2015/16 Annual Report

Northern Health


PASSIONATE
We
care
COLLABORATIVE
We are
a team
DEDICATED
We are
focused
PROGRESSIVE
We look
to improve
PARTNERSHIP
We
Collaborate

Our Vision

Outstanding health care for our community.

Our Mission

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

Our Strategic Goals

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

Our Values

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

At Northern Health, we are committed to the wellbeing of the people of Melbourne's north.

We draw upon the richness, knowledge and strength of northern communities as we partner with them in their care.

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Board Chair and Chief Executive Report

Northern Health has grown substantially since its establishment in 2000. From humble beginnings as a mid-sized community hospital, the health service has evolved to become a major provider of health care for Melbourne's northern suburbs.

Melbourne's north is home to a richly diverse community where 120 languages are spoken. Northern Health staff, many of whom come from culturally diverse backgrounds, strive to deliver excellence in patient-centred care that is both respectful and accessible. We aim to make community members feel comfortable, confident and satisfied with the health care they receive at Northern Health.

The growth of our diverse northern community continues, with estimates showing more than 230,000 new residents will live in our catchment area by 2031. The evolution and expansion of Northern Health's services in order to meet increased demand for services and capacity—both today and in the years ahead—is ongoing. As a result, we are adding new sub-specialties to our service delivery model and exploring non-hospital services to ensure that our community receives the right health care in the right health setting.

In 2015-16, presentations to The Northern Hospital's Emergency Department rose by more than 10 per cent, and a record 3,589 babies were born at The Northern Hospital over the last 12 months, making us yet again one of the busiest health services in Victoria. Northern Health still faces many challenges around providing timely patient access—an area in which we continue to work to produce positive change—but we have seen improvements in both emergency and elective surgeries this year. Compared to 2014-15, the number of patients being treated within clinically recommended times has risen from 61 per cent to 76 per cent, which brings us much closer to our Statement of Priorities target of 80 per cent.

Similarly, the year-on-year increases in our elective surgery waiting list has been halted and we have experienced a reduction in the waiting list of approximately 10 per cent, despite waiting list admissions growing by five per cent.

The demand for Northern Health's services will continue to rise each year which is why we are working closely with government to find options that will enable us to expand our infrastructure. To that end, significant planning work is underway with the Northern Growth Corridor Steering Committee and Ministerial Advisory Committee on Statewide Services and Infrastructure.

This year we opened a new 32 bed inpatient ward at The Northern Hospital to provide additional capacity for the increasing number of admissions and also warmly welcomed the Victorian Government's announcement of $17.3 million to expand the elective surgery centre at Broadmeadows Health Service. Work at the Broadmeadows Surgical Centre is expected to be completed by mid-2017 and the finished facilities will allow us to perform an additional 2,500 elective procedures locally each year.

Financial sustainability is critical to Northern Health's future, and the Board and leadership team are pursuing that sustainability with unrelenting vigour to ensure taxpayer funds are spent in the most appropriate manner.

Three Northern Health Board members retired on June 30, and we thank Brian Joyce, Sabine Phillips and John Fitzgerald for their significant contributions. Our thanks also go to our valued community health care and academic partners, and we extend our gratitude to the Northern Health Foundation, our donors, supporters, patients and staff.

2016-17 will no doubt bring challenges of its own, but we step into the year ahead with reinvigorated confidence in our ability to build the foundations for our future.

In accordance with the *Financial Management Act 1994*, we are pleased to present the Report of Operations for Northern Health for the year ending 30 June 2016.

Jennifer Williams
Board Chair
Northern Health
25/08/2016

Siva Sivarajah
Chief Executive Officer
Northern Health
25/08/2016

Northern Health Board

Jennifer Williams
Board Chair

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

She has previously worked as a Chief Executive to several large health care organisations including Austin Health (five years), Alfred Health (seven years) and most recently, as Chief Executive of the Australian Red Cross Blood Service (seven years). Jennifer is now a non-executive director and in addition to her Northern role she is also currently Chair of Yooralla and a Council Member of La Trobe University.

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

Jim Bailey

A Graduate member of the Australian Institute of Company Directors (AICD), Jim Bailey joined the Board in November 2014. He has provided strategic business advice, coaching and consulting services to key executives in many companies and across a number of sectors.

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

Jim is an active member of three Boards in total, including a not for profit organisation, as well as chairing an advisory board for a university faculty. Both of the professional bodies to which Jim belongs, namely AHRI and the Recruitment Consulting Services Association (RCSA), have awarded him their highest honour of Life Fellowship.

In addition, his involvement with Bailey Shaw's executive recruitment clients has given him a wealth of exposure to a broad cross section of some of Australia's best companies.

Juliann Byron

Juliann Byron was appointed to the Northern Health Board on 8 December 2015.

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

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

Northern Health Board

John Fitzgerald

Associate Professor Fitzgerald is an expert in Alcohol and Drug Policy, with a PhD in Pharmacology on the drug ecstasy and a second PhD in English on the discourse and language used to understand psychoactive substances.

A/Prof Fitzgerald has received numerous research grants from national funding bodies and has worked internationally assisting with health training and policy development. He has served as Associate Dean (Knowledge Transfer) in the Faculty of Medicine, Dentistry and Health Sciences and worked at the Victorian Health Promotion Foundation where he led the research, alcohol, tobacco and healthy eating programs and acted as CEO for 10 months. A/Prof Fitzgerald also has an active media profile appearing on TV and radio as an expert commentator on matters relating to alcohol, tobacco, healthy eating and healthy urban planning strategies.

A/Prof Fitzgerald joined the Northern Health Board in October 2013 and is currently working at The University of Melbourne continuing his teaching, supervision of research higher degree students and research on issues ranging from diabetes self-care, preventive health financing and population health approaches to health and wellbeing.

Brian Joyce

Brian Joyce is a Certified Practicing Accountant and Master of Administration (Monash.) He has extensive experience in Hospitals and Health Services management and financing.

Until 2008 Mr Joyce was Regional Director of the North and West Metropolitan Region of the Department of Human Services (DHS). During his career with DHS Mr Joyce held a number of senior executive positions including Director, Primary and Community Health, Executive Director Operations, and Regional Director, Southern Metropolitan Region. Mr Joyce also held the position of Deputy Chief General Manager of the former State Department of Health.

Prior to joining the public service Mr Joyce held the positions of Finance Director, Box Hill Hospital and Manager, Finance and Services, of the Victorian Branch of the Health Insurance Commission and Medibank Private.

Since retiring from the public service Mr Joyce has served as the government appointed Administrator of Western Education Support and Training Network (WestNet) and Advisor to a Youth Justice Custodial Services Taskforce. Mr Joyce also undertakes service review work in the Human Services sector.

Alison Lilley

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

Dr Lilley brings with her a wealth of experience from both the world of clinical medicine as well as senior level management in the public health system. Her past appointments include 10 years as Director of Anaesthesia and six years as Director of Perioperative Services at the Royal Women's Hospital. She has also been Chair of the Senior Medical Staff at RWH, and a member of the Industrial Relations sub-committee of the Board of the AMA (Vic). In addition she is an Examiner for the Australian and New Zealand College of Anaesthetists, and is a member of the Anaesthetic Advisory Committee, and of the Obstetric Medical Advisory Committee at Epworth Health Care.

She has received a number of Research grants, including a NH&MRC grant of $225,000 for an investigation into the role of cytokines in pelvic pain in women.

Alison has a Masters in Public Policy and Management, and a Graduate Certificate in Health Economics from Monash University, and is a passionate supporter of women's health in the public sector and a firm believer in the right of every member of the Australian public to have equity of access to the highest quality health care. She is involved in a number of safety and quality and risk management committees at various hospitals, and most recently consulted on the development of quality audit processes for the development of four new public health programs at a large community health provider in Massachusetts, USA.

Northern Health Board

Peter McWilliam

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

Peter understands the importance and value of staff in an organisation's success and has many years of experience in implementing training and mentoring programs to maintain organisational viability. Peter sat on the Australian Standards subcommittee on Building Facades and Glazings in the late 1980s and initiated and implemented Australian and International Standards ISO9001 and 9002 at Paramount Plastics (Aust.) from the mid 1990s, successfully being audited and retaining accreditation for Paramount Plastics (Aust.) from then until his retirement.

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

Sabine Phillips

Sabine Phillips is a Partner at Gadens lawyers, a national law firm. Sabine's practice is in health, retirement living, disability services and aged care. She specialises in corporate and clinical governance, risk management, compliance and dispute resolutions.

Ms Philips holds a Master of Laws, a Master of Business (Organisation Behaviour) and a Bachelor of Applied Science (Advanced Nursing). She is also a non-practising registered nurse and is a Fellow of the Australian Institute of Company Directors.

Ms Phillips is also a board member of Australian Children's Education and Care Quality Authority (ACECQA), a board member of Uniting AgeWell and a board advisor to Alzheimer's Australia (Victoria).

Corporate Governance

APPOINTMENT OF DIRECTORS

Terms of appointment vary from one to three years, at an annual salary set by the Minister in accordance with guidelines issued by the Victorian Public Sector Commission.

Board changes during the financial year were as follows:

- On the recommendation of the Minister for Health, the Governor-in-Council appointed Jennifer Williams as Chairperson from 1 July 2015 to 30 June 2018.
- On the recommendation of the Minister for Health, the Governor-in-Council appointed Juliann Byron as Director from 8 December 2015 to 30 June 2018.

ROLE OF THE BOARD

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

Key aspects of this governance role include:

- Setting the organisation's strategic direction.
- Establishing a policy framework and primary policy.
- Appointing and monitoring the performance of the Chief Executive.
- Evaluating organisational performance.
- Ensuring organisational accountability and compliance with legislative requirements.
- Evaluation of the Board's own effectiveness in governance.

The Directors contribute to the governance of Northern Health collectively as a Board by attending to business through meetings and a range of informal processes throughout the year.

In addition to attending Board meetings Directors contribute through participation in or chairing the various committees of the Board. Directors also attend significant functions and ministerial events within Northern Health and externally with external stakeholders.

The Board meets monthly. There were 11 Board meetings held in the financial year 1 July 2015 to 30 June 2016.

BOARD MEETINGS AND ACCESS TO MANAGEMENT

At Board and committee meetings, the Executive and other senior members of staff regularly present papers relevant to their areas of responsibility in the health service. Between meetings, individual Board members have contact with management through committee or project involvement and are contacted by the Chief Executive Officer on major issues. Directors undertake site visits to Northern Health's separate campuses in order to view first-hand the activities and services provided at hospitals and facilities.

DELEGATION OF FUNCTIONS

The by-laws provide for the delegation of duties by the Board. The Board has approved a detailed Delegations Policy, enabling designated Northern Health Executives to perform their duties through the exercise of specified authorities.

BOARD COMMITTEES

Directors lend their expertise to the operations of committees of the Board and in this way some of the general functions of the Board are delegated to small groups of Directors.

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

Audit and Risk Committee

Ms Sabine Phillips - Director (Chair)

Ms Jennifer Williams - Board Chair

Mr Brian Joyce - Director

Ms Juliann Byron – Director (from February 2016)

The following executive staff attend this Committee:

Mr Siva Sivarajah - Chief Executive Officer

Mr Colin Holland – Interim Chief Financial Officer (until February 2016)

Mr Basil Ireland – Chief Financial Officer (from April 2016)

Dr Alison Dwyer – Chief Medical Officer (from November 2015)

Ms Michelle Fenwick – Executive Director, People and Culture (from September 2015)

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

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

Finance Committee

Mr Brian Joyce - Director (Chair)

Ms Jennifer Williams - Board Chair

Mr Peter McWilliam - Director

Mr Jim Bailey - Director

Mr Siva Sivarajah - Chief Executive Officer

Mr Colin Holland – Interim Chief Financial Officer (until February 2016)

Mr Basil Ireland – Chief Financial Officer (from April 2016)

Ms Jenni Smith – General Manager Access, Performance and Partnerships / Chief Allied Health Officer

Ms Michelle Fenwick – Executive Director People and Culture

Ms Jodie Ashworth – General Manager Surgery, Women's and Children's, Operating Theatres and ICU / Chief Nursing Officer (from March 2016)

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

Strategy Planning and Workforce Committee

The Strategy, Planning and Workforce Committee was disbanded after July 2015.

Quality Committee

Dr Alison Lilley – Director (Chair)

Ms Jennifer Williams - Board Chair

Ms Sabine Phillips – Director

Mr Siva Sivarajah - Chief Executive

Dr Kwang Lim - Chief Medical Officer (until October 2015)

Dr Alison Dwyer – Chief Medical Officer (from December 2015)

Ms Jenni Smith – General Manager Access, Performance and Partnerships / Chief Allied Health Officer

Ms Jodie Ashworth – General Manager Surgery, Women's and Children's, Operating Theatres and ICU / Chief Nursing Officer (from March 2016)

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

Remuneration and Appointments Committee

Ms Jennifer Williams - Board Chair (Chair)

Mr Brian Joyce – Director

Associate Professor John Fitzgerald – Director

The role of the Remuneration Committee is to advise and make recommendations to the Board in relation to executive and senior staff remuneration, performance and recruitment.

