
Non Salary Labour Costs	334,163	5,261	-	1,110	105,441	445,975
Supplies & Consumables	185,130	180,353	4,902	24,801	301,553	696,739
Other Expenses	260,227	249,735	16,534	88,002	1,200,670	1,815,168
<b>Total Expenditure from Operating Activities</b>	<b>2,512,460</b>	<b>3,935,982</b>	<b>425,810</b>	<b>1,214,138</b>	<b>4,280,685</b>	<b>12,369,075</b>
Depreciation (refer Note 4)	-	-	-	-	1,509,611	1,509,611
Finance Costs (refer Note 5)	-	-	-	-	9,691	9,691
<b>Total Other Expenses</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1,519,302</b>	<b>1,519,302</b>
<b>Total Expenses</b>	<b>2,512,460</b>	<b>3,935,982</b>	<b>425,810</b>	<b>1,214,138</b>	<b>5,799,987</b>	<b>13,888,377</b>

**Note 3a: Analysis of expense and revenue by internally managed and restricted specific purpose funds**

	Expense		Revenue	
	2015	2014	2015	2014
	\$	\$	\$	\$
<b>Commercial Activities</b>				
Radiology	55,736	56,687	91,895	61,305
Meals on Wheels	46,082	46,396	51,530	62,402
Cafeteria	93,277	77,800	51,602	55,510
Primary Care Partnership	281,245	221,121	285,716	239,271
<b>TOTAL</b>	<b>476,340</b>	<b>402,004</b>	<b>480,743</b>	<b>418,488</b>

**Note 4: Depreciation**

	2015	2014
	\$	\$
Buildings	1,111,920	997,697
Land Improvements	5,140	16,000
Plant and Equipment	200,750	323,186
Motor Vehicles	102,939	88,937
Furniture and Fittings	59,051	66,123
Computer and Communications	21,205	11,789
Loddon Mallee Rural Health Alliance	11,148	5,879
<b>TOTAL DEPRECIATION</b>	<b>1,512,153</b>	<b>1,509,611</b>

**Note 5: Finance Costs**

	2015	2014
	\$	\$
Finance charges on Hire		
Purchase Liabilities	4,285	9,691
<b>TOTAL FINANCE COSTS</b>	<b>4,285</b>	<b>9,691</b>



**Note 6: Cash and Cash Equivalents**

For the purposes of the Cash Flow Statement, cash assets includes cash on hand and in banks, and short-term deposits which are readily convertible to cash on hand, and are subject to an insignificant risk of change in value, net of outstanding bank overdrafts.

	2015 \$	2014 \$
Cash on Hand	670	670
Cash at Bank	924,716	2,810,844
<b>TOTAL CASH AND CASH EQUIVALENTS</b>	<b>925,386</b>	<b>2,811,514</b>
<b>Represented by:</b>		
Cash for Health Service Operations (as per Cash Flow Statement)	619,001	2,569,087
Cash for Monies Held in Trust		
- Deposits at Call	7,382	7,382
- Resident Trust Account	25,864	27,231
- Loddon Mallee Rural Health Alliance	273,139	207,814
<b>TOTAL CASH AND CASH EQUIVALENTS</b>	<b>925,386</b>	<b>2,811,514</b>

**Note 7: Receivables**

	2015 \$	2014 \$
<b>CURRENT</b>		
<b>Contractual</b>		
Inter Hospital Debtors		
Trade Debtors	189,486	276,695
Patient Fees	35,251	20,460
Accrued Investment Income	21,210	14,339
Accrued Revenue - Other	22,744	39,849
Loddon Mallee Rural Health Alliance Receivables	1,775	3,520
LESS Allowance for Doubtful Debts Patient Fees	(1,721)	(1,721)
LESS Allowance for Doubtful Debts LMRHA	-	(700)
	<b>268,745</b>	<b>352,442</b>
<b>Statutory</b>		
Accrued Revenue - Department of Health	-	53,030
FBT Credit	-	5,780
GST Receivable	114,900	252,030
Loddon Mallee Rural Health Alliance GST Receivables	2,230	4,195
	<b>117,130</b>	<b>315,035</b>
<b>TOTAL CURRENT RECEIVABLES</b>	<b>385,875</b>	<b>667,477</b>
<b>NON CURRENT</b>		
<b>Contractual</b>		
Bond Debtors	1,644	1,644
	<b>1,644</b>	<b>1,644</b>
<b>Statutory</b>		
Long Service Leave - DHHS	257,233	295,032
	<b>257,233</b>	<b>295,032</b>
<b>TOTAL NON-CURRENT RECEIVABLES</b>	<b>258,877</b>	<b>296,676</b>
<b>TOTAL RECEIVABLES</b>	<b>644,752</b>	<b>964,153</b>

**(a) Movement in the Allowance for doubtful debts**

	2015 \$	2014 \$
Balance at the beginning of year - REDHS	1,721	14,000
Balance at the beginning of year - LMRHA	700	312
Increase/(decrease) in allowance recognised in net result	(700)	(11,891)
<b>Balance at end of year</b>	<b>1,721</b>	<b>2,421</b>

**(b) Ageing analysis of receivables**

Please refer to note 20(b) for the ageing analysis of contractual receivables.

**(c) Nature and extent of risk arising from receivables**

Please refer to note 20(b) for the nature and extent of credit risk arising from contractual receivables.

## Note 8: Investments and Other Financial Assets

### CURRENT

#### Term Deposit

Aust. Dollar Term Deposits(i)

#### TOTAL CURRENT

#### Represented by:

Health Services Investments

Accommodation Bonds (Refundable Entrance Fees)

Term Deposits

#### TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS

	Capital		Total	
	2015	2014	2015	2014
	\$	\$	\$	\$
	7,176,032	3,475,237	7,176,032	3,475,237
<b>TOTAL CURRENT</b>	<b>7,176,032</b>	<b>3,475,237</b>	<b>7,176,032</b>	<b>3,475,237</b>
	768,982	1,058,982	768,982	1,058,982
	4,304,268	2,415,499	4,304,268	2,415,499
	2,102,782	756	2,102,782	756
<b>TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS</b>	<b>7,176,032</b>	<b>3,475,237</b>	<b>7,176,032</b>	<b>3,475,237</b>

Notes:

(i) Term deposits under 'investment and other financial assets' class include only term deposits with maturity greater than 90 days.

#### (a) Ageing analysis of other financial assets

Please refer to note 20(b) for the ageing analysis of investments and other financial assets.

#### (b) Nature and extent of risk arising from other financial assets

Please refer to note 20(b) for the nature and extent of credit risk arising from investments and other financial assets.

In accordance with Standing Direction 4.5.6, the Health Service is required to invest surplus funds with TCV/VFMC. As at 30 June 2015 the Health Service is compliant with this Standing Direction.

## Note 9: Inventories

### CURRENT

Pharmaceuticals - at cost

Catering Supplies - at cost

Housekeeping - at cost

Medical and Surgical Lines - at cost

Administration Stores - at cost

#### TOTAL INVENTORIES

	2015	2014
	\$	\$
	12,249	12,171
	10,964	16,961
	852	6,309
	33,814	22,425
	3,380	4,650
<b>TOTAL INVENTORIES</b>	<b>61,259</b>	<b>62,516</b>

## Note 10: Other Assets

### Current:

Prepayments

Loddon Mallee Rural Health Alliance

#### TOTAL OTHER ASSETS

	2015	2014
	\$	\$
	104,751	98,078
	4,407	7,186
<b>TOTAL OTHER ASSETS</b>	<b>109,158</b>	<b>105,264</b>

## Note 11: Investment Accounted for Using Joint Operations

Name of entity	Principal Activity	Ownership Interest	
		2015 %	2014 %
Loddon Mallee Rural Health Alliance	Information Technology	4.00	3.88

Rochester and Elmore District Health Services interest in assets employed in the above jointly controlled operations and assets in detail below. The amounts are included in the financial statements under their respective asset categories:

	2015 \$	2014 \$
<b>CURRENT ASSETS</b>		
Cash and Cash Equivalents	273,139	207,808
Receivables	4,005	7,015
Prepayments	4,407	7,186
<b>TOTAL CURRENT ASSETS</b>	<b>281,551</b>	<b>222,009</b>
<b>NON-CURRENT ASSETS</b>		
Property, Plant and Equipment	18,837	18,364
<b>TOTAL NON-CURRENT ASSETS</b>	<b>18,837</b>	<b>18,364</b>
<b>TOTAL ASSETS</b>	<b>300,388</b>	<b>240,373</b>
<b>CURRENT LIABILITIES</b>		
Payables	32,303	30,651
<b>TOTAL CURRENT LIABILITIES</b>	<b>32,303</b>	<b>30,651</b>
<b>NET ASSETS</b>	<b>268,085</b>	<b>209,722</b>

Rochester & Elmore District Health Service's interest in revenue and expenses resulting from jointly controlled operations and assets is detailed below:

Revenue from Continuing Operations	326,609	241,259
Capital Purpose Income	(29)	27,309
<b>Total Revenue</b>	<b>326,580</b>	<b>268,568</b>
Other Expenses from Continuing Operations	287,790	284,297
<b>Total Expenses</b>	<b>287,790</b>	<b>284,297</b>
<b>Net Result</b>	<b>38,790</b>	<b>(15,729)</b>

### Contingent Assets and Liabilities

The joint venture does not have any known contingent assets or contingent liabilities as at 30 June 2015.

**Note 12: Property, Plant and Equipment****(a) Gross carrying amount and accumulated depreciation**

	<b>2015</b>	<b>2014</b>
	<b>\$</b>	<b>\$</b>
<b>Land</b>		
- Land at Fair Value	382,000	382,000
- Landscaping at Fair Value	257,000	257,000
Less Accumulated Depreciation	(5,140)	-
<b>Total Land</b>	<b>633,860</b>	<b>639,000</b>
<b>Buildings</b>		
- Buildings at Fair Value	36,325,000	36,325,000
Less Accumulated Depreciation	(1,111,920)	-
<b>Total Buildings</b>	<b>35,213,080</b>	<b>36,325,000</b>
<b>Plant and Equipment</b>		
- Plant and Equipment at Fair Value	2,840,246	2,867,929
Less Accumulated Depreciation	(2,319,094)	(2,170,296)
- Loddon Mallee Rural Health Alliance at Fair Value	35,835	36,343
Less Accumulated Depreciation	(16,998)	(17,985)
<b>Total Plant and Equipment</b>	<b>539,989</b>	<b>715,991</b>
<b>Computers and Communication</b>		
- Computers and Communication at Fair Value	143,738	53,010
Less Accumulated Depreciation	(32,994)	(11,789)
<b>Total Computers and Communications</b>	<b>110,744</b>	<b>41,221</b>
<b>Furniture and Fittings</b>		
- Furniture and Fittings at Fair Value	628,642	625,933
Less Accumulated Depreciation	(395,857)	(336,807)
<b>Total Furniture and Fittings</b>	<b>232,785</b>	<b>289,126</b>
<b>Motor Vehicles</b>		
- Motor Vehicles at Fair Value	477,557	530,538
Less Accumulated Depreciation	(287,424)	(244,080)
<b>Total Motor Vehicles</b>	<b>190,133</b>	<b>286,458</b>
<b>Under Construction</b>		
- Work in Progress	170,176	-
<b>Total Assets under construction</b>	<b>170,176</b>	<b>-</b>
<b>TOTAL</b>	<b>37,090,767</b>	<b>38,296,796</b>

## Note 12: Property, Plant and Equipment (Continued)

Reconciliations of the carrying amounts of each class of asset at the beginning and end of the previous and current financial year is set out below.

	Land	Buildings	Plant & Equipment	Furniture & Fittings	Computer Equip	Motor Vehicles	Under Construction	Total
	\$	\$	\$	\$	\$	\$	\$	\$
<b>Balance at 1 July 2013</b>	695,000	24,888,041	1,041,952	274,332	28,500	276,888	169,811	27,374,524
Additions	-	12,950	59,871	127,347	24,510	200,660	476,706	902,044
Transfers In/(out)	-	763,251	(70,304)	(46,430)	-	-	(646,517)	-
Revaluation increments	(40,000)	11,658,455	-	-	-	-	-	11,618,455
Loddon Mallee Rural Health Alliance	-	-	18,358	-	-	-	-	18,358
Disposals	-	-	(4,821)	-	-	(102,153)	-	(106,974)
Depreciation (see Note 4)	(16,000)	(997,697)	(329,065)	(66,123)	(11,789)	(88,937)	-	(1,509,611)
<b>Balance at 30 June 2014</b>	639,000	36,325,000	715,991	289,126	41,221	286,458	-	38,296,796
Additions	-	-	24,268	2,710	90,729	62,448	170,176	350,331
Transfers In/(out)	-	-	-	-	-	-	-	-
Revaluation increments	-	-	-	-	-	-	-	-
Loddon Mallee Rural Health Alliance	-	-	11,627	-	-	-	-	11,627
Disposals	-	-	-	-	-	(55,834)	-	(55,834)
Depreciation (see Note 4)	(5,140)	(1,111,920)	(211,897)	(59,051)	(21,206)	(102,939)	-	(1,512,153)
<b>Balance at 30 June 2015</b>	633,860	35,213,080	539,989	232,785	110,744	190,133	170,176	37,090,767

### Land and buildings carried at valuation

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

Fair value of plant and equipment has been assessed by management in accordance with Financial Reporting Direction 103F. Management have obtained second-hand values for equipment where possible, or completed an assessment of value based on depreciated replacement cost.