Patient Experience and Community Advisory Committee

Associate Professor John Fitzgerald - Director (Chair)

Mr Peter McWilliam - Director

Mr Jim Bailey - Director

Mr Siva Sivarajah - Chief Executive

Dr Alison Dwyer – Chief Medical Officer (from December 2015)

Ms Jenni Smith – General Manager Access, Performance and Partnerships/Chief Allied Health Officer

Ms Anastasia Ah Tong – Consumer representative

Ms Maureen Canzano – Consumer representative

Ms Fiona Micelotta – Consumer representative

Ms Nurcihan Ozturk – Consumer representative

Ms Dalal Sleiman – Consumer representative

Dr Ken Ekersall – Consumer representative (until September 2015)

Ms Rahimah Mah – Consumer representative

Mr Russ Pata – Consumer representative (until April 2016)

Ms Donna Wright – Consumer representative

Mr Peter Uzande – Consumer representative (from November 2015)

Mr Tom Cobban – Consumer representative (from April 2016)

Ms Jennefer Williams - Consumer representative (from April 2016)

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

Primary Care and Population Health Advisory Committee

Associate Professor John Fitzgerald - Director (Chair)

Mr Brian Joyce – Director

Ms Juliann Byron – Director (from February 2016)

Mr Siva Sivarajah - Chief Executive Officer

Ms Jenni Smith – General Manager Access, Performance and Partnerships/Chief Allied Health Officer

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

Ms Suzanne Miller - CEO Nexus Primary Health

Mr Neil Cowen - Chief Executive Officer, Dianella Community Health

Mr Tim Fry - Area Manager Aged Services and Northern Area, Department of Health and Human Services, and West Metropolitan Region

Mr Neville Kurth - Manager Health, Access and Bushfire Recovery, City of Whittlesea

Ms Margarita Caddick - Director City Communities, Hume City Council

Mr John Dermanakis – Manager, Northern Area Mental Health Service

Ms Hayley Carr – Manager, Northern Region, Royal District Nursing Service

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

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

Ms Helen Riseborough - Chief Executive Officer, Women's Health in the North

Ms Robin Whyte - Chief Executive Officer, Eastern Melbourne Primary Health Network (from December 2015)

Ms Jodi Briggs - Director Strategy, Commissioning and Innovation, Eastern Melbourne Primary Health Network (from December 2015)

Ms Julie Borninkhof - Executive Director, Primary Care Improvement, North West Melbourne Primary Health Network

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

The Population Health Advisory Committee assists the Board with inter-agency planning and the integration of health services in the catchment area - particularly as it relates to the primary care and acute sectors. The committee also assists the Board in identifying community health needs with a view to establishing innovative programs to improve the accessibility and responsiveness of Northern Health services. This includes creating direct service partnerships with other health and community services, commissioning research in relevant areas and working in partnership with other local agencies on health promotion schemes.

DIRECTOR'S ATTENDANCE FOR BOARD AND SUB COMMITTEE MEETINGS: 1 JULY 2015 - 30 JUNE 2016

	Board	Finance Committee	Audit and Risk Committee	Quality Committee	Strategy Planning and Workforce Committee	Patient Experience and Community Advisory Committee	Primary Care and Population Health Committee	Remuneration and Appointments Committee	**Total**
No. of Meetings	***12***	***13***	***7***	***7***	***1***	***5***	***5***	***1***	
Ms Jennifer Williams	*12*	*9*	*5*	*2*	*0*	*2*	*1*	*1*	*32*
Ms Sabine Phillips	*11*	*2*	*7*	*5*	*1*	*0*	*0*	*0*	*26*
Mr Brian Joyce	*12*	*13*	*7*	*0*	*1*	*1*	*3*	*1*	*38*
Mr Peter McWilliam	*12*	*13*	*5*	*2*	*1*	*5*	*0*	*0*	*38*
Associate Professor John Fitzgerald	*10*	*0*	*0*	*1*	*1*	*4*	*5*	*1*	*22*
Dr Alison Lilley	*6*	*2*	*1*	*5*	*1*	*0*	*0*	*0*	*15*
Mr Jim Bailey	*9*	*12*	*1*	*1*	*1*	*5*	*0*	*0*	*29*
Ms Juliann Byron (commenced December 2015)	*6*	*2*	*2*	*0*	*0*	*0*	*2*	*0*	*12*

Northern Health Executive

Siva Sivarajah

Chief Executive Officer

Commenced 17 August 2015

Siva Sivarajah brings a wealth of knowledge, experience, partnership and leadership capabilities to Northern Health. Siva is a highly skilled health care leader with over 25 years' experience within Victorian Health Services. For the last eight years, Siva was employed as the Chief Operating Officer for Monash Health (formerly Southern Health).

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

In addition to Siva's leadership and health care management capabilities, he is also skilled in the delivery of major capital projects and engineering/infra-structure services within Monash Health.

Jodie Ashworth

General Manager, Surgery, Women's and Children's, Operating Theatres and ICU and Chief Nursing and Midwifery Officer

Commenced 29 February 2016

Since 1989 Jodie Ashworth has worked in the public health sector across three states of Australia in services ranging from small, rural to large tertiaries. Since her commencement at Northern Health in 2014, Jodie has consistently and clearly demonstrated a synergy between her values and purpose with that of Northern Health's strategic direction and has delivered on all set key performance indicators from the Executive and Board.

Jodie is passionate about nursing and midwifery as a profession and considers it paramount that Northern Health continues to develop standards through teaching, research and innovative practice. Jodie has had significant managerial and operational experience at executive and senior management level that has involved financial accountability, development of service capability, responsibility for patient access and flow and multi-disciplinary team management.

Robina Bradley

General Manager, Bundoora Extended Care Centre

Commenced 29 February 2016

Robina Bradley brings a diverse and unique range of program management experience with over 25 years in the industry working with clinicians in the implementation of business and quality improvement and leading major change. Robina has worked at both state and national level across acute, primary and community services and government departments in the implementation of innovative programs, tenders and business cases.

Robina commenced at Northern Health in 2014 after a stint at The Commission for Hospital Improvement and has contributed to the overall leadership and management for palliative care, rehabilitation and aged care services with joint responsibility with the Professor/Clinical Program Director. Robina has improved the program's operations to maximise business, operational, people and financial management to deliver the best patient care.

Robina is a member of The College of Health Service Administration, Australia Institute of Company Directors, Royal College of Nursing and has post graduate qualifications in Critical Care and Emergency Nursing and Health Systems Management. Robina's particular strengths are in building relationships, governance, strategy and working with operational teams to develop new models of care to achieve activity targets and performance standards.

Northern Health Executive

Alison Dwyer

Chief Medical Officer

Commenced 19 October 2015

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

Her previous experience includes Medical Director for Quality, Safety and Risk Management at Austin Health for five years (2010-2015), and five years as the Director Medical Services at Royal Melbourne Hospital (2006-2010).

Alison has also held roles in the Department of Health Victoria Quality Unit and a number of metropolitan and rural health services in medical administration. She is currently surveyor for Australian Council on Healthcare Standards. Alison holds a medical degree (MBBS) from Melbourne University, dual management masters from Monash University (MBA, Master Health Services Management), Fellowship of the Royal Australasian College of Medical Administrators 2006 (FRACMA) winning the top national prize for outstanding Fellow in the FRACMA examinations, Fellowship of the Australian College of Health Service Managers (FCHSM) and is a Graduate member of the Australian Institute of Company Directors (GAICD).

Michelle Fenwick

Executive Director, People and Culture

Commenced April 2016

Michelle Fenwick has worked in the public and private health care industry for over 20 years in operational, management and consulting roles. She has an extensive background in sustainable workforce planning within health care and has implemented a number of human resource management systems across large tertiary and speciality hospitals. Michelle is passionate about the positive impact which People and Culture is able to deliver to an organisation, especially when our people are our number one asset.

Michelle has a Masters in Administration - Human Resource Management Industrial Relations and has candidature for her Doctorate in Business Administration research topic: Impact of nurse casualisation.

She is an Associate Fellow with the Australian College of Administration and earlier this year stepped down from the Australian Health Services Financial Management Association (AHSFMA) board after eight years of service.

Basil Ireland

Chief Financial Officer

Commenced 29 March 2016

Basil Ireland is a highly motivated and results driven CFO, with a proven track record of success in large and complex, private and public organisations. With over ten years' experience working at a senior financial capacity in health, he possesses a powerful suite of finance, leadership and senior executive capabilities in the areas of financial management, client data management, business support and environmental support services.

Basil has a strong capability to lead and develop high performance teams and build productive and effective relationships based on the delivery of results and strong financial advice. He is committed to providing transparency to stakeholders, demonstrating that decisions are made equitably and working in a collaborative manner.

Northern Health Executive

Belinda Scott

General Manager, Broadmeadows Health Service and Craigieburn Health Service

Commenced 29 February 2016

Belinda Scott is a skilled executive with expertise in strategic, operational and large program service delivery, and was appointed to the position of General Manager, Broadmeadows Health Service and Craigieburn Health Service in 2016. A transformational leader with a strong clinical background, Belinda commenced with Northern Health in 1999, and has worked in varied roles including Program Director, Emergency Services and Director, Quality, Safety and Clinical Governance. She has also held nursing positions at Western Health, and worked as a Risk Consultant with the Victorian Managed Insurance Authority.

Belinda is passionate about engaging others to achieve performance outcomes, and her skills and capabilities include the service redesign, financial reform, capability building and change management. Her industry experience is complemented by continuous learning, and has a Masters in Nursing and a Graduate Diploma in Health Service Management, along with significant executive leadership professional development and public speaking engagements.

Jenni Smith

General Manager, Access, Performance and Partnerships

Chief Allied Health Officer

Jenni Smith has been a member of the senior executive team at Northern Health since 2009. In February 2016 she was appointed to the position of General Manager, Access, Performance and Partnerships and Chief Allied Health Officer. She has an extensive background in the delivery of health care services in both the public and private sectors and has served on numerous industry and professional committees. This experience has included the development and implementation of sustainable quality improvement systems and integrated care pathways.

Jenni is committed to building strong collaborative partnerships to improve community health outcomes in Melbourne's north.

Doris Vella

General Manager, Emergency, Medical Beds and Cardiology

Commenced 25 April 2016

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

Doris has over 15 years of management experience in senior health care roles where she has demonstrated success in achieving both divisional and organisational outcomes in both operational and strategic roles across complex health care settings. Her previous appointments include, Director of Nursing and Operations (acute, subacute, community and site management experience) and she has acted in various roles such as Executive Director of Nursing and Allied Health, and Divisional Director.

Doris is a health care leader capable of empowering staff from all disciplines and backgrounds to implement new models of care and improve clinical practice.

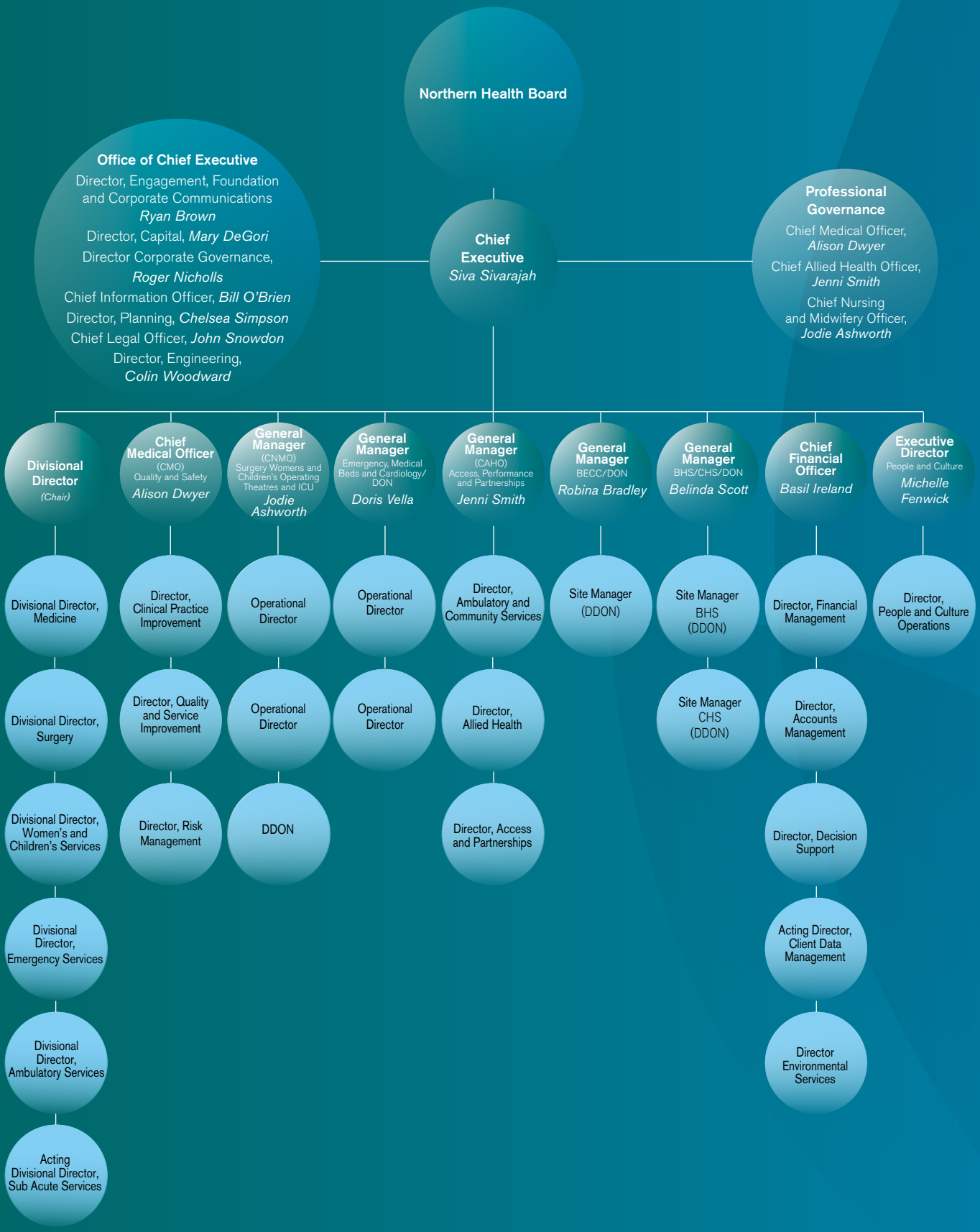
She is passionate about leading quality healthcare and ensuring the patient is at the centre of all that we do.