## Note 12: Property, plant & equipment (continued)

### (c) Fair value measurement hierarchy for assets as at 30 June 2015

	Carrying amount as at 30 June 2015	Fair value measurement at end of reporting period using:		
		Level 1 <sup>(1)</sup>	Level 2 <sup>(1)</sup>	Level 3 <sup>(1)</sup>
<b>Land at fair value</b>				
Non-specialised land	140,200	-	140,200	-
Specialised land	241,800	-	-	241,800
<b>Total of land at fair value</b>	<b>382,000</b>	<b>-</b>	<b>140,200</b>	<b>241,800</b>
<b>Buildings at fair value</b>				
Non-specialised buildings	1,490,775	-	1,490,775	-
Specialised buildings	33,722,305	-	-	33,722,305
<b>Total of building at fair value</b>	<b>35,213,080</b>	<b>-</b>	<b>1,490,775</b>	<b>33,722,305</b>
<b>Land Improvements at fair value</b>				
Specialised land improvements	251,860	-	-	251,860
<b>Total of land improvements at fair value</b>	<b>251,860</b>	<b>-</b>	<b>-</b>	<b>251,860</b>
<b>Plant and Equipment at fair value</b>				
Plant and Equipment	539,989	-	-	539,989
<b>Total of plant and equipment at fair value</b>	<b>539,989</b>	<b>-</b>	<b>-</b>	<b>539,989</b>
<b>Computer and Communication at fair value</b>				
Computers and Communication	110,744	-	-	110,744
<b>Total Computer and communication at fair value</b>	<b>110,744</b>	<b>-</b>	<b>-</b>	<b>110,744</b>
<b>Furniture and Fittings at fair value</b>				
Furniture and Fittings	232,785	-	-	232,785
<b>Total Furniture and Fittings at fair value</b>	<b>232,785</b>	<b>-</b>	<b>-</b>	<b>232,785</b>
<b>Motor Vehicles at fair value</b>				
Motor Vehicles	190,133	-	-	190,133
<b>Total Motor Vehicles at fair value</b>	<b>190,133</b>	<b>-</b>	<b>-</b>	<b>190,133</b>
<b>Under Construction</b>				
Work in Progress	170,176	-	-	170,176
<b>Total Motor Vehicles at fair value</b>	<b>170,176</b>	<b>-</b>	<b>-</b>	<b>170,176</b>
	<b>37,090,767</b>	<b>-</b>	<b>1,630,975</b>	<b>35,459,792</b>

#### Note

<sup>(1)</sup> Classified in accordance with the fair value hierarchy, see Note 1

There have been no transfers between levels during the period.

## Note 12: Property, plant & equipment (continued)

### (c) Fair value measurement hierarchy for assets as at 30 June 2014

	Carrying amount as at 30 June 2014	Fair value measurement at end of reporting period using:		
		Level 1 <sup>(1)</sup>	Level 2 <sup>(1)</sup>	Level 3 <sup>(1)</sup>
<b>Land at fair value</b>				
Non-specialised land	140,200	-	140,200	-
Specialised land	241,800	-	-	241,800
<b>Total of land at fair value</b>	<b>382,000</b>	-	<b>140,200</b>	<b>241,800</b>
<b>Buildings at fair value</b>				
Non-specialised buildings	1,529,000	-	1,529,000	-
Specialised buildings	34,796,000	-	-	34,796,000
<b>Total of building at fair value</b>	<b>36,325,000</b>	-	<b>1,529,000</b>	<b>34,796,000</b>
<b>Land Improvements at fair value</b>				
Specialised land improvements	257,000	-	-	257,000
<b>Total of land improvements at fair value</b>	<b>257,000</b>	-	-	<b>257,000</b>
<b>Plant and Equipment at fair value</b>				
Plant and Equipment	715,991	-	-	715,991
<b>Total of plant and equipment at fair value</b>	<b>715,991</b>	-	-	<b>715,991</b>
<b>Computer and Communication at fair value</b>				
Computers and Communication	41,221	-	-	41,221
<b>Total Computer and communication at fair value</b>	<b>41,221</b>	-	-	<b>41,221</b>
<b>Furniture and Fittings at fair value</b>				
Furniture and Fittings	289,126	-	-	289,126
<b>Total Furniture and Fittings at fair value</b>	<b>289,126</b>	-	-	<b>289,126</b>
<b>Motor Vehicles at fair value</b>				
Motor Vehicles	286,458	-	-	286,458
<b>Total Motor Vehicles at fair value</b>	<b>286,458</b>	-	-	<b>286,458</b>
<b>Under Construction</b>				
Work in Progress	-	-	-	-
<b>Total Motor Vehicles at fair value</b>	-	-	-	-
	<b>38,296,796</b>	-	<b>1,669,200</b>	<b>36,627,596</b>

#### Note

<sup>(1)</sup> Classified in accordance with the fair value hierarchy, see Note 1

There have been no transfers between levels during the period.

## Note 12: Property, plant & equipment (continued)

### Non-specialised land and non-specialised buildings

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

For non-specialised land and non-specialised buildings, an independent valuation was performed by independent valuers *Countrywide Valuers* on behalf of 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.

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

### Specialised land, specialised buildings and specialised land improvements

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

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

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

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

### Motor Vehicles

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

### Other Non-Financial Assets - Plant & Machinery, Medical Equipment, Furniture & Fitting, Computers & Communication, Non-Medical Equipment

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

There were no changes in valuation techniques throughout the period to 30 June 2015.

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

### (d) Reconciliation of Level 3 fair value 2015

	Land	Buildings	Land Improvements	Plant and Equipment	Computers & Communication	Furniture & Fittings	Motor Vehicles	Assets under construction
<b>Opening Balance</b>	241,800	34,834,225	257,000	727,618	41,221	289,126	286,458	-
<b>Purchases (sales)</b>	-	-	-	24,268	90,729	2,710	6,614	170,176
<b>Transfers in (out) of Level 3</b>	-	-	-	-	-	-	-	-
Gains or losses recognised in net result								
- Depreciation	-	(1,111,920)	(5,140)	(211,897)	(21,206)	(59,051)	(102,939)	-
- Impairment loss	-	-	-	-	-	-	-	-
<b>Subtotal</b>	<b>241,800</b>	<b>33,722,305</b>	<b>251,860</b>	<b>539,989</b>	<b>110,744</b>	<b>232,785</b>	<b>190,133</b>	<b>170,176</b>
Items recognised in other comprehensive income								
- Revaluation	-	-	-	-	-	-	-	-
<b>Subtotal</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>Closing Balance</b>	<b>241,800</b>	<b>33,722,305</b>	<b>251,860</b>	<b>539,989</b>	<b>110,744</b>	<b>232,785</b>	<b>190,133</b>	<b>170,176</b>
Unrealised gains/(losses) on non-financial assets	-	-	-	-	-	-	-	-
	<b>241,800</b>	<b>33,722,305</b>	<b>251,860</b>	<b>539,989</b>	<b>110,744</b>	<b>232,785</b>	<b>190,133</b>	<b>170,176</b>

#### Note

There have been no transfers between levels during the period.

(d) Reconciliation of Level 3 fair value 2014

	Land	Buildings	Land Improvements	Plant and Equipment	Computers & Communication	Furniture & Fittings	Motor Vehicles	Assets under construction
Opening Balance	276,570	23,892,519	320,000	1,041,952	28,500	274,332	276,888	169,811
Purchases (sales)	-	-		(12,752)	24,510	83,032	114,292	(169,811)
Transfers in (out) of Level 3	-	-						
Gains or losses recognised in net result								
- Depreciation		-	-	(313,210)	(11,789)	(68,238)	(104,721)	-
- Impairment loss	-	-	-	-	-	-	-	-
Subtotal	276,570	23,892,519	320,000	715,990	41,221	289,126	286,459	-
Items recognised in other comprehensive income								
- Revaluation	(34,770)	10,903,481	(63,000)	-	-	-	-	-
Subtotal	(34,770)	10,903,481	(63,000)	-	-	-	-	-
Closing Balance	241,800	34,796,000	257,000	715,990	41,221	289,126	286,459	-
Unrealised gains/(losses) on non-financial assets	-	-	-	-	-	-	-	-
	241,800	34,796,000	257,000	715,990	41,221	289,126	286,459	-

Note  
There have been no transfers between levels during the period.

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

	Valuation technique (i)	Significant unobservable inputs (i)
Specialised land	Market approach	Community Service Obligation (CSO) adjustment
Specialised buildings	Depreciated replacement cost	Direct cost per square metre  Useful life of specialised buildings
Landscaping & Grounds	Depreciated replacement cost	Direct replacement cost  Useful life of Landscaping & Grounds
Plant & Equipment	Depreciated replacement cost	Cost per unit  Useful life of PPE
Motor Vehicles	Depreciated replacement cost	Cost per unit  Useful life of vehicles
Computers and Communication	Depreciated replacement cost	Cost per unit  Useful life of furniture & fittings
Furniture & Fittings at fair value	Depreciated replacement cost	Cost per unit  Useful life of furniture & fittings

## Note 13: Payables

	2015	2014
	\$	\$
<b>CURRENT</b>		
<b>Contractual</b>		
Trade Creditors	107,720	260,484
Accrued Expenses	273,898	87,339
Accrued Audit Fees	16,000	11,719
Other Payable - Social Club/OffLine S & W	72,655	10,408
Loddon Mallee Rural Health Alliance	32,303	30,651
	<b>502,576</b>	<b>400,601</b>
<b>Statutory</b>		
GST Payable	46,320	207,414
PAYG Payable	-	104,385
<b>TOTAL CURRENT</b>	<b>46,320</b>	<b>311,799</b>
<b>TOTAL PAYABLES</b>	<b>548,896</b>	<b>712,400</b>

### (a) Maturity analysis of payables

Please refer to Note 20(c) for the ageing analysis of contractual payables.

### (b) Nature and extent of risk arising from payables

Please refer to note 20(c) for the nature and extent of risks arising from contractual payables.

## Note 14: Borrowings

	2015	2014
	\$	\$
<b>CURRENT</b>		
Australian Dollar Borrowings		
– Hire Purchase Liability (refer Note 21)	-	132,679
<b>Total Current Australian Dollars Borrowings</b>	<b>-</b>	<b>132,679</b>
<b>NON CURRENT</b>		
Australian Dollar Borrowings		
– Hire Purchase Liability (refer Note 21)	-	-
<b>Total Non-Current Australian Dollars Borrowings</b>	<b>-</b>	<b>-</b>
<b>TOTAL BORROWINGS</b>	<b>-</b>	<b>132,679</b>

Rochester and Elmore District Health Service no longer have any Hire Purchase agreements, since the final payments for existing agreements were completed during the year

Finance costs of the Health Service incurred during the year are accounted for as follows:

Amount of Finance Costs recognised as expenses (see Note 5)	4,285	9,691
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### (a) Maturity analysis of interest bearing liabilities

Please refer to note 20(c) for the ageing analysis of interest bearing liabilities

### (b) Nature and extent of risk arising from interest bearing liabilities

Please refer to note 20(c) for the nature and extent of risks arising from interest bearing liabilities.

### (c) Defaults and breaches

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



**Note 15: Provisions**

	2015 \$	2014 \$
<b>CURRENT PROVISIONS</b>		
Employee Benefits (Note 15(a))		
Annual Leave (Note 15(a))		
- Unconditional and expected to be settled within 12 months (ii)	652,255	521,612
- Unconditional and expected to be settled after 12 months (ii)	109,271	196,550
ADO (Note 15(a))		
- Unconditional and expected to be settled within 12 months (ii)	7,235	11,363
- Unconditional and expected to be settled after 12 months (ii)	1,212	1,698
Long Service Leave (Note 15(a))		
- Unconditional and expected to be settled within 12 months (ii)	289,123	512,552
- Unconditional and expected to be settled after 12 months (ii)	939,965	740,937
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (ii)	74,055	59,300
- Unconditional and expected to be settled after 12 months (ii)	12,406	21,804
<b>TOTAL CURRENT PROVISIONS</b>	<b>2,085,522</b>	<b>2,065,816</b>
<b>NON-CURRENT PROVISIONS</b>		
Employee Benefits (i) (Note 15(a))	286,067	406,318
Provisions related to employee benefits on-costs (Note 15(a) and 15(b))	-	-
<b>TOTAL NON-CURRENT PROVISIONS</b>	<b>286,067</b>	<b>406,318</b>
<b>TOTAL PROVISIONS</b>	<b>2,371,589</b>	<b>2,472,134</b>
<b>(a) Employee Benefits and Related On-Costs</b>		
<b>CURRENT EMPLOYEE BENEFITS AND RELATED ON-COSTS</b>		
Annual Leave Entitlements	761,526	718,162
Accrued Wages and Salaries	226,680	279,791
Accrued Days Off	8,447	13,061
Unconditional Long Service Leave Entitlements	1,002,408	973,698
<b>NON-CURRENT EMPLOYEE BENEFITS AND RELATED ON-COSTS</b>		
Conditional Long Service Leave Entitlements (iii)	286,067	406,318
Current On-Costs	74,055	59,300
Non-Current On-Costs	12,406	21,804
<b>TOTAL EMPLOYEE BENEFITS AND RELATED ON-COSTS</b>	<b>2,371,589</b>	<b>2,472,134</b>
<b>(b) Movements in Provisions</b>		
<b>Movement in Long Service Leave:</b>		
Balance at start of year	1,380,016	1,427,183
Provision made during the year	197,581	140,299
Settlement made during the year	(289,123)	(187,466)
<b>Balance at end of year</b>	<b>1,288,474</b>	<b>1,380,016</b>

(i) Employee benefits consist of annual leave and long service leave accrued by employees. On-costs such as payroll tax and workers compensation insurance are not employee benefits and are reflected as a separate provision.

(ii) The amounts disclosed are at present values.

(iii) The provision for onerous lease contracts represents the present value of the future lease payments that the Health Service is presently obligated to make in respect of onerous lease contracts under non-cancellable operating lease agreements, less income expected to be earned on the lease including estimated future sub-lease income, where applicable. The estimate may vary as a result of changes in utilisation of the leased premises and sub lease arrangements where applicable. The unexpired term of the leases range from 3 to 5 years.

**Note 16: Superannuation**

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

The Health Service does not recognise any defined benefit liability in respect of the plan(s) because the entity has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance discloses the State's defined benefits liabilities in its disclosure for administered items.