Other members of the Northern Health Executive in 2015-16

- Robert Burnham – Current
- Janet Compton – until 21 August, 2015
- Kwang Lim, as Chief Medical Officer – until 19 October 2015
- Michelle McDade – until 18 September, 2015
- Clare McGuiness – until 18 September, 2015
- Zemeel Saba – until 28 August, 2015

Organisational Structure

Northern Health



Our Services

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

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

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

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

The Northern Growth Corridor population is expected to grow by 59 per cent, or over 230,000 people, by 2031. This includes 19 per cent growth between 2016 and 2021, an increase of over 73,000 people, within the next five years.[1]

Northern Health treats patients from many different socio-economic backgrounds, who are born in more than 130 countries and speak over 120 different languages. The breadth of complex disease in the community is significant, with residents of the outer north having generally poorer health status, including higher than average levels of type 2 diabetes, heart disease and high-blood pressure, higher rates of smoking and drug-related issues and significantly higher rates of Family Incident Reports submitted by Victoria Police.[2]

Our busy emergency department treated over 85,000 patients in 2015-16, including an average of 56 paediatric patients and 63 ambulance arrivals each day. Our dedicated staff assisted with 69 births per week and a record breaking 3589 babies were delivered in the past 12 months. Our Outpatient Department continues to provide over 3900 appointments per week and we perform around 288 elective surgeries each week and 113 emergency operations.

Northern Health is working hard to achieve our vision of providing outstanding health care for our community and will continue to develop services, and pathways to services, to ensure our patients can access the right care, at the right time by highly skilled health professionals.

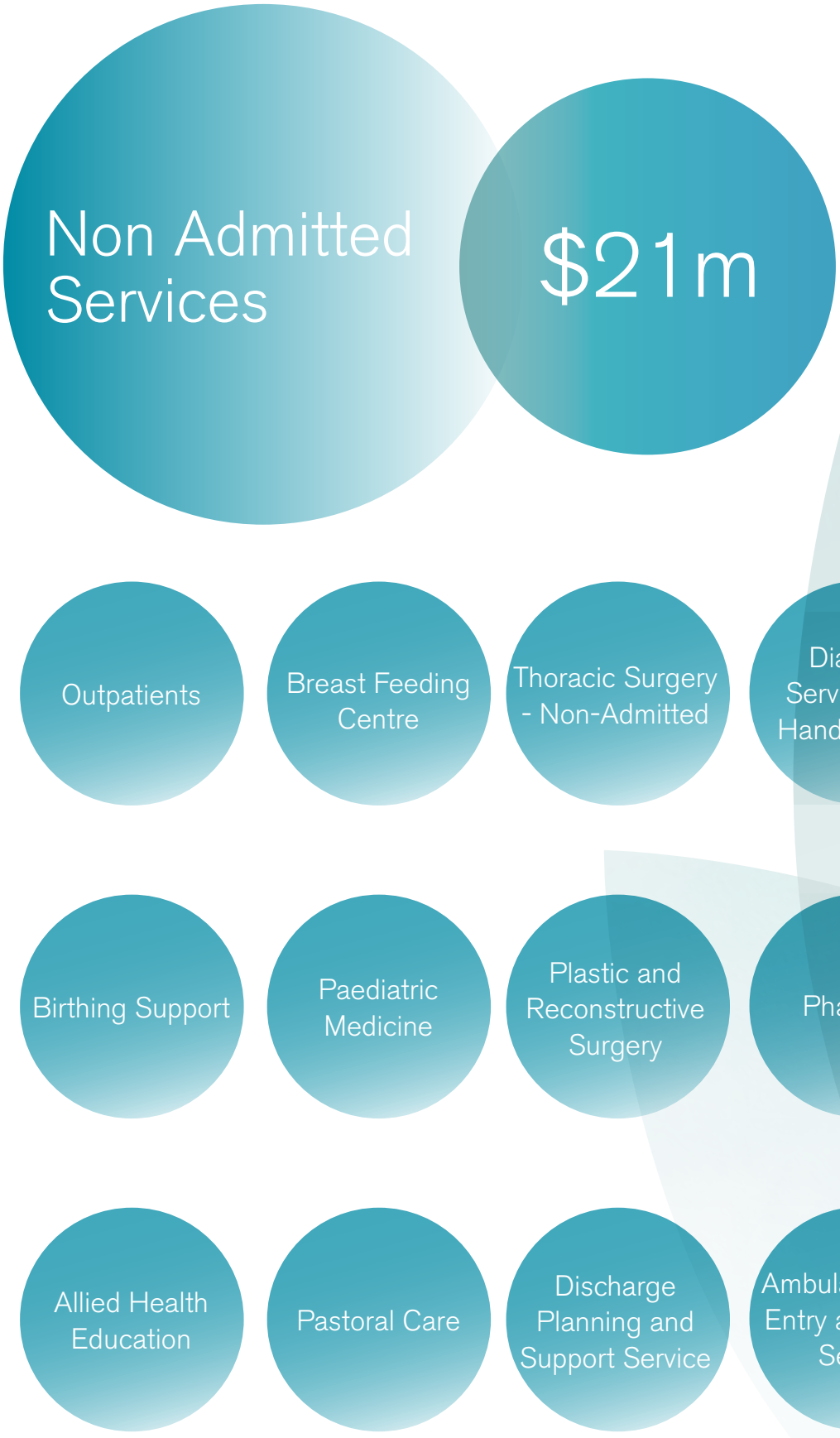
[1] ***Department of Environment, Land, Water and Planning (2015), Victoria in Future 2015, accessed at:*** *http://www.dtpli.vic.gov.au/data-and-research/population/census-2011/victoria-in-future-2015*

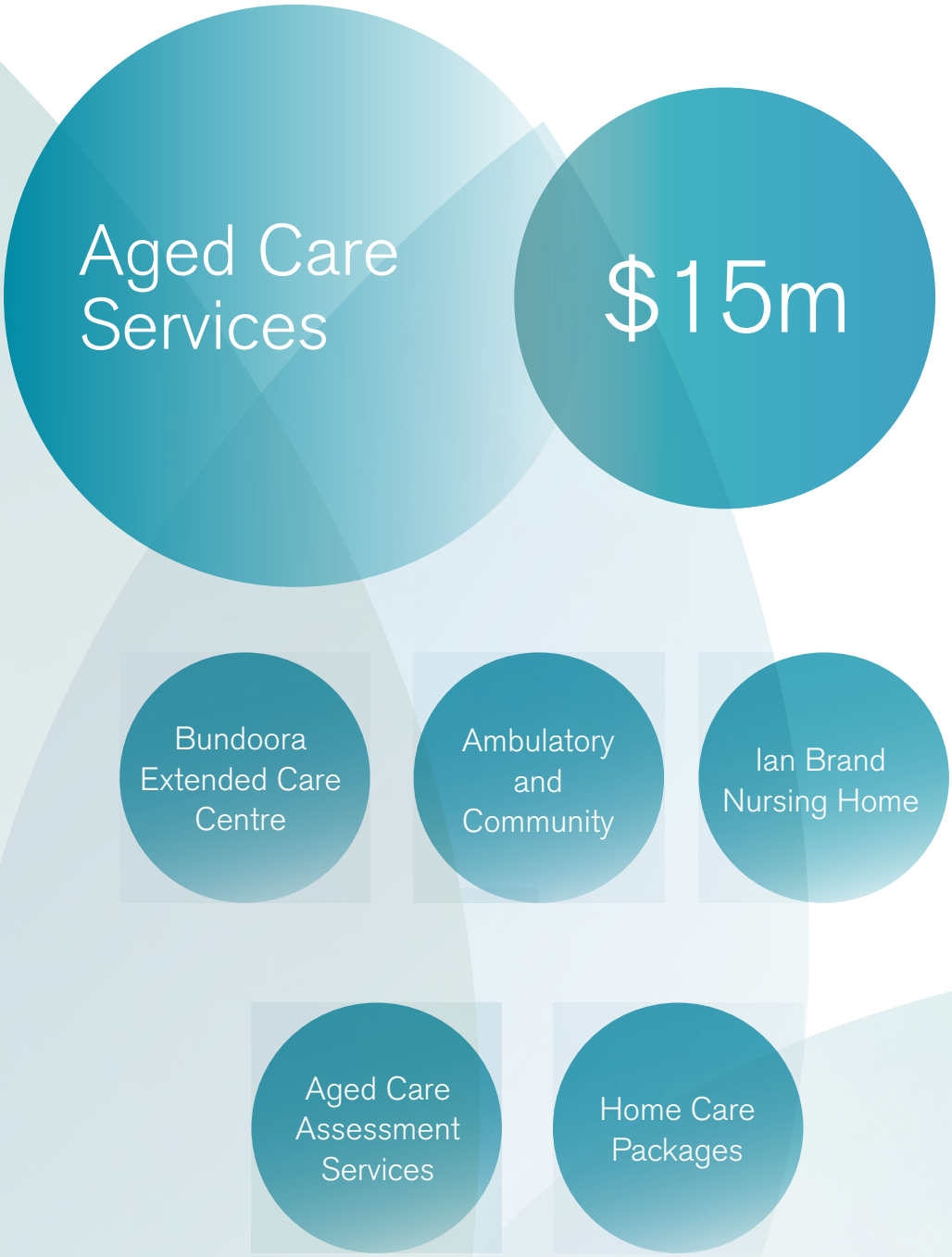
[2] ***Victoria Police, Family Incidents Reports 2009/10 – 2013/14, accessed at:*** *http://www.police.vic.gov.au/content.asp?a=internetBridgingPage&Media_ID=72311*

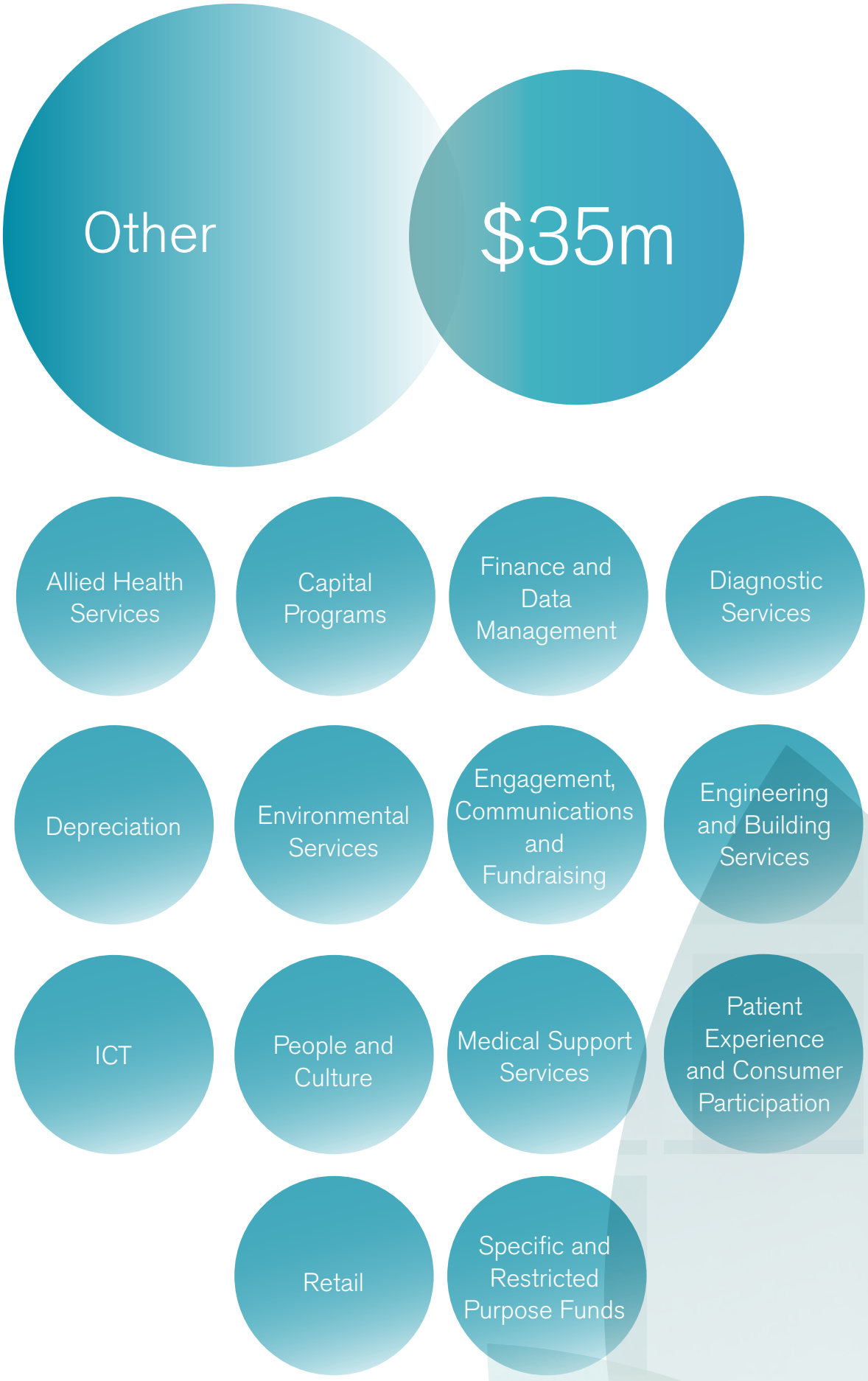
Admitted Patients, Sub Acute & Emergency Services

$381m

- Access, Performance and Partnerships
- Ambulatory and Community
- Broadmeadows Health Service
- Craigieburn Health Service
- Bundoora Extended Care Centre
- Medical, Emergency and Cardiology Services
- Nursing and Medical Workforce
- Quality and Safety
- Surgical, Women's, Children's and ICU Services
- Oncology
- Hospital Admission Risk Program
- Intensive Care Sevices


Non Admitted Services
$21m
Outpatients
Breast Feeding Centre
Thoracic Surgery - Non-Admitted
Diabetes Services and Hand Therapy
Birthing Support
Paediatric Medicine
Plastic and Reconstructive Surgery
Pharmacy
Allied Health Education
Pastoral Care
Discharge Planning and Support Service
Ambulatory Care Entry and Triage Service


Aged Care Services
$15m
Bundoora Extended Care Centre
Ambulatory and Community
Ian Brand Nursing Home
Aged Care Assessment Services
Home Care Packages


Other
$35m
Allied Health Services
Capital Programs
Finance and Data Management
Diagnostic Services
Depreciation
Environmental Services
Engagement, Communications and Fundraising
Engineering and Building Services
ICT
People and Culture
Medical Support Services
Patient Experience and Consumer Participation
Retail
Specific and Restricted Purpose Funds

Our Achievements

PROVIDE A BALANCED MIX OF QUALITY SERVICES

At Northern Health we strive to deliver high quality health services that ensure the very best outcomes for our patients. As our services continue to grow to accommodate increased demand from our community, we carefully monitor and assess our programs in order to increase the efficiency of our services and reduce clinical risk.