However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of the Health Service. The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the Health Service are as follows:

	2015 \$	2014 \$
<b>Defined benefit plans:</b>		
Health Super	-	3,173
<b>Defined Contribution plans:</b>		
Health Super	593,572	634,245
Hesta	150,005	127,955
<b>TOTAL</b>	<b>743,577</b>	<b>765,373</b>

**Note 17: Other Current Liabilities**

	2015 \$	2014 \$
<b>CURRENT</b>		
Monies Held in Trust*		
- Patient Monies Held in Trust	25,864	27,231
- Accommodation Bonds (Refundable Entrance Fees)	4,304,268	2,415,499
Rochester Community House	7,382	7,382
<b>TOTAL CURRENT</b>	<b>4,337,514</b>	<b>2,450,112</b>
<b>* Total Monies Held in Trust</b>		
<b>Represented by the following assets:</b>		
Cash Assets (refer to Note 6)	25,864	27,231
Receivables (refer to Note 7)	1,644	1,644
Other Financial Assets (refer to Note 8)	3,651,124	1,762,355
Land and Buildings	651,500	651,500
Rochester Community House	7,382	7,382
<b>TOTAL</b>	<b>4,337,514</b>	<b>2,450,112</b>

**Note 18: Equity****(a) Surpluses****Property, Plant and Equipment Revaluation Surplus**

Balance at the beginning of the reporting period

- Land	196,325	253,325
- Buildings	17,856,701	6,181,246

**Revaluation Increment/Decrement**

- Land	-	(57,000)
- Buildings	-	11,675,455

**Balance at the end of the reporting period****18,053,026 18,053,026****Balance at the end of the reporting period\*****\* Represented by:**

- Land	196,325	196,325
- Buildings	17,856,701	17,856,701
	<b>18,053,026</b>	<b>18,053,026</b>

**Restricted Specific Purpose Surplus**

Balance at the beginning of the reporting period

822,050 1,038,631

Transfer to and from Restricted Purpose Surplus  
Bequests45,955 (216,581)  
-**Balance at the end of the reporting period****868,005 822,050****TOTAL SURPLUSES****18,921,031 18,875,076****(b) Contributed Capital**

Balance at the beginning of the reporting period

7,369,839 7,369,839

Capital Contribution received from Victorian Government

-

**Balance at the end of the reporting period****7,369,839 7,369,839****(c) Accumulated Surpluses/(Deficits)**

Balance at the beginning of the reporting period

13,703,240 14,586,027

Net Result for the year

(1,198,800) (1,099,368)

Transfer to and from Restricted Purpose Surplus

(45,955) 216,581

**Balance at the end of the reporting period****12,458,485 13,703,240****TOTAL EQUITY AT END OF FINANCIAL YEAR****38,749,355 39,948,155****Note 19: Reconciliation of the net result for the year to net cash inflow/(outflow) from operating activities****Net result for the period**

2015	2014
\$	\$
(1,198,800)	(1,099,368)

**Non-cash movements:**

Depreciation

1,512,153 1,509,611

Share of Net Result from LMRHA

46,490 (21,873)

**Movements included in investing and financing activities:**

Net (Gain)/Loss from Sale of Motor Vehicles

(1,805) (2,208)

**Movements in assets and liabilities:**

Change in operating assets and liabilities

(Increase)/Decrease in Receivables

(319,403) 195,730

(Increase)/Decrease in Prepayments

3,894 (82,819)

Change in Inventories

(1,256) (5,054)

Increase/(Decrease) in Payables

163,505 (514,345)

Increase/(Decrease) in Provisions

100,545 35,572

**NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES****305,323 15,246**

## Note 20: Financial Instruments

### (a) Financial Risk Management Objectives and Policies

The Rochester and Elmore District Health Service's principal financial instruments comprise of:

- Cash Assets
- Term Deposits
- Receivables (excluding statutory receivables)
- Payables (excluding statutory payables)
- Finance Lease Payables
- Accommodation Bonds

Details of the significant accounting policies and methods adopted, including the criteria for recognition, the basis of measurement and the basis on which income and expenses are recognised, with respect to each class of financial asset, financial liability and equity instrument are disclosed in Note 1 to the financial statements.

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

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

The main purpose in holding financial instruments is to prudentially manage Rochester and Elmore District Health Services financial risks within the government policy parameters.

### Categorisation of financial instruments

Details of each categories in accordance with AASB 139, shall be disclosed either on the face of the balance sheet or in the notes.

	Contractual financial assets/liabilities designated at fair value through profit/loss	Contractual financial assets/liabilities held-for-trading at fair value through profit/loss	Contractual financial assets - loans and receivables	Contractual financial assets - available for sale	Contractual financial liabilities at amortised cost	Total
2015	\$	\$	\$	\$	\$	\$
<b>Contractual Financial Assets</b>						
Cash and cash equivalents	-	-	925,386	-	-	925,386
Receivables						-
- Trade Debtors	-	-	224,737	-	-	224,737
- Other Receivables	-	-	44,008	-	-	44,008
Other Financial Assets						
- Term Deposit	-	-	7,176,032	-	-	7,176,032
<b>Total Financial Assets <sup>(i)</sup></b>	<b>-</b>	<b>-</b>	<b>8,370,163</b>	<b>-</b>	<b>-</b>	<b>8,370,163</b>
<b>Financial Liabilities</b>						
Payables					454,273	454,273
Other Financial Liabilities						
- Accomodation bonds	-	-	-	-	4,304,268	4,304,268
<b>Total Financial Liabilities <sup>(ii)</sup></b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>4,758,541</b>	<b>4,758,541</b>

	Contractual financial assets/liabilities designated at fair value through profit/loss	Contractual financial assets/liabilities held-for-trading at fair value through profit/loss	Contractual financial assets - loans and receivables	Contractual financial assets - available for sale	Contractual financial liabilities at amortised cost	Total
2014	\$	\$	\$	\$	\$	\$
<b>Contractual Financial Assets</b>						
Cash and cash equivalents	-	-	2,811,514	-	-	2,811,514
Receivables						-
- Trade Debtors	-	-	297,155	-	-	297,155
- Other Receivables	-	-	54,808	-	-	54,808
Other Financial Assets						
- Term Deposit	-	-	3,475,237	-	-	3,475,237
<b>Total Financial Assets <sup>(i)</sup></b>	<b>-</b>	<b>-</b>	<b>6,638,714</b>	<b>-</b>	<b>-</b>	<b>6,638,714</b>
<b>Financial Liabilities</b>						
Payables					358,231	358,231
Other Financial Liabilities						
- Accomodation bonds	-	-	-	-	2,415,499	2,415,499
- Other	-	-	-	-	132,679	132,679
<b>Total Financial Liabilities <sup>(ii)</sup></b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>2,906,409</b>	<b>2,906,409</b>

(i) The total amount of financial assets disclosed here excludes statutory receivables

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

**Note 20: Financial Instruments (continued)**
**(b) Net holding gain/(loss) on financial instruments by category**

	Net holding gain/(loss) \$	Total interest income / (expense) \$	Fee income / (expense) \$	Impairment loss \$	Total \$
<b>2015</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	-	159,567	-	-	-
Designated at Fair Value through Profit or Loss	-	-	-	-	-
Held-for-Trading at Fair Value through Profit or Loss	-	-	-	-	-
Loans and Receivables	-	-	-	-	-
Available for Sale	-	-	-	-	-
<b>Total Financial Assets</b>	-	<b>159,567</b>	-	-	-
<b>Financial Liabilities</b>					
Designated at Fair Value through Profit or Loss	-	-	-	-	-
Held-for-Trading at Fair Value through Profit or Loss	-	-	-	-	-
At Amortised Cost	-	-	-	-	-
<b>Total Financial Liabilities</b>	-	-	-	-	-
<b>2014</b>					
<b>Financial Assets</b>					
Cash and Cash Equivalents	-	124,120	-	-	-
Designated at Fair Value through Profit or Loss	-	-	-	-	-
Held-for-Trading at Fair Value through Profit or Loss	-	-	-	-	-
Loans and Receivables	-	-	-	-	-
Available for Sale	-	-	-	-	-
<b>Total Financial Assets</b>	-	<b>124,120</b>	-	-	-
<b>Financial Liabilities</b>					
Designated at Fair Value through Profit or Loss	-	-	-	-	-
Held-for-Trading at Fair Value through Profit or Loss	-	-	-	-	-
At Amortised Cost	-	-	-	-	-
<b>Total Financial Liabilities</b>	-	-	-	-	-

**(c) Credit Risk**

Credit risk arises from contractual financial assets of the Health Service, which comprise cash and deposits, non-statutory receivables and available for sale contractual financial assets. The Health Service's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to the Health Service. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with the Health Service's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is the Health Service's policy to only deal with entities with high credit ratings of a minimum Triple-B rating and to obtain sufficient collateral or credit enhancements, where appropriate.

In addition, the Health Service does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash assets, which are mainly cash at bank. As with the policy for debtors, the Health Service's policy is to only deal with banks with high credit ratings.

Provision of impairment for contractual financial assets is recognised when there is objective evidence that the Health Service will not be able to collect a receivable. Objective evidence includes financial difficulties of the debtor, default payments, debts which are more than 60 days overdue, and changes in debtor credit ratings.

Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Rochester and Elmroe District Health Service's maximum exposure to credit risk without taking account of the value of any collateral obtained.

	Financial Institutions (AA credit Rating) \$	Government agencies (AAA credit Rating) \$	Financial Institutions (A credit Rating) \$	Other (min BBB credit Rating) \$	Total \$
<b>2015</b>					
<b>Financial Assets</b>					
Cash and cash equivalents	-	-	925,386	-	925,386
Receivables	-	-	-	-	-
- Trade Debtors	-	-	-	224,737	224,737
- Other Receivables	-	-	-	44,008	44,008
Other Financial Assets					
- Term Deposit	2,736,074	1,000,000	3,439,958	-	7,176,032
<b>Total Financial Assets</b>	-	<b>1,000,000</b>	<b>4,365,344</b>	<b>268,745</b>	<b>8,370,163</b>
<b>2014</b>					
<b>Financial Assets</b>					
Cash and cash equivalents	-	-	2,811,514	-	2,811,514
Receivables	-	-	-	-	-
- Trade Debtors	-	-	-	297,155	297,155
- Other Receivables	-	-	-	54,808	54,808
Other Financial Assets					
- Term Deposit	-	-	3,475,237	-	3,475,237
<b>Total Financial Assets</b>	-	-	<b>6,286,751</b>	<b>351,963</b>	<b>6,638,714</b>

**Note 20: Financial Instruments (continued)**
**(c) Credit Risk (continued)**
**Ageing analysis of Financial Assets as at 30 June**

	<b>Total Carrying Amount \$</b>	<b>Not Past Due and Not Impaired \$</b>	<b>Less than 1 Month \$</b>	<b>Past Due But Not Impaired 1 to 3 Months \$</b>	<b>3 months to 1 Year \$</b>	<b>1 to 5 Years \$</b>
<b>2015</b>						
<b>Financial Assets</b>						
Cash & Cash Equivalents	925,386	925,386	-	-	-	-
Receivables						
- Trade Debtors	224,737	214,223	327	8,311	1,876	-
- Other Receivables	44,008	44,008	-	-	-	-
Other Financial Assets						
-Term Deposit	7,176,032	7,176,032	-	-	-	-
<b>Total Financial Assets</b>	<b>8,370,163</b>	<b>8,359,649</b>	<b>327</b>	<b>8,311</b>	<b>1,876</b>	<b>-</b>
<b>2014</b>						
<b>Financial Assets</b>						
Cash & Cash Equivalents	2,811,514	2,811,514	-	-	-	-
Receivables						
- Trade Debtors	297,155	190,464	94,805	11,886	-	-
- Other Receivables	54,808	54,808	-	-	-	-
Other Financial Assets						
- Term Deposit	3,475,237	3,475,237	-	-	-	-
<b>Total Financial Assets</b>	<b>6,638,714</b>	<b>6,532,023</b>	<b>94,805</b>	<b>11,886</b>	<b>-</b>	<b>-</b>

**(d) Liquidity Risk**

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

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

The following table discloses the contractual maturity analysis for Rochester and Elmore District Health Service'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**

	<b>Carrying Amount \$</b>	<b>Nominal Amount \$</b>	<b>Less than 1 Month \$</b>	<b>Maturity Dates 1 to 3 Months \$</b>	<b>3 months to 1 Year \$</b>	<b>1 to 5 Years \$</b>
<b>2015</b>						
<b>Financial Liabilities</b>						
Payables	454,273	454,273	454,273	-	-	-
Borrowings Note 14	-	-	-	-	-	-
Other Financial Liabilities(i)						
- Monies Held in Trust	4,304,268	4,304,268	25,864	31,731	4,246,673	-
<b>Total Financial Liabilities</b>	<b>4,758,541</b>	<b>4,758,541</b>	<b>480,137</b>	<b>31,731</b>	<b>4,246,673</b>	<b>-</b>
<b>2014</b>						
<b>Financial Liabilities</b>						
Trade Creditors & Accruals	358,231	358,231	358,231	-	-	-
Borrowings Note 14	132,679	132,679	3,052	9,239	120,388	-
Other Financial Liabilities(i)						
- Monies Held in Trust	2,415,499	2,415,499	25,150	4,516	2,385,833	-
<b>Total Financial Liabilities</b>	<b>2,906,409</b>	<b>2,906,409</b>	<b>386,433</b>	<b>13,755</b>	<b>2,506,221</b>	<b>-</b>

(i) Aging analysis of financial liabilities excludes the types of statutory financial liabilities (ie GST Payable)



**Note 20: Financial Instruments (continued)**

**(e) Market Risk**

Rochester and Elmore District Health Service's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage these risks are disclosed below.

**Currency Risk**

Rochester and Elmore District Health Service is exposed to insignificant foreign currency risk through its payables relating to purchases of supplies and consumables from overseas. This is because of a limited amount of purchases denominated in foreign currencies and a short timeframe between commitments and settlement.

**Interest Rate Risk**

Exposure to interest rate risk might arise primarily through the Rochester and Elmore District Health Services' other financial assets. Minimisation of risk is achieved by mainly holding fixed rate or non-interest bearing financial instruments. For financial liabilities, the Hospital mainly holds financial assets 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.