Good health is just a tele-call away

Northern Health, in partnership with The Kilmore and District Hospital and Seymour Health, has launched a new Tele Health Service, which will enable patients in rural communities to receive more comprehensive emergency treatment closer to home.

Tele Health involves the use of digital information and communication technologies, such as computers and mobile devices, to manage a patient's health and diagnosis remotely, reducing the need for frequent face to face consultations.

Urgent Care Centres at The Kilmore and District Hospital and Seymour Health are open 24 hours a day, seven days a week, and are operated by highly skilled nursing staff able to provide expert emergency care. In addition to the service provided by local GP's, patients may now be triaged and diagnosed by a doctor via a video conferencing link between the Centre and The Northern Hospital Emergency Department.

This new initiative enables Northern Health to support staff at Kilmore and Seymour by providing clinical consults electronically, reducing unnecessary travel time and improving the patient outcome.

Northern Health teams up with Jacana School for Autism

Over 30 secondary students from the Jacana School for Autism have added a splash of colour to the walls in The Northern Hospital Outpatient Department with some hand crafted artwork.

Northern Health believes in forming strong relationships with local schools to continue to provide outstanding health care to the local community. By engaging with local schools we have been able to brighten up the Outpatients Department with stunning artwork and enhance our patient experience.

Record baby boom in Melbourne's north

Northern Health has delivered the highest number of babies in a single month with 329 newborns delivered at The Northern Hospital in June, and a record 3,589 born over the last 12 months.

The number of births at The Northern Hospital has increased from 3,420 in the 2014-15 financial year, to 3,589 in the 2015-16 financial year. Northern Health's Maternity Service provides expert maternity care to a unique, multicultural population which is expected to grow by more than 220,000 residents by 2031.

Environmental performance

Northern Health has been actively working towards reducing the impact our activities have on the environment, and continue to collaborate with both internal and external stakeholders to achieve this. In the past 12 months we have engaged with staff members and service providers in the conversation about the interactions between the environment and public health. We collaborate with environmental sustainability experts in health care at state, national and international levels to identify and achieve best practice.

Our waste management practices are continuing to evolve to both reduce waste generated and capture additional recycling streams. We have recently implemented a food waste recycling unit that will prevent food waste from entering landfill with associated Green House Gas reductions of up to 90 per cent. In addition, we have decreased our paper use by approximately eight per cent and implemented more than 15 projects. These leadership and waste management practices contribute to public health by ensuring our community has a healthy environment in which to survive and thrive.

Improving care for complex patients at Bundoora Extended Care Centre

The specialist geriatric behavioural management unit, situated in the Kath Atkinson Wing of Bundoora Extended Care Centre, is a 15 bed secure ward providing comprehensive geriatric assessment to older patients with behavioural and psychological symptoms of dementia. Patients have an average length of stay of six weeks and the unit continues to experience an increase in demand. There has also been a significant increase in the complexity and severity of needs of the people requiring the service and it is expected that demand will continue to grow with the increasing prevalence of dementia.

Over the last year, Northern Health has invested in training to assist staff identify and focus on safety including the introduction of 24 hour security services on site and has continued to embed a person centred approach into our model of care.

The work has been developed in a collaborative partnership between the Safety First team, nursing, senior medical, and allied health staff and has increased skills, knowledge and yielded substantial benefits for the team and the patients we care for.

Our Achievements

FULLY UTILISE OUR RESOURCES AND DEVELOP OUR INFRASTRUCTURE

Making the best use of Northern Health's resources and infrastructure is a critical step in our transformational journey, enabling us to meet the future demand for health care services from the fast growing northern community.

Private Practice Midwives provide greater continuity of care

Pregnant women in Melbourne's north are now able to give birth under the care of a private midwife as part of a new pilot program at Northern Health. The Collaborative Midwife Pilot Project, launched in May this year, provides greater continuity of care, and allows women to have the same midwife throughout their pregnancy journey and birth of their baby, through to discharge.

The program assists with flow and access for maternity patients and helps to ensure our women are seen in the right place at the right time by skilled health professionals.

Short Stay Unit for youngest patients

On 28 September 2015, Northern Health opened a new four bed Paediatric Short Stay Unit (PSSU), located within the Children's Ward at The Northern Hospital. Currently admitting between 180 – 210 children each month, this space provides improved patient experience and access for some of our youngest patients.

Children are cared for and observed in a more comfortable environment than the busy Emergency Department in a ward designed to admit children for less than 24 hours and observe and assess children to establish whether they need admission or are safe to go home. This has also improved patient flow and accessibility within Northern Health's Paediatric Emergency Department.

The opening of MAC

The Northern Health Maternity Assessment Centre (MAC) was officially opened on 4 November 2015 at The Northern Hospital. This project was a result of concerns that pregnant women weren't always being seen in the right place at the right time. MAC is staffed by two midwives, seven days per week, from 9 am – 5 pm.

MAC is for antenatal women requiring increased surveillance with high risk pregnancies, as well as unplanned admissions for assessment of labour and fetal wellbeing. This helps to ensure that the Birth Suite is essentially for birthing women, and assists with flow through the unit.

Multimillion dollar expansion at The Northern Hospital

On 9 June 2016 The Northern Hospital IPU Stage 1 'Tower' development was completed.

The new three storey facility at The Northern Hospital now connects a 32-bed inpatient unit to the main hospital via an aerial link, and encompasses state-of-the-art, brand new medical equipment, a mix of single and double patient rooms, two negative pressure isolation rooms, two bariatric rooms, natural light throughout the ward, including windows in each patient room and a relaxing patient lounge.

Northern Health is increasing our services and capacity to ensure that we can continue to provide outstanding health care for the northern community. The new T2 Ward caters for a mix of both general medical and respiratory patients at Northern Health, with the aim of becoming a full Respiratory Unit by 2017.

By opening T2 and reconfiguring our wards, Northern Health can continue to provide patients with the right care, at the right time, in the right space, by skilled health care professionals.

Tap On, Tap Off

In May, Northern Health installed a Tap On, Tap Off system at The Northern Hospital.

This system provides the ability for staff to swipe their Northern Health ID Cards to quickly access essential computer programs. This new system is designed to address the congestion around shared computers and allow for easier, more widespread ICT access.

Opening of Unit 1 at Broadmeadows Health Service

In October 2015, Northern Health opened Unit 1, an acute medical and surgical ward at Broadmeadows Health Service.

This ward encompasses both medical and surgical beds and offers greater access to theatre for patients who require overnight care and increased continuity of care for patients who need access to services such as dialysis and rehabilitation. Unit 1 has admitted over 750 patients in the past six months, and will help us continue to meet the needs of our community now and into the future.

Northern Health has a strong commitment to our satellite sites, and the allocation of funding in the 2016 state budget to expand the Broadmeadows Surgical Centre will help us to assist more residents in Melbourne's north to receive surgery locally, in a timely manner


TBC
Scope results
What matters to me today?
NIL

Our Achievements

STRENGTHEN OUR ORGANISATIONAL CAPABILITY

By strengthening Northern Health's organisational capability, we enhance our ability to provide outstanding health care for our community. Delivering sound financial performance, becoming a leader in clinical research and education, growing our partnerships and engaging our community all contribute to improved health outcomes in the north.

Accreditation periodic review

In September 2015 Northern Health underwent a periodic review by the Australian Council on Health Care Standards (ACHS) as part of our four year cycle for accreditation.

This review included a full assessment of:

- Standard 1- Governance for Safety and Quality in Health Service Organisation
- Standard 2 - Partnering with Consumers
- Standard 3 - Preventing and Controlling Health Care Associated Infections

This review surveyed all of the recommendations from the previous Organisation Wide survey in 2014 and the mandatory requirements of the EQuIPNational Standards 11-15.

Northern Health achieved an excellent result where all actions from all standards being assessed (133) were given a rating of satisfactorily met and all previous 32 recommendations were addressed "most satisfactorily" and therefore closed.

What is most pleasing is that Northern Health was upgraded to a Met with Merit in 12 of the actions in the following areas:

Standard 1 Governance - Five Met with Merits

- Regular reports on safety and quality indicators and quality performance data are monitored by the executive level of governance
- An organisation risk register is used and regularly monitored
- An organisation quality management system is used and regularly monitored
- Systems are in place to analyse and implement improvements in response to complaints
- Data collected from patient feedback systems are used to measure and improve health services in the organisation.

Standard 2 Partnering with Consumers - Four Met with Merit's

- Consumers and/or carers are involved in the governance of the health service organisation
- Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)
- Consumers and or carers participate in the design and redesign of health services
- Clinical leaders, senior managers and the workforce access training on patient centred care and the engagement of individuals in their care.

Standard 3 Preventing and Controlling Health Care Infections - Three Met with Merits

- Workforce compliant with current national hand hygiene guidelines is regularly audited
- Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation
- Action is taken to address non-compliance, or the inability to comply, with the current national hand hygiene guidelines.

Celebrating outstanding volunteers

During National Volunteer Week, Northern Health is celebrating the valuable contribution of our Northern Health volunteers. Northern Health has over 350 passionate and dedicated volunteers helping to provide outstanding health care for our community.

They provide a variety of important services both out in the community and across our campuses, including fundraising, offering spiritual support, guiding patients and

Our Achievements (cont'd)

visitors, maintaining gardens in our courtyards and supporting patients in Emergency and Outpatient Departments.

Northern Health simply could not provide all our services, put on great events, or offer the level of care that we do without our dedicated team of volunteers, and we thank them for helping provide outstanding health care for our community.

Open Access Board Meeting

On Tuesday, 1 December 2015, the Northern Health Board hosted an Open Access Board Meeting for our consumers, volunteers and staff to enable direct communication with Board Members and other Northern Health Senior Leaders.

Feedback from our community is essential to assist Northern Health in improving our services and helping us understand the needs of the community. This Open Board Meeting was the first time the format was changed to include round table discussions and an open microphone for consumers to voice their feedback and give suggestions for improvement.

Over 70 people were in attendance and the meeting opened with short presentations about Northern Health's performance and future demands as well as recent successful consumer led improvement activities. The round table discussions were very informative and engaging, enabling community members to discuss specific highlights they have experienced at Northern Health, service improvement priorities and how we can communicate more effectively with our diverse community.

EMERGO exercise

Northern Health conducted an External Disaster (Code Brown) training exercise at The Northern Hospital on 30 September 2015. This exercise included participants from Ambulance Victoria, Metropolitan Fire Brigade, Victoria Police, Victorian Medical Assistance Teams the Department of Health and Human Services, and allowed Northern Health to test our systems and processes and provide a learning opportunity for all involved.

Our Achievements

ATTRACT AND DEVELOP A HIGH PERFORMING WORKFORCE

Developing, attracting and retaining a high-performing workforce is integral to Northern Health's ability to meet the rising demand for health services in our rapidly expanding community. As the demand for health services grows, so too does the need for innovative and flexible workforce models and our work continues to build staff capability and help us become an employer of choice with a values-driven culture.

New medical interns join Northern Health

In 2016, 41 passionate and dedicated medical interns commenced at Northern Health, from over 1100 applications, working across a range of health disciplines, including Emergency, General Medical and Surgical areas. Northern Health is committed to meeting the complex and challenging health care needs of our patients and continue to attract high quality medical interns who come to learn, and choose to live, within the northern community. We are proud to play such an important role in the training and professional development of junior doctors in Victoria.

Award winning doctor providing expert care

In 2015, Northern Health clinician Dr Anastasia Vlachadis Castles was named the Postgraduate Medical Council of Victoria Junior Doctor of the Year!

The prestigious award recognises Junior Doctors who have made outstanding contributions to the field of medicine and research in Australia, and Dr Castles is a prime example of the passionate and dedicated staff we have here at Northern Health.

Dr Castles has positively impacted the care of some of our most complex patients, particularly as a part of our cardiology and research teams. She has also made significant contributions to the education of new medical students by implementing the Medical Student Mentoring Program, and she continues to help to supervise and teach medical students throughout their placements at Northern Health.

Melbourne Medical School Academy of Clinical Teachers

In October 2015, six Northern Health staff members were welcomed into the Melbourne Medical School Academy of Clinical Teachers in recognition of their highly regarded and prolonged contribution to the training of medical students. Professors Russell Buchanan and Wei Qi Fan were admitted as Fellows, along with Professor Doug Crompton and Doctors Barbara Hayes, Kurt Wendelborn, and Elizabeth McCarthy.

The role of the Academy is to promote excellence in clinical teaching and professional engagement with the University's health sector colleagues, and members are recognised for the important leadership role they play in the education of medical students within the health service.

New Nurse Practitioners

Two Northern Health Nurses, Anne Rodda and Lisa Bethune, were endorsed as Nurse Practitioners in 2016. Anne has been working as a Nurse Practitioner Candidate at The Northern Hospital and has been a key in the development of the Stroke Service provided at Northern Health over the previous three years. Lisa is part of Northern Health's Palliative Care Consultancy team and has also been working towards endorsement over the last three years.

New Professor for Northern Health

In 2016, Northern Health was delighted to congratulate Professor Peter Barlis, who has been appointed by The University of Melbourne as a Professor in our Cardiology team.

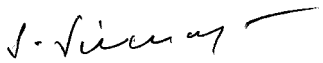
Professor Barlis has been at Northern Health since 2008 and his recent appointment is testament to the dedication to research and innovative works in the Cardiology Department at Northern Health. Collaboratively, he has worked with the Cardiology Department to successfully build a strong research profile for Northern Health which has attracted international exposure.

Northern Health Clinical Leadership Program

This Clinical Leadership Program is designed to provide nominated staff with an opportunity to receive structured developmental experiences to adequately prepare them for a clinical leadership role with Northern Health.
The Northern Health Clinical Leadership program gives high performing staff from different wards an opportunity to work alongside a Clinical Leader and Northern Health Mentor for a designated period of time, to gain exposure to the types of tasks and responsibilities experienced in a clinical leadership role. Development of clinical staff at Northern Health is integral to the growth of our organisation and our ability to build capability in our staff to take on clinical leadership roles.

Attestation for compliance with the Ministerial Standing Direction 4.5.5– Risk Management Framework and Processes

I, Siva Sivarajah, Chief Executive Officer, certify that Northern Health has complied with Ministerial Direction 4.5.5 – Risk Management Framework and Processes. The Northern Health Audit Committee has verified this.



Siva Sivarajah
Chief Executive Officer
Northern Health
25/08/2016

Statement of Priorities

In 2015-16 Northern Health will contribute to the achievement of the government's commitments by:

Domain	Action	Deliverable	Outcome
Patient Experience and Outcomes	Drive improved health outcomes through a strong focus on patient-centred care in the planning, delivery and evaluation of services, and the development of new models for putting patients first.	To implement the Patient Experience plan developed in conjunction with the Patient Experience and Consumer Participation Committee (PECAC). This will help ensure we place patients first in all improvement efforts.	***In progress*** Results from the Open Access Board Meeting and outstanding items from the previous work plan are being compiled to inform 2016-17 work plan.
	Use consumer feedback and develop participation processes to improve person and family centred care, health service practice and patient experiences.	To aim for an increase in the Net Promoter Scores achieved by Northern Health's acute services as provided through patient feedback.	***Achieved*** Uptake of the Net Promoter Scores across inpatient areas is increasing each month. Work continues with managers to increase and sustain Net Promoter Score completion rates.
	Develop an organisational policy for the provision of safe, high quality end of life care in acute and subacute settings, with clear guidance about the role of, and access to, specialist palliative care.	To develop and implement a strategy that enhances the delivery of specialist palliative care in response to the *VAGO 2015 Palliative Care Review* recommendations. A key deliverable in 2015-16 will be to review and enhance the referral process for patients moving into palliative care.	***In progress*** Patients have been admitted to Unit 3 under the Healthlinks Program from the community. Further work in promoting the alternate pathway with patients and families is required. Palliative Care beds at The Northern Hospital have been implemented with all medical teams referring to the Integrated Palliative Care team. Further work is required to ensure timely referrals and care change occurs. This work will continue in 2016-17 to embed into practice.
	Demonstrate an organisational commitment to quality cancer services through engagement with the local Integrated Cancer Service and implementation of Optimal Care Pathways.	To develop a comprehensive three year strategy for cancer services that includes early referral and integration with palliative care services.	***In progress*** Draft strategic plan in development and to be circulated to internal and select external key stakeholders imminently.
	Strengthen the response of health services to family violence. This includes implementing interventions, processes and systems to prevent, identify and respond appropriately to family violence at an individual and community level.	Review and update Northern Health policies and procedures relating to family violence. Development of education and training to front line staff to better identify and respond to patients disclosing family violence.	***In progress*** A multidisciplinary steering committee, including consumers and external expert stakeholders, has been established with approved terms of reference and commenced work on implementation of the Royal Melbourne Hospital Bendigo toolkit.

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
			In addition there is ongoing discussion regarding options for rollout of the the Royal Women's Hospital toolkit along with White Ribbon accreditation and costings have been obtained. At present this work has been divided amongst working groups, and it is planned that roll out of this program will be staggered with a focus on an initial rollout across Emergency, Women's and Children's and Aged Care by the end of 2016.
Governance, leadership and culture	Demonstrate an organisational commitment to occupational health and safety, including mental health and wellbeing in the workplace.	To deliver the *Safety First Plan* and the *Health and Wellbeing Plans* and associated programs of work.	***Achieved*** The Safety First KPI's have been developed and will be reviewed in three months. Three Safety First Executive Committee meetings have occurred. OH&S metrics and workers compensation report complete. Next Step: Review committee structure and health and safety rep staff.
	Ensure accessible and affordable support services are available for employees experiencing mental ill health.	To implement the new and enhanced Employee Assistance Program (EAP) that Northern Health designed in 2014-15.	***Achieved*** Positive feedback has been received re: the engagement of the new Employee Assistance Program provider.
	Work collaboratively with the Department of Health and Human Services and professional bodies to identify and address systemic issues of mental ill health amongst the medical professions.	To collaborate with the Chair of our Medical Group and the Department in the design and development of appropriate care models. This work will build on the strategies articulated in the *Safety First Plan*.	***Achieved*** The pilot project is complete. Feedback and findings have been included in the 2016-17 Safety First Plan.
	Monitor and publically report incidents of occupational violence.	To transparently monitor and report on incidents of occupational violence through the *Health and Wellbeing Balanced Scorecard*. Northern Health will ensure that appropriate reporting from the scorecard is publically available.	***Achieved*** The aggression management framework has been completed and tabled for Emeregency Management meeting in August, and the Executing meeting in September.

Domain	Action	Deliverable	Outcome
	Work collaboratively with the Department of Health and Human Services to develop systems to prevent the occurrence of occupational violence.	To incorporate the management of occupational violence in detailed policy guidelines that are being developed to support the *Safety First Plan.* Northern Health will work in collaboration with the Department using our partnerships framework to develop appropriate processes and systems to implement these policy guidelines.	***Achieved*** The Northern Health Aggression Management Framework is complete, pending a number of items being amended and presented for endorsement at the August Emergency Management Executive Committee. Aggression management training pilot iscomplete and being reviewed.
	Promote a positive workplace culture and implement strategies to prevent bullying and harassment in the workplace.	To deliver a bullying awareness education program as articulated in the *Safety First Plan.*	***Achieved*** VAGO requirements reviewed. Bullying and harassment placed on Northern Health Risk Register (Extreme risk rating). Northern Health OH&S Executive Committee and Board briefed.
	Monitor trends of complaints of bullying and harassment and identify and address organisational units exhibiting poor workplace culture and morale.	To transparently monitor and report on bullying and harassment issues and complaints through *Health and Wellbeing Balanced Scorecard.*	***In progress*** Monitoring for 12 month and complaints trends. Framework to be developed and implemented. - Communications complete. - Listed on risk register as extreme. - Board Presentation in September 2016.
		To implement a complaints KPI reporting framework at the program level in order to drive performance improvement at the unit level.	***Achieved*** Face to face training delivered to senior leadership staff. Bullying and harassment added to risk register as extreme and framework to be developed. VAGO requirements reviewed.
	Undertake an annual board assessment to identify and develop board capability to ensure all board members are well equipped to effectively discharge their responsibilities.	To implement the Northern Health *Board Charter* and *Corporate Governance Framework.*	***Achieved***

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
	Build workforce capability and sustainability by supporting formal and informal clinical education and training for staff and health students, in particular inter-professional learning.	To implement a capability framework that ensures appropriate clinical practice and leadership across Northern Health.	***Achieved*** Executives have position descriptions mapped to the Statement of Priorities. Responsibility for KPI's are included in budget and EFT performance reviews.
Safety and quality	Ensure management plans are in place to prevent, detect and contain Carbapenem Resistant Enterobacteriaceae as outlined in Hospital Circular 02/15 (issued 16 June 2015).	To implement all requirements in *EquipNational Standard 3 Preventing and Controlling Healthcare Associated Infections.* This will support delivery of this action.	***Achieved*** Point Prevalence Survey for Intensive Care and Unit M on 7 June 2016. No further positive CPE cases identified. Point Prevalence Survey as per requirements of Department of Health conducted on 7 June 2016. All results were negative.
	Implement effective antimicrobial stewardship practices and increase awareness of antimicrobial resistance, its implications and actions to combat it, through effective communication, education, and training.	To implement all requirements in *EquipNational Standard 3 Preventing and Controlling Healthcare Associated Infections.* This will support delivery of this action.	***In progress*** Since April of this year: • Continued antimicrobial stewardship rounds three times a week. • Continued to make progress on the development of Northern Health-specific antibiotic guides: o Completed rollout of the General Medicine Antibiotic Guides i.e. now available on PROMPT, GuidanceMS, abbreviated lanyard cards and in the HMO handbooks; education completed. o Finalised the General Surgery Antibiotic Guides. Now in the process of getting them onto PROMPT and lanyard card versions. Educations sessions have been scheduled for August. • Almost completed simplifying the restricted antibiotic indication lists in GuidanceMS to make it easier for prescribers to pick the correct indication and take less time to get an approval (estimated completion date is 31 July 2016). • Started contributing The Northern Hospital antimicrobial usage data to the National Antimicrobial Utilisation

Domain	Action	Deliverable	Outcome
			Surveillance Program (NAUSP). First report comparing our usage to national data to be presented at the July Standard 3 Clinical Improvement Committee meeting. • Working with the education unit to develop a fact sheet on GuidanceMS for interns and HMOs. Started preparing for Antibiotic Awareness Week (14-20 August) by booking display spaces at all campuses.
	Ensure that emergency response management plans are in place, regularly exercised and updated, including trigger activation and communication arrangements.	To complete all annual emergency compliance and operational staff training requirements.	***Achieved*** Emergency Management training is current at 75 per cent and improving toward the 95 per cent target.
		To complete the scheduled EMERGO training exercise and review and update all emergency response plans by October 2015.	***Achieved*** The review is complete and findings are now being implemented. A Cap 1 request for replacement of radios has been forwarded for approval, Level 3 guideline (staff reporting criminal acts) has been developed, and a business continuity plan is progressing. The Emergency Services Liaison Committee has been established (including Ambulance Victoria and Victoria Police reps). Code black and code purple responses updated.
		To review and enhance the current suite of Critical Incident Management policies, plans and procedures.	***Achieved***

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
Financial Sustainability	Improve cash management processes to ensure that financial obligations are met as they are due.	To fully implement Northern Health's *Cash Flow Forecasting and Cash Management Guidelines.*	***Achieved*** Northern Health developed and implemented a comprehensive suite of new policies and procedures for cash flow forecasting and cash management. This included the development of a five year Cash Strategy 2016-2021 to enable Northern Health to meet capital renewal and replacement needs, including provision for implementing an Electronic Medical Record. The Board approved this five year Cash Strategy which is now supporting sustainable asset renewal and innovation.
	Identify opportunities for efficiency and better value service delivery.	To implement a demand capacity forecasting management framework and tools that will enable Northern Health to achieve compliance with our bed plan, better match our rosters with activity and reduce variation in service delivery.	***Project Discontinued*** McKesson project discontinued due to non-support of business case. To be removed from SOP tasks. Northern Health is currently exploring another project to strengthen budget and demand forecasting (proposal submitted to Better Care Victoria Fund). 2016-17 budget build has been developed based on known peaks and troughs of activity.
		To reconfigure our workforce to improve patient care delivery.	***Achieved*** Nurse pool now at 65 EFT. Locum usage has decreased over 60 per cent in the last seven months. Nurse pool is predominantly being used currently to fill establishment deficits and personal leave. Pilot project has commenced to reduce personal leave for the top five cost centres with positive results for three cost centres to date. Established deficit project commenced in early July.