The Health Service has minimal exposure to cash flow interest rate risks through its cash and deposits, term deposits and bank overdrafts that are at floating rates.

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

**Interest rate exposure of Financial Assets and Liabilities as at 30 June**

	Weighted Average Effective Interest Rates	Carrying Amount	Interest Rate Exposure		
	Rates (%)	\$	Fixed Interest Rate	Variable Interest Rate	Non Interest Bearing
		\$	\$	\$	\$
<b>2015</b>					
<b>Financial Assets</b>					
Cash & Cash Equivalents	2.00	925,386	-	925,386	-
Receivables(i)		224,737	-	-	224,737
- Trade Debtors		44,008	-	-	44,008
- Other Receivables					
Other Financial Assets					
- Term Deposits	2.68	7,176,032	7,176,032	-	-
<b>Total Financial Assets</b>		8,370,163	7,176,032	925,386	268,745
<b>Financial Liabilities</b>					
Payables(i)		454,273	-	-	454,273
Borrowings		-	-	-	-
Other Financial Liabilities					
- Monies Held in Trust		4,304,268	-	-	4,304,268
<b>Total Financial Liabilities</b>		4,758,541	-	-	4,758,541
<b>2014</b>					
<b>Financial Assets</b>					
Cash & Cash Equivalents	2.25	2,811,514	-	2,811,514	-
Receivables(i)		297,155	-	-	297,155
- Trade Debtors		54,808	-	-	54,808
- Other Receivables					
Other Financial Assets					
- Term Deposits	3.45	3,475,237	3,475,237	-	-
<b>Total Financial Assets</b>		6,638,714	3,475,237	2,811,514	351,963
<b>Financial Liabilities</b>					
Payables(i)		358,231	-	-	358,231
Borrowings	5.38	132,679	132,679	-	-
Other Financial Liabilities					
- Monies Held in Trust		2,415,499	-	-	2,415,499
<b>Total Financial Liabilities</b>		2,906,409	132,679	-	2,773,730

(i) The carrying amount must exclude types of statutory financial assets and liabilities (ie GST input tax credit and GST Payable)

**Sensitivity Disclosure Analysis**

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, Rochester and Elmore District Health Service believes the following movements are 'reasonably possible' over the next 12 months (Based rates are sourced from Reserve Bank of Australia).

A parallel shift of 1% in market interest rates (AUD) from year end rates of 3%.

A parallel shift of 1% in inflation rate from year end rates of 3%.

A movemnet of 15% up and down (2014: 15%) for the top ASX 200 index.

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

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-1%		+1%	
		Profit \$	Equity \$	Profit \$	Equity \$	Profit \$	Equity \$	Profit \$	Equity \$
<b>2015</b>	\$								
<b>Financial Assets</b>									
Cash & Cash Equivalents	925,386	(9,253)	(9,253)	9,253	9,253	-	-	-	-
Receivables									
- Trade Debtors	224,737	-	-	-	-	-	-	-	-
- Other Receivables	44,008	-	-	-	-	-	-	-	-
Other Financial Assets									
- Term Deposits	7,176,032	(71,760)	(71,760)	71,760	71,760	-	-	-	-
<b>Financial Liabilities</b>									
Payables	454,273	-	-	-	-	-	-	-	-
Interest Bearing Liabilities	-	-	-	-	-	-	-	-	-
Other Financial Liabilities									
- Monies Held in Trust	4,304,268	-	-	-	-	-	-	-	-
		(81,013)	(81,013)	81,013	81,013	-	-	-	-

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-1%		+1%	
		Profit \$	Equity \$	Profit \$	Equity \$	Profit \$	Equity \$	Profit \$	Equity \$
<b>2014</b>	\$								
<b>Financial Assets</b>									
Cash & Cash Equivalents	2,811,514	(28,115)	(28,115)	28,115	28,115	-	-	-	-
Receivables									
- Trade Debtors	297,155	-	-	-	-	-	-	-	-
- Other Receivables	54,808	-	-	-	-	-	-	-	-
Other Financial Assets									
-Term Deposits	3,475,237	(34,752)	(34,752)	34,752	34,752	-	-	-	-
<b>Financial Liabilities</b>									
Payables	358,231	-	-	-	-	-	-	-	-
Interest Bearing Liabilities	132,679	1327	1327	(1,327)	(1,327)	-	-	-	-
Other Financial Liabilities									
-Monies Held in Trust	2,415,499	-	-	-	-	-	-	-	-
		(61,540)	(61,540)	61,540	61,540	-	-	-	-

**Note 20: Financial Instruments (continued)****(f) Fair Value**

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

- Level 1 - the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices;
- Level 2 - the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, with directly or indirectly; and
- Level 3 - the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

The Health Service considers that the carrying amount of financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows that the fair values of most of the contractual financial assets and liabilities are the same as the carrying amounts.

**Comparison between carrying amount and fair value**

	<b>Carrying Amount 2015 \$</b>	<b>Fair value 2015 \$</b>	<b>Carrying Amount 2014 \$</b>	<b>Fair value 2014 \$</b>
<b>Financial Assets</b>				
Cash and Cash Equivalents	925,386	925,386	2,811,514	2,811,514
Receivables				
- Trade Debtors	224,737	224,737	297,155	297,155
- Other Receivables	44,008	44,008	54,808	54,808
Other Financial Assets				
- Term Deposit	7,176,032	7,176,032	3,475,237	3,475,237
<b>Total Financial Assets</b>	<b>8,370,163</b>	<b>8,370,163</b>	<b>6,638,714</b>	<b>6,638,714</b>
<b>Financial Liabilities</b>				
Payables	454,273	454,273	358,231	358,231
Interest Bearing Liabilities	-	-	132,679	132,679
Other Financial Liabilities				
- Monies Held in Trust	4,304,268	4,304,268	2,415,499	2,415,499
<b>Total Financial Liabilities</b>	<b>4,758,541</b>	<b>4,758,541</b>	<b>2,906,409</b>	<b>2,906,409</b>

**Note 21: Commitments****Hire Purchases**

Commitments in relation to Hire Purchases are payable as follows:

Less than 1 year

Longer than 1 year but not longer than 5 years

**Minimum Hire Purchase Payments**

Less Future Finance Charges

**Total Hire Purchase Commitments**

<b>2015 \$</b>	<b>2014 \$</b>
-	132,679
-	-
-	<b>132,679</b>
-	-
-	<b>132,679</b>
<b>Representing Hire Purchase Liabilities:</b>	
Current (refer Note 14)	- 132,679
Non-Current (refer Note 14)	- -
<b>TOTAL COMMITMENTS</b>	<b>- 132,679</b>

**Note 22: Contingent Assets & Contingent Liabilities**

Details and estimates of maximum amounts of contingent assets or contingent liabilities are as follows:

**Contingent Assets**

Rochester and Elmore District Health Service does not have any known contingent assets at 30 June, 2015