Domain	Action	Deliverable	Outcome
	Invest in revenue optimisation initiatives to ensure maximisation of revenue from both public and private sources.	To deliver the 2015-16 Financial Sustainability Plan and the private and commercial revenue generation initiatives within this.	***Achieved*** Northern Health has achieved a budgeted operating surplus. The sustainability initiatives have been achieved. The operating surplus for the year was $159,000 against a budgeted operating surplus of $5,000.
Access	Implement integrated care approaches across health and community support services to improve access and responses for disadvantaged Victorians.	To continue the rollout of the *Northern Health Partnerships Framework* that involves formalising partnerships with metropolitan and neighbouring health services and improving partnerships with primary care providers	***Achieved*** Northern Health continues to work in partnership through the Shared Vision for the North initiative, collaboration with the two PHNs and ongoing close collaboration with the regional and central offices of Department of Health and Human Services, North Western Mental Health Services and Kilmore and District Hospital. Northern Health continues to work with relevant agencies to address specific population needs (for example, Sexual and Reproductive Health, Mental health, etc.)
		Northern Health will utilise the *VicHealth Partnerships Analysis* tool to support the achievement of this deliverable.	***In progress*** The Vic Health tool has been utalised to assess partnership approaches in the Shared Vision for the North collaborative project, and Northern Health is working to implement an annual process to assess partnerships utilising this tool. 2016 analysis will be completed in the second quarter of the 2016-17 Financial Year and reported to the PC&PH Advisory Committee.
	Progress partnerships with other health services to ensure patients can access treatments as close to where they live when it is safe and effective to so, making the most efficient use of available resources across the system.	To fully imbed the Partnership Agreements developed in 2014-15 with the Royal Children's Hospital and Austin Health.	***In progress*** Royal Children's Hospital collaboration being established for: • Royal Children's Hospital ward transfer to The Northern Hospital wards (bypassing ED). Aim to begin in August 2016. • Royal Children's Hospital General Paediatric Outpatient clinics will stop accepting primary care referrals from Northern catchment area due to long waiting times for non-urgent appointments. A letter endorsing The Northern

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
			Hospital co-signed by heads of department from Royal Children's Hospital and Northern Health will be sent to GPs by September 2016. Austin Health partnership agreement for Paediatric surgery continues. The Northern Hospital now covers all elective paediatric and emergency surgery for the two hospitals.
		To continue to develop and strengthen partnerships with community-based health service providers, particularly with The Kilmore and District Hospital where 10 GEM service beds will be delivered.	***Achieved*** Further opportunities for improvement in this partnership have been identified, including improving local knowledge of services available in Kilmore, enhancing interdisciplinary model of care, strengthening local risk management. Meeting to commence implementation of improvement initiatives to occur in August 2016.
	Optimise system capacity by ensuring that allocated points of care are implemented as per the Travis Review recommendations.	To implement and optimise the additional nine cubicles in the Emergency Department provided for following the Travis Review.	***Achieved***
	Work collaboratively with Ambulance Victoria to achieve timely transfer of patients.	Northern Health recognises that the number of admissions in the Emergency Department leads to an increase in off-stretcher time for Ambulance Victoria.	***In progress*** The redesign project continues. The diagnostic phase has identified areas for improvement and strategies are being developed to address three key problems. Opening of the Observation Unit will assist in reducing congestion in the Emergency Department by reducing the number of admitted patients waiting for a bed in the Emergency Department and thereby reduce ambulance off-load times. Also, a revision of the Short Stay Unit model of care will also lead to more efficient flow from the Emergency Department – again leading to a reduction in the congestion and therefore ambulance off-load times. Post benchmarking with other agencies, Northern Health will implement an Ambulance Victoria surge nurse to expedite

Domain	Action	Deliverable	Outcome
			ambulance off-load – particularly in times of high-demand within the department.
		Northern Health and Ambulance Victoria have formalised a partnership agreement that has been developed in accordance with the Northern Health Partnerships Framework.	***Achieved*** Northern Health and Ambulance Victoria meet regularly to discuss performance and opportunities to improve performance, particularly off-stretcher time.
		As part of this agreement Northern Health will work with Ambulance Victoria to: (i) optimise SSU beds throughput with a focus on patient selection to enable two patients per bed per day; and (ii) implement an escalation process to address Ambulance Victoria off-stretcher times at 20 minutes on-site.	***In progress*** The Short Stay Unit has improved its throughput since the last update. Throughput is now at 40-45 patients per day. However, regular achievement of the 80 per cent NEAT target is not consistent. Therefore, the next piece of work will be a review and amendment of the Short Stay Unit model of care and the Short Stay Unit referral, admission and flow processes and increase accountability monitoring re: adherence to process. (ii) The ED Escalation plan has been reviewed and redrafted following the recent audit. This will be forwarded to the Access team for review. The lack of an organisation wide escalation process for access issues has been identified as a gap. The Access team is developing a draft of an organisation-wide access escalation plan.
	Reduce unplanned readmissions – with a focus on identifying high risk patients; delivering coordinated and integrated responses; and reducing the use of avoidable acute services, where practical and safe to do so.	To further develop and refine the Emergency Department streaming model that seeks to better tailor the nature of care provided to Emergency Department patients.	***In progress*** The Healthlinks project has commenced – with patient identification determined by DHHS. Initial patient recruitment commenced and extended care plan development commenced 1 July 2016.
		To optimise integration with community palliative care providers through the NorthWest Metropolitan Palliative Care Consortium.	***In progress*** The Victorian Palliative Care Clinical Network working group has met a number of times in the past eight months. Northern Health has a representative on this group. There is a 12 month timeframe to develop tools which will support patients and families to understand

Statement of Priorities (cont'd)

Domain	Action	Deliverable	Outcome
			what services are available and how to access them. This work will continue in 2016-17 as we wait the development of state wide resources.
		To consider Hospital in the Home (HITH) and Health Independence Program (HIP) platforms for appropriate patients to ensure appropriate home-based and follow-up care is in place to minimise risk of re-admission.	***Achieved*** Forty beds have commenced in HITH. Further growth is being explored as demand dictates. HITH have relocated to support and advanced model of care. GEM@Home flexes up two beds as required to assist with demand.
	Ensure that policies, procedures and service delivery models are in place to manage and monitor colonoscopy referrals and ensure timely access for patients with an urgent clinical need.	To introduce standardised practices across disciplines regarding the receipt and processing of clinical referral information to support more accurate patient categorisation.	***Achieved*** Conversion to WIES from MBS at Broadmeadows Health Service has been achieved. Theatre Bookings have been centralised at The Northern Hospital to standardise referral processes. The new service has been renamed the Elective Surgery Centre. The Head of Endoscopy has developed a new template for endoscopy referral that has gone to the Endoscopists for review and then implementation.

Performance Priorities

SAFETY AND QUALITY PERFORMANCE

Key Performance Indicator	Target	2015-16 actuals
Compliance with NSQHS Standards accreditation	Full compliance	Achieved
Compliance with the Commonwealth's Aged Care Accreditation Standards	Full compliance	Full compliance
Cleaning Standards - Overall compliance with standards	Full compliance	Full compliance
Cleaning Standards - Very high risk (Category A)	90 points	Achieved
Cleaning Standards - High risk (Category B)	85 points	Achieved
Cleaning Standards - Moderate risk (Category C)	85 points	Achieved
Compliance with the Hand Hygiene Australia program	80%	84.3%
Percentage of healthcare workers immunised for influenza	75%	75.8%

PATIENT EXPERIENCE AND OUTCOMES PERFORMANCE

Key Performance Indicator	Target	2015-16 actuals
Victorian Healthcare Experience Survey - data submission	Full compliance	Achieved
Victorian Healthcare Experience Survey – patient experience Quarter 1	95% positive experience	89.9%
Victorian Healthcare Experience Survey – patient experience Quarter 2	95% positive experience	93.5%
Victorian Healthcare Experience Survey – patient experience Quarter 3	95% positive experience	84.9%
Number of patients with surgical site infection	No outliers	Achieved
ICU central line-associated blood stream infection	No outliers	Achieved
SAB rate per occupied bed days[1]	< 2/10,000	< 0.4/10,000
Maternity – Percentage of women with prearranged postnatal home care	Full compliance	Full compliance

GOVERNANCE, LEADERSHIP AND CULTURE PERFORMANCE

Key Performance Indicator	Target	2015-16 actuals
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	83%

Performance Priorities (cont'd)

FINANCIAL SUSTAINABILITY PERFORMANCE

Key Performance Indicator	Target	2015-16 actuals
Finance		
Operating result	0.00	0.2
Trade creditors	< 60 days	54
Patient fee debtors	< 60 days	52
Public & private WIES[2] performance to target	100%	100.3%
Asset management		
Asset management plan	Full compliance	Achieved
Adjusted current asset ratio	0.7	0.4
Days of available cash	14 days	5

ACCESS PERFORMANCE

Key Performance Indicator	Target	2015-16 actuals
Emergency care		
Percentage of ambulance patients transferred within 40 minutes	90%	78%
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended times	80%	76%
Percentage of emergency patients with a length of stay less than four hours	81%	59%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	0
Elective surgery		
Percentage of elective patients removed within clinically recommended timeframes	94%	74%
Percentage of Urgency Category 1 elective patients removed within 30 days	100%	100%
10% longest waiting Category 2 and 3 removals from the elective surgery waiting list	100%	100%
Number of patients on the elective surgery waiting list[3]	2,990	2,562
Number of hospital initiated postponements per 100 scheduled admissions	≤8 /100	5.4
Number of patients admitted from the elective surgery waiting list – annual total	8,060	7,856
Critical care		
Adult ICU number of days below the agreed minimum operating capacity[4]	0	24

[1]SAB is staphylococcus aureus bacteraemia
[2]WIES is a Weighted Inlier Equivalent Separation.
[3]The target shown is the number of patients on the elective surgery waiting list as at 30 June 2016.
[4]The agreed minimum operating capacity is 7 ICU equivalents.

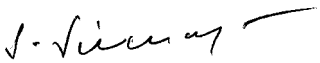
Activity and Funding

Funding type	2015-16 Activity achievement
Acute Admitted	
WIES Public	44,370
WIES Private	4,986
WIES (Public and Private)	49,356
WIES DVA	330
WIES TAC	248
WIES TOTAL	49,934
Acute Non-Admitted	
Emergency services	85,015
Specialist clinics - DVA	56
Specialist clinics – Non DVA	201,621
Renal Dialysis - Home ABF	317
Subacute and Non-Acute Admitted	
Rehab Public	20,334
Rehab Private	3,126
Rehab DVA	381
GEM Public	28,306
GEM Private	5,484
GEM DVA	826
Palliative Care Public	7,243
Palliative Care Private	1,980
Palliative Care DVA	244
Transition Care - Bed days	8,519
Transition Care - Home day	15,012
Subacute Non-Admitted	N/A
Health Independence Program	93,662
Aged Care	
Aged Care Assessment Service	3,589
Residential Aged Care	10,879
HACC	49,989

Activity and Funding (cont'd)

Attestation on Data Integrity

I, Siva Sivarajah, Northern Health Chief Executive Officer, certify that Northern Health has put in place appropriate internal controls and processes to ensure that reported data reasonably reflects actual performance. Northern Health has critically reviewed these controls and processes during the year.



Siva Sivarajah
Chief Executive Officer
Northern Health
25/08/2016

Corporate Information

GENERAL INFORMATION

Northern Health was established in July 2000 under the *Health Services (Governance and Accountability) Act 2004* and under the auspices of the Minister for Health.

It provides a wide range of health care services to a primary and secondary catchment of over 555,000 people living in Melbourne's middle to outer northern suburbs and the semi-rural regions beyond the urban fringe.

Northern Health comprises:

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

CONSULTANCIES

Consultancy fees greater than $10,000 in individual amount.

In 2015-16 Northern Health engaged five consultancies with an individual amount greater than $10,000. This is detailed below.

Consultant	Purpose of consultancy	Period	Total project fee	Consulting	Commitments
MIDNIGHTSKY	Finalisation of communications strategy.	July 2015	$50,000	$50,000	-
ERNST and YOUNG	Financial analysis and financial recovery planning.	August 2015 to January 2016	$119,564	$119,564	-
KPMG	Finalisation of ICT funding business case to DHHS.	July 2015	$34,543	$34,543	-
ENTERPRISE KNOWLEDGE	Assessment of corporate record keeping against Public Record Office Victorian Standards.	April 2016 to July 2016	$21,600	$21,600	-
LA TROBE UNIVERSITY	Evaluation of Shared Vision For the North strategy.	July 2015 to December 2015	$25,000	$25,000	-
				$250,707	

Consultancies less than $10,000 in individual amount

In 2015-16 Northern Health engaged six consultancies where the total fees payable to the consultants was less than $10,000. The total value of these consultancies was $20,270 (excluding GST).

Corporate Information (cont'd)

OCCUPATIONAL HEALTH AND SAFETY CLAIMS

- 2015-16: 34
- 2014-15: 30
- 2013-14: 31
- 2012-13: 21
- 2011-12: 25
- 2010-11: 26
- 2009-10: 16

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

OCCUPATIONAL VIOLENCE STATISTICS

- Workcover accepted claims with an occupational violence cause per 100 FTE 0.012
- Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked. 0.72
- Number of occupational violence incidents reported 441
- Number of occupational violence incidents reported per 100 FTE 1.69
- Percentage of occupational violence incidents resulting in a staff injury, illness or condition 14%

Definitions

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

- Occupational violence - any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.
- Incident - occupational health and safety incidents reported in the health service incident reporting system. Code Grey reporting is not included.
- Accepted Workcover claims – Accepted Workcover claims that were lodged in 2015-16.
- Lost time – is defined as greater than one day.

BUILDING ACT 1993

During the financial year, it has been Northern Health's practice to obtain building permits for new projects, and Certificates of Occupancy or Certificates of Final Inspection for all completed projects.

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

Completed and operational as at 30 June 2016:

- Stage 1 - Northern Health Acute Inpatient Unit Tower Block project
- NCHER Level 3 East Centre of Learning fit-out

Current projects in design phase:

- Broadmeadows Health Service Surgery Centre Redevelopment project

NATIONAL COMPETITION POLICY

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

- Patient transport
- Waste management
- Car parking
- Fleet management
- Supply
- Medical imaging/radiology
- Pathology
- Food service
- Biomedical engineering
- Cleaning services
- Laundry
- Security
- Retail services
- Financial services
- Information and communications technology
- Clinical services
- Building and engineering services
- Community services
- Electricity
- Gas supply
- Telecommunications
- Pharmaceutical products.

Market testing of services will continue as scheduled, and according to the contract cycle, into the 2016-17 financial year.

FREEDOM OF INFORMATION

937 Freedom of Information applications were received by Northern Health during the 2015-16 financial year.

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

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

The applications were processed as follows:

- 937 applications received
- 813 granted in full
- 56 granted in part
- 7 denied
- 8 withdrawn
- 24 not finalised
- 29 no document (patient did not attend organisation for requested dates).

OTHER INFORMATION

Additional Information available on request

Details in respect of the items listed below have been retained by Northern Health and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

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

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

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

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

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

(f) Details of major research and development activities undertaken by the Health Service that are not otherwise covered either in the Report of Operations or in a document that contains the financial statements and Report of Operations;

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

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

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

(j) General statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the Report of Operations;

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

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

VICTORIAN INDUSTRY PARTICIPATION POLICY

Northern Health complies with the intent of the *Victorian Industry Participation Policy (VIPP) Act (Vic) 2003* which is to encourage, where possible, local industry participation in the supply of goods and services to government agencies.

MERIT AND EQUITY PRINCIPLES

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

CARERS AND CARE RELATIONSHIPS

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

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

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

PROTECTED DISCLOSURE ACT 2012

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

CAR PARKING FEES

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

INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) EXPENDITURE

The total expenditure during 2015-16 is $7.73m (excluding GST) with the details shown below.

Business As Usual (BAU) ICT Expenditure ($000)* (excluding GST)	Non-BAU ICT Expenditure ($000)	Operational Expenditure ($000)	Capital Expenditure ($000)
$7,440	288	284	4

Corporate Information (cont'd)

WORKFORCE INFORMATION

The full time equivalent (FTE) head count for Northern Health as at 30 June 2015 and 30 June 2016 is provided below.

Labour category	June Current Month FTE*		June YTD FTE*		June Headcount	
	2015	***2016***	***2015***	***2016***	***2015***	***2016***
Grand Total	2,595	2,699	2,525	2,609	3,521	3,715
Nursing Services	1,219	1,283	1,175	1,219	1,701	1,811
Administration and Clerical	447	425	416	425	588	571
Medical Support Services	159	163	163	161	195	204
Hotel and Allied Services	137	132	138	132	178	176
Medical Officers	55	61	54	57	62	69
Hospital Medical Officers	241	285	244	268	267	303
Sessional Medical Officers	66	73	62	68	189	215
Ancillary Support Services	270	278	273	278	341	366

FINANCIAL RESULTS

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

Report of Operations Disclosure	2016 000's	2015* 000's	2014* 000's	2013* 000's	2012 000's
Total Revenue	457,196	397,861	393,122	363,790	339,355
Total Expenses	452,870	416,471	385,295	356,132	350,855
Net Result (Including Capital and Specific Items)	4,326	(18,610)	7,827	7,658	(11,500)
Accumulated Deficits	(53,093)	(57,419)	(41,511)	(48,909)	(51,268)
Total Assets	433,050	417,273	430,567	317,437	310,404
Total Liabilities	119,831	108,379	103,062	88,709	89,335
Net Assets	313,219	308,894	327,505	228,728	221,069
Total Equity	**313,219**	**308,894**	**327,505**	**228,728**	**221,069**

* The comparative figures for 2013-2015 have been restated to take account of a change in accounting treatment adopted in 2016 for two service agreements extending into February 2013 and February 2016 respectively.

Disclosure Information

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

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

MINISTERIAL DIRECTIONS

REPORT OF OPERATIONS

Legislation	Requirement	Page Ref
CHARTER AND PURPOSE		
FRD 22G	Manner of establishment and the relevant Ministers	A43
FRD 22G	Purpose, functions, powers and duties	A9-12
FRD 22G	Initiatives and key achievements	A21-34
FRD 22G	Nature and range of services provided	A16-20
MANAGEMENT AND STRUCTURE		
FRD 22G	Organisational structure	A15
FINANCIAL AND OTHER INFORMATION		
FRD 10A	Disclosure index	A48-49
FRD 11A	Disclosure of ex gratia expenses	F59
FRD 21B	Responsible person and executive officer disclosures	A5and F1
FRD 22G	Application and operation of *Protected Disclosure 2012*	A45
FRD 22G	Application and operation of *Carers Recognition Act 2012*	A45
FRD 22G	Application and operation of *Freedom of Information Act 1982*	A44
FRD 22G	Compliance with building and maintenance provisions of *Building Act 1993*	A44
FRD 22G	Details of consultancies over $10,000	A43
FRD 22G	Details of consultancies under $10,000	A43
FRD 22G	Employment and conduct principles	A21-22 and A27
FRD 22G	Major changes or factors affecting performance	A5
FRD 22G	Occupational health and safety	A44
FRD 22G	Operational and budgetary objectives and performance against objectives	A29-38
FRD 24C	Reporting of office-based environmental impacts	A21
FRD 22G	Significant changes in financial position during the year	A46
FRD 22G	Statement on National Competition Policy	A44
FRD 22G	Subsequent events	F59
FRD 22G	Summary of the financial results for the year	A40 and A46
FRD 22G	Workforce Data Disclosures including a statement on the application of employment and conduct principles	A46
FRD 25B	Victorian Industry Participation Policy disclosures	A45
FRD 29A	Workforce Data disclosures	A27 and A46

Legislation	Requirement	Page Ref
SD 4.2(g)	Specific information requirements	A16
SD 4.2(j)	Sign-off requirements	A5
SD 3.4.13	Attestation on data integrity	A42
SD 4.5.5	Ministerial Standing Direction 4.5.5 compliance attestation	A28

FINANCIAL STATEMENTS

Financial statements required under Part 7 of the FMA

SD 4.2(a)	Statement of changes in equity	F4
SD 4.2(b)	Comprehensive operating statement	F2
SD 4.2(b)	Balance sheet	F3
SD 4.2(b)	Cash flow statement	F5

OTHER REQUIREMENTS UNDER STANDING DIRECTIONS 4.2

SD 4.2(a)	Compliance with Australian accounting standards and other authoritative pronouncements	F6
SD 4.2(c)	Accountable officer's declaration	F1
SD 4.2(c)	Compliance with Ministerial Directions	F6
SD 4.2(d)	Rounding of amounts	F9

LEGISLATION

Freedom of Information Act 1982	A44
Protected Disclosure Act 2012	A45
Carers Recognition Act 2012	A45
Victorian Industry Participation Policy Act 2003	A45
Building Act 1993	A44
Financial Management Act 1994	A5

Northern Health

Financial Statements
and Accompanying Notes

For the Year Ended
30 June 2016

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

We certify that the attached financial report for Northern Health, including controlled entities, has been prepared in accordance with Standing Direction 4.2 of the *Financial Management Act* 1994, applicable *Financial Reporting Directions*, Australian Accounting Standards, Australian Accounting Interpretations and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out for the Northern Health Comprehensive Operating Statement, the Balance Sheet, Statement of Changes in Equity, Cash Flow Statement and notes forming part of the financial report, presents fairly the financial transactions during the year ended 30 June 2016 and financial position of Northern Health at 30 June 2016.

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

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

Ms Jennifer Williams
Board Chair

Northern Health
17th August 2016

Mr Siva Sivarajah
Chief Executive Officer

Northern Health
17 August 2016

Mr Basil Ireland
Chief Financial Officer

Northern Health
17 August 2016

Northern Health
Comprehensive Operating Statement
For the Year Ended 30 June 2016

	Note	Parent Entity 2016 $'000	Parent Entity 2015 $'000	Consol'd 2016 $'000	Consol'd 2015 $'000
Revenue from Operating Activities	2	421,210	377,770	421,189	377,669
Revenue from Non-Operating Activities	2	7,145	6,239	8,054	6,987
Employee Expenses	3	(297,876)	(272,752)	(298,089)	(272,753)
Non Salary Labour Costs	3	(9,662)	(10,633)	(9,662)	(10,633)
Supplies and Consumables	3	(78,206)	(67,005)	(78,206)	(67,007)
Other Expenses	3	(42,455)	(42,503)	(42,750)	(42,950)
Net Result Before Capital and Specific Items		**156**	**(8,884)**	**536**	**(8,687)**
Capital Purpose Income	2	28,239	16,413	27,940	13,148
Depreciation and Amortisation	4	(22,925)	(22,032)	(22,925)	(22,032)
Finance Costs	5	(27)	(17)	(27)	(17)
Capital Purpose Expenditure	3	(311)	(1,079)	(312)	(1,079)
Specific Expenses	3b	(803)	-	(803)	-
Net Result after Capital and Specific items		**4,329**	**(15,599)**	**4,409**	**(18,667)**
Net Gain/(Loss) on Non-financial Assets	2a	(84)	55	(84)	55
Total Other Economic Flows Included in Net Result		**(84)**	**55**	**(84)**	**55**
NET RESULT FOR THE YEAR		**4,245**	**(15,544)**	**4,325**	**(18,611)**
COMPREHENSIVE RESULT		**4,245**	**(15,544)**	**4,325**	**(18,611)**

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

Northern Health
Balance Sheet
As at 30 June 2016

	Note	Parent Entity 2016 $'000	Parent Entity 2015 $'000	Consol'd 2016 $'000	Consol'd 2015 $'000
Current Assets					
Cash and Cash Equivalents	6	18,988	7,443	19,660	8,061
Receivables	7	9,473	8,847	9,473	8,850
Inventories	8	2,373	1,950	2,373	1,950
Prepayments and Other Assets	9	1,465	872	1,465	872
Total Current Assets		**32,299**	**19,112**	**32,971**	**19,733**
Non-Current Assets					
Receivables	7	7,417	5,008	7,417	5,008
Property, Plant and Equipment	10	392,286	391,927	392,286	391,927
Intangible Assets	11	376	605	376	605
Total Non-Current Assets		**400,079**	**397,540**	**400,079**	**397,540**
TOTAL ASSETS		**432,378**	**416,652**	**433,050**	**417,273**
Current Liabilities					
Payables	12	25,643	26,439	25,771	26,595
Borrowings	13	281	283	281	283
Provisions	14	66,932	55,282	66,932	55,282
Other Current Liabilities	16	1,748	937	1,748	937
Total Current Liabilities		**94,604**	**82,941**	**94,732**	**83,097**
Non-Current Liabilities					
Provisions	14	10,368	9,358	10,368	9,358
Borrowings	13	181	487	181	487
Other Non-Current Liabilities	16	14,552	15,438	14,552	15,438
Total Non-Current Liabilities		**25,101**	**25,283**	**25,101**	**25,283**
TOTAL LIABILITIES		**119,705**	**108,224**	**119,833**	**108,380**
NET ASSETS		**312,673**	**308,428**	**313,217**	**308,893**
EQUITY					
Property, Plant and Equipment Revaluation Surplus	17a	200,146	200,146	200,146	200,146
Restricted Specific Purpose Surplus	17a	243	329	4,941	4,532
Capital Projects Reserve Surplus	17a	-	-	-	-
Contributed Capital	17b	161,634	161,634	161,634	161,634
Accumulated Deficits	17c	(49,350)	(53,682)	(53,504)	(57,420)
TOTAL EQUITY		**312,673**	**308,427**	**313,217**	**308,893**
Commitments	20				
Contingent Assets and Contingent Liabilities	21				

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

Northern Health
Statement of Changes in Equity
For the Year Ended 30 June 2016

Consolidated	**Note**	**Property Plant and Equipment Revaluation Surplus**	**Restricted Specific Purpose Surplus**	**Capital Projects Reserve Surplus**	**Contributions by Owners**	**Accumulated Surplus/ (Deficits)**	**Total**
		$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Restated Balance at 1 July 2014	17	200,146	3,935	3,300	161,634	(41,512)	**327,503**
Net result for the year restated	17c	-	-	-	-	(18,611)	**(18,611)**
Other comprehensive income for the year	17a	-	-	-	-	-	**-**
Transfers to accumulated surplus/ (deficit)	17a,c		597	(3,300)		2,703	**-**
Restated Balance at 1 July 2015		**200,146**	**4,532**	**-**	**161,634**	**(57,420)**	**308,893**
Net result for the year	17c	-	-	-	-	4,325	**4,325**
Other comprehensive income for the year	17a	-	-	-	-	-	**-**
Transfers to accumulated surplus/ (deficit)	17a,c	-	409	-	-	(409)	**-**
		-	**409**	**-**	**-**	**3,916**	**4,325**
Balance at 30 June 2016		**200,146**	**4,941**	**-**	**161,634**	**(53,504)**	**313,217**

Parent	**Note**	**Property Plant and Equipment Revaluation Surplus**	**Restricted Specific Purpose Surplus**	**Capital Projects Reserve Surplus**	**Contributions by Owners**	**Accumulated Surplus/ (Deficits)**	**Total**
		$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Restated Balance at 1 July 2014	17	200,146	250	3,300	161,634	(41,359)	**323,971**
Net result for the year restated	17c	-	-	-	-	(15,544)	**(15,544)**
Other comprehensive income for the year	17a	-	-	-	-	-	**-**
Transfers to accumulated surplus/ (deficit)	17a,c	-	79	(3,300)	-	3,221	**-**
Restated Balance 30 June 2015		**200,146**	**329**	**-**	**161,634**	**(53,682)**	**308,427**
Net result for the year	17c	-	-	-	-	4,246	**4,246**
Other comprehensive income for the year	17a	-	-	-	-	-	**-**
Transfers to accumulated surplus/ (deficit)	17a,c	-	(86)	-	-	86	**-**
		-	**(86)**	**-**	**-**	**4,332**	**4,246**
Balance at 30 June 2016		**200,146**	**243**	**-**	**161,634**	**(49,350)**	**312,673**

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

Northern Health
Cash Flow Statement
For the Year Ended 30 June 2016

	Note	Parent Entity 2016 $'000	Parent Entity 2015 $'000	Consol'd 2016 $'000	Consol'd 2015 $'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating Grants from Government		382,427	348,514	382,427	348,511
Capital Grants from Government		29,379	11,540	29,379	11,540
Patient and Resident Fees Received		16,792	15,172	16,792	15,172
Private Practice Fees Received		3,597	2,437	3,597	2,437
Donations and Bequests Received		-	495	744	781
GST Received from/(paid to) ATO		9,548	8,657	9,551	8,606
Recoupment from private practice for use of hospital facilities		2,375	2,363	2,377	2,363
Interest Received		902	867	918	933
Other capital receipts		-	3,000	-	-
Other Receipts		15,649	15,664	15,837	16,100
Total Receipts		**460,669**	**408,709**	**461,622**	**406,443**
Employee Expenses Paid		(282,937)	(268,898)	(283,150)	(268,897)
Non Salary Labour Costs		(9,662)	(10,483)	(9,662)	(10,483)
Payments for Supplies and Consumables		(82,384)	(74,591)	(82,427)	(74,588)
Finance Costs		(27)	(17)	(27)	(17)
Other Payments		(50,681)	(45,971)	(51,324)	(46,373)
Total Payments		**(425,691)**	**(399,960)**	**(426,590)**	**(400,358)**
NET CASH INFLOW FROM OPERATING ACTIVITIES	18	**34,978**	**8,749**	**35,032**	**6,085**
CASH FLOWS FROM INVESTING ACTIVITIES					
Payments for Non-Financial Assets		(23,138)	(20,691)	(23,138)	(20,691)
Proceeds from sale of Non-Financial Assets		14	56	14	56
NET CASH OUTFLOW FROM INVESTING ACTIVITIES		**(23,124)**	**(20,635)**	**(23,124)**	**(20,635)**
CASH FLOWS FROM FINANCING ACTIVITIES					
Repayment of Borrowings		(310)	(145)	(310)	(145)
NET CASH OUTFLOW FROM FINANCING ACTIVITIES		**(310)**	**(145)**	**(310)**	**(145)**
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS HELD		**11,544**	**(12,031)**	**11,598**	**(14,695)**
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		**7,437**	**19,468**	**8,055**	**22,750**
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR (Excludes Patients Money Held In Trust)	6	**18,981**	**7,437**	**19,653**	**8,055**

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 Northern Health for the period ending 30 June 2016. The purpose of the report is to provide users with information about Northern Health's stewardship of the resources entrusted to it.

(a) Statement of compliance

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

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

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

The annual financial statements were authorised for issue by the Board of Northern Health on 17th August 2016.

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

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

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

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

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

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

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

- the fair value of land, buildings, infrastructure, plant and equipment (refer to Note 1(j));
- superannuation expense (refer to Note 1(g)); 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(k)).

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

Note 1: Summary of Significant Accounting Policies

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

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

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

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

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

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

(c) Reporting entity

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

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

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

Objectives and funding

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

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

(d) Principles of consolidation

In accordance with AASB 10 Consolidated Financial Statements:

- the consolidated financial statements of Northern Health incorporate the assets and liabilities of all entities controlled by Northern Health as at 30 June 2016, and their income and expenses for that part of the reporting period in which control existed; and
- the consolidated financial statements exclude bodies of Northern Health that are not controlled by Northern Health and therefore are not consolidated.
- control exists when Northern Health has the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable are taken into account. The consolidated financial statements include the audited financial statements of the controlled entities listed in Note 27.

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

Bodies consolidated into the Northern Health reporting entity are

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

Intersegment Transactions

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

(e) Scope and presentation of financial statements

Fund Accounting

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

Note 1: Summary of Significant Accounting Policies

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

Residential Aged Care Service

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

Comprehensive operating statement

The comprehensive operating statement includes the subtotal entitled 'Net Result Before Capital & Specific items' to enhance the understanding of the financial performance of Northern Health. This subtotal reports the result excludes items outside of day-today operating activities such as capital grants, assets received or provided free of charge, depreciation, expenditure using capital purpose income and items of an unusual nature and 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 Northern Health, DHHS and the Victorian Government to measure the ongoing operating performance of Health Services.

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

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

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

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

Balance sheet

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

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

Statement of changes in equity

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

Note 1: Summary of Significant Accounting Policies

Cash flow statement

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

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

Rounding

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

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

Comparative Information

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

(f) 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 Northern Health and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.

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

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

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

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

Indirect Contributions from the DHHS

Insurance is recognised as revenue following advice from the DHHS.

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.

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 car parking and retail activities are 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.

Note 1: Summary of Significant Accounting Policies

Interest Revenue

Interest revenue is recognised as it is received.

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.

(g) Expense recognition

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

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 Northern Health to the superannuation plans in respect of the services of current staff during the reporting period. Superannuation contributions are made to the plans based on the relevant rules of each plan, and are based upon actuarial advice.

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

The name and details of the major employee superannuation funds and contributions made by Northern Health are disclosed in Note 15: 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 DHHS. Assets with a cost in excess of $1,000 are capitalised. Depreciation on depreciable assets is provided so as to allocate their cost or valuation over their estimated useful lives.

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

Note 1: Summary of Significant Accounting Policies

	2016	2015
Buildings		
Structure Shell Building Fabric	5 - 53 Years	5 - 53 Years
Site Engineering Services and Central Plant	17 - 33 Years	17 - 33 Years
Central Plant		
Fit Out	2 - 18 Years	2 - 18 Years
Trunk Reticulated Building Systems	7 - 23 Years	7 - 23 Years
Medical Equipment	7 - 10 Years	7 - 10 Years
Computers and Communication	3 Years	3 Years
Furniture and Fittings	10 Years	10 Years
Motor Vehicles	4 Years	4 Years
Non-Medical Equipment	3 - 10 Years	3 - 10 Years

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

Amortisation

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

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

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

Northern Health tests all intangible assets with indefinite useful lives for impairment by comparing the recoverable amount for each asset with its carrying amount:

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

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

Intangible assets with finite useful lives are amortised over 3 years (2015: 3 years).

Finance costs

Finance costs are recognised as expenses in the period in which they are incurred.
Finance costs for Northern Health include:

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

Grants and other transfers

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

Other operating expenses

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

Supplies and consumables

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

Note 1: Summary of Significant Accounting Policies

Bad and doubtful debts

Refer to Note 1 (j) 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.

(h) Other economic flows included in net result

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

Net gain/ (loss) on non-financial assets

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

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

  Refer to Note 1(j) 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 (j)); and
- disposals of financial assets and derecognition of financial liabilities.

Amortisation of non-produced intangible assets

Intangible non-produced assets with finite lives are amortised as an 'other economic flow' on a systematic basis over the asset's useful life. Amortisation begins when the asset is available for use, that is when it is in the location and condition necessary for it to be capable of operating in the manner intended by management.

Impairment of non-financial assets

Goodwill and intangible assets with indefinite useful lives (and intangible assets not available for use) are tested annually for impairment and whenever there is an indication that the asset may be impaired. Refer to Note 1 (j) Assets.

Revaluations of financial instrument at fair value

Refer to Note 1 (i) Financial instruments.

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:

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

(i) Financial instruments

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

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

The following refers to financial instruments unless otherwise stated.

Note 1: Summary of Significant Accounting Policies

Loans and receivables

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

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

Financial liabilities at amortised cost

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

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

(j) 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.

Receivables

Receivables consist of:

- contractual receivables, which includes mainly debtors in relation to goods and services, accrued investment income, 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.

Northern Health 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.

Northern Health 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.

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

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

Note 1: Summary of Significant Accounting Policies

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 loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government are transferred at their carrying amount.

More details about the valuation techniques and inputs used in determining the fair value of non-financial physical assets are discussed in Note 10 Property, plant and equipment.

Crown land is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the asset(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.

Cultural Assets (Artworks) are recognised initially at cost and subsequently measured at fair value less impairment.

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, Northern Health's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Intangible assets

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

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

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

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

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(h) – Other economic flows included in net results

Impairment of non-financial assets

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

All other non-financial assets are assessed annually for indications of impairment.

Note 1: Summary of Significant Accounting Policies

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 of disposal.

Impairment of financial assets

At the end of each reporting period Northern Health assesses whether there is objective evidence that a financial asset or group of financial 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.

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

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

(k) Liabilities

Payables

Payables consist of:

- contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to Northern Health prior to the end of the financial year that are unpaid, and arise when Northern Health becomes obliged to make future payments in respect of the purchase of those goods and services. The normal credit terms for accounts payable are usually Net 45 days.
- statutory payables, such as goods and services tax and fringe benefits tax payables.

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

Borrowings

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs (refer also to Note 1(l) 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 Northern Health has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

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

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

Note 1: Summary of Significant Accounting Policies

Employee benefits

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

Wages and salaries, annual leave and accrued days off

Liabilities for wages and salaries, annual leave and accrued days off are all recognised in the provision for employee benefits as 'current liabilities', because the health service does not have an unconditional right to defer settlements of these liabilities.

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

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

Long service leave (LSL)

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

Unconditional LSL is disclosed in the notes to the financial statements as a current liability, even where Northern Health does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months.

The components of this current LSL liability are measured at:

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

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

Any gain or loss followed revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in 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.
Northern Health recognises termination benefits when it is demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

On-costs related to employee expense

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

Superannuation liabilities

Northern Health does not recognise any unfunded defined benefit liability in respect of the superannuation plans because the entity has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance administers and discloses the State's defined benefit liabilities in its financial report.

(l) 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 lessor

Northern Health does not hold any finance lease arrangements with other parties.

Operating leases

Entity as lessor

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

Note 1: Summary of Significant Accounting Policies

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 given to the lessee, the aggregate cost of incentives are recognised as a reduction of rental income over the lease term, on a straight-line basis unless another systematic basis is more appropriate of the time pattern over which the economic benefit of the leased asset is diminished.

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.

Leasehold Improvements

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

(m) 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 and 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 Northern Health has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

(n) Commitments

Commitments for future expenditure include operating and capital commitments arising from contracts are not recognised in the balance sheet. These commitments are disclosed by way of a note (refer to Note 20) 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.

(o) Contingent assets and contingent liabilities

Contingent assets and contingent liabilities are not recognised in the balance sheet, but are disclosed by way of note (refer to Note 21) and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

Note 1: Summary of Significant Accounting Policies

(p) 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.

In terms of cash flow the GST components of cash flows arising from 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.

(q) Foreign currency

All foreign currency transactions during the financial year are brought to account using the exchange rate in effect at the date of the transaction. Foreign monetary items existing at the end of the reporting period are translated at the closing rate at the date of the end of the reporting period.

(r) Events after the reporting period

Assets, liabilities, income or expenses arise from past transactions or other past events. Where the transactions result from an agreement between Northern Health and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reporting period.

Adjustments are made to amounts recognised in the financial statements for events which occur between the end of the reporting period and the date when the financial statements are authorised for issue, where those events provide information about conditions which existed at the reporting date. Note disclosure is made about events between the end of the reporting period and the date the financial statements are authorised for issue where the events relate to conditions which arose after the end of the reporting period that are considered to be of material interest.

Note 1: Summary of Significant Accounting Policies

(s) AASs issued that are not yet effective

Certain new Australian Accounting Standards (AASs) have been published that are not mandatory for the 30 June 2016 reporting period. The Department of Treasury and Finance assesses the impact of all these new standards and advises Health Services including Northern Health of their applicability and early adoption where applicable.

As at 30 June 2016 the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Northern Health has not adopted these standards in the preparation of the 2015/16 Financial Accounts.

Standard/Interpretation	Summary	Applicable for annual reporting periods beginning on	Impact on public sector entity financial statements
AASB 9 Financial Instruments	The key changes include the simplified requirements for the classification and measurement of financial assets, a new hedging accounting model and a revised impairment loss model to recognise impairment losses earlier, as opposed to the current approach that recognises impairment only when incurred.	1-Jan-18	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. While the preliminary assessment has not identified any material impact arising from AASB 9, it will continue to be monitored and assessed.
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)	The requirements for classifying and measuring financial liabilities were added to AASB 9. The existing requirements for the classification of financial liabilities and the ability to use the fair value option have been retained. However, where the fair value option is used for financial liabilities the change in fair value is accounted for as follows: · The change in fair value attributable to changes in credit risk is presented in other comprehensive income (OCI); and · Other fair value changes are presented in profit and loss. If this approach creates or enlarges an accounting mismatch in the profit or loss, the effect of the changes in credit risk are also presented in profit or loss.	1-Jan-18	The assessment has identified that the amendments are likely to result in earlier recognition of impairment losses and at more regular intervals. Changes in own credit risk in respect of liabilities designated at fair value through profit and loss will now be presented within other comprehensive income (OCI). For entities with significant lending activities, an overhaul of related systems and processes may be needed.
AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15	Amends the measurement of trade receivables and the recognition of dividends. Trade receivables, that do not have a significant financing component, are to be measured at their transaction price, at initial recognition. Dividends are recognised in the profit and loss only when: · the entity's right to receive payment of the dividend is established; · it is probable that the economic benefits associated with the dividend will flow to the entity; and · the amount can be measured reliably.	1 Jan 2017, except amendments to AASB 9 (Dec 2009) and AASB 9 (Dec 2010) apply from 1 Jan 2018	The assessment has indicated that there will be no significant impact for the public sector.

Note 1: Summary of Significant Accounting Policies

AASB 2015-8 *Amendments to Australian Accounting Standards – Effective Date of AASB 15*	This Standard defers the mandatory effective date of AASB 15 from 1 January 2017 to 1 January 2018.	1-Jan-18	This amending standard will defer the application period of AASB 15 to the 2018-19 reporting period in accordance with the transition requirements.
AASB 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	This Standard amends AASB 15 to clarify the requirements on identifying performance obligations, principal versus agent considerations and the timing of recognising revenue from granting a licence. The amendments require: · A promise to transfer to a customer a good or service that is 'distinct' to be recognised as a separate performance obligation; · For items purchased online, the entity is a principal if it obtains control of the good or service prior to transferring to the customer; and · For licences identified as being distinct from other goods or services in a contract, entities need to determine whether the licence transfers to the customer over time (right to use) or at a point in time (right to access).	1-Jan-18	The assessment has indicated that there will be no significant impact for the public sector, other than the impact identified in AASB 15.
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are current not recognised) on balance sheet.	1-Jan-19	The assessment has indicated that as most operating leases will come on balance sheet, recognition of lease assets