**TOTAL CONTINGENT ASSETS**

<b>2015 \$'000</b>	<b>2014 \$'000</b>
-	-
-	-

**Contingent Liabilities**

Air Conditioner Contract - BURNS P/L

**TOTAL CONTINGENT LIABILITIES**

65,333	-
<b>65,333</b>	<b>-</b>

## Note 23: Operating Segments

	Health Services		RACS		Other Services		Total	
	2015	2014	2015	2014	2015	2014	2015	2014
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
<b>REVENUE</b>								
External Segment Revenue	6,474,251	7,593,487	5,998,026	5,005,807	313,405	-	12,785,682	12,599,294
<b>Total Revenue</b>	<b>6,474,251</b>	<b>7,593,487</b>	<b>5,998,026</b>	<b>5,005,807</b>	<b>313,405</b>	<b>-</b>	<b>12,785,682</b>	<b>12,599,294</b>
<b>EXPENSES</b>								
External Segment Expenses	(9,577,955)	(9,516,894)	(4,382,145)	(4,361,792)	(276,541)	-	(14,236,641)	(13,878,686)
<b>Total Expenses</b>	<b>(9,577,955)</b>	<b>(9,516,894)</b>	<b>(4,382,145)</b>	<b>(4,361,792)</b>	<b>(276,541)</b>	<b>-</b>	<b>(14,236,641)</b>	<b>(13,878,686)</b>
<b>Net Result from ordinary activities</b>	<b>(3,103,703)</b>	<b>(1,923,407)</b>	<b>1,615,881</b>	<b>644,015</b>	<b>36,864</b>	<b>-</b>	<b>(1,450,959)</b>	<b>(1,279,392)</b>
Interest Expense	(4,285)	(9,691)	0	0	0	-	(4,285)	(9,691)
Interest Income	112,555	34,574	116,877	155,141	27,012	-	256,444	189,715
<b>Net Result for Year</b>	<b>(2,995,433)</b>	<b>(1,898,524)</b>	<b>1,732,757</b>	<b>799,156</b>	<b>63,876</b>	<b>-</b>	<b>(1,198,800)</b>	<b>(1,099,368)</b>
<b>OTHER INFORMATION</b>								
Segment Assets	11,140,805	7,277,519	24,048,591	21,815,717	-	-	35,189,396	29,093,236
Unallocated Assets	-	-	-	-	10,817,958	16,622,244	10,817,958	16,622,244
<b>Total Assets</b>	<b>11,140,805</b>	<b>7,277,519</b>	<b>24,048,591</b>	<b>21,815,717</b>	<b>10,817,958</b>	<b>16,622,244</b>	<b>46,007,354</b>	<b>45,715,480</b>
Segment Liabilities	2,346,252	2,065,808	4,253,089	3,162,512	-	-	6,599,340	5,228,320
Unallocated Liabilities	-	-	-	-	658,659	539,005	658,659	539,005
<b>Total Liabilities</b>	<b>2,346,252</b>	<b>2,065,808</b>	<b>4,253,089</b>	<b>3,162,512</b>	<b>658,659</b>	<b>539,005</b>	<b>7,257,999</b>	<b>5,767,325</b>
Acquisition of property, plant and equipment and intangible assets	26,978	224,678	0	476,706	153,177	200,660	180,155	902,044
Depreciation expense	(990,663)	(997,697)	(315,211)	(308,595)	(206,279)	(203,319)	(1,512,153)	(1,509,611)
Non cash expenses other than depreciation	-	-	-	-	-	-	-	-

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

### Business Segments

Residential Aged Care Services (RACS)

Acute

### Services

Nursing Home Services

Hostel Facilities

Acute Hospital Services

Ambulatory

Aged Care Services

Primary Health Services

### Geographical Segment

Rochester and Elmore District Health Service operates predominantly in Rochester and Elmore, Victoria. More than 90% of revenue, net surplus from ordinary activities and segment assets related to operations in Rochester and Elmore, Victoria.

## Note 24a: 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.

### Responsible Ministers:

The Honourable David Davis, MLC, Minister for Health and Ageing

The Honourable Jill Hennessy, MLC, Minister for Health, Minister for Ambulance Services

The Honourable Martin Foley, Minister for Housing, Disability and Ageing

Period
01/07/2014-03/12/2014
04/12/2014-30/06/2015
04/12/2014-30/06/2015

### Governing Boards

Mr A Darbyshire

Mr T Fulton

Mr G Hodgins

Mr R Johnson

Ms K Lee

Mr B Maw

Dr C McKinstry

Mr K Oberin

Ms M O'Sullivan

01/07/2014 - 30/06/2015
01/07/2014 - 30/06/2015
01/07/2014 - 30/06/2015
01/07/2014 - 30/06/2015
01/07/2014 - 30/06/2015
01/07/2014 - 30/06/2015
01/07/2014 - 30/06/2015
01/07/2014 - 30/06/2015
01/07/2014 - 30/06/2015
01/07/2014 - 30/06/2015

No remuneration was paid to any Governing Board Members for the Financial Year ended 30 June 2015.

### Accountable Officers

Mrs Anne McEvoy

01/07/2014-30/06/2015

### Remuneration of Responsible Persons

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

#### Income Band

\$0

\$100,000 - \$109,999

\$120,000 - \$129,999

2015 No.	2014 No.
9	9
0	2
1	0
10	11
\$126,580	\$236,737

#### Total Numbers

Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:

Amounts relating to Responsible Ministers are reported in the financial statements of the Department of Premier and Cabinet.

### Other Transactions of Responsible Persons and their Related Parties

No responsible person or their related parties received any remuneration or retirement benefits during the year.

### Note 24b: Executive Officer Disclosures

There are no executive officers whose total remuneration exceeds \$100,000.

## Note 25: Remuneration of auditors

### Victorian Auditor-General's Office

Audit or review of financial statements

#### TOTAL

2015 \$	2014 \$
16,000	14,500
16,000	14,500

### Note 26: Events occurring after the Balance Sheet Date.

No events occurred after Balance Sheet Date.

**Rochester and Elmore District Health Service**  
**Appendix A - Alternative presentation of Comprehensive Operating Statement**

*The below Comprehensive Operating Statement has been prepared in line with Department of Treasury and Finance requirements, **and do not form part of the audited financial statements.***

	<b>2015</b>	<b>2014</b>
	<b>\$'000</b>	<b>\$'000</b>
Interest and Dividends	253,867	271,480
Sales of goods and services	1,959,323	2,161,925
Grants	9,261,364	8,705,633
Other income	1,578,821	1,649,971
<b>Total revenue</b>	<b>13,053,375</b>	<b>12,789,009</b>
Employee expenses	10,031,621	9,857,168
Depreciation	1,512,153	1,509,611
Finance expenses	4,285	9,691
Other operating expenses	2,704,116	2,511,907
<b>Total expenses</b>	<b>14,252,175</b>	<b>13,888,377</b>
<b>Net result from transactions - Net operating balance</b>	<b>(1,198,800)</b>	<b>(1,099,368)</b>
Other gains / (losses) from other economic flows	0	11,618,455
<b>Total other economic flows included in net result</b>	<b>0</b>	<b>11,618,455</b>
<b>Net result</b>	<b>(1,198,800)</b>	<b>10,519,087</b>

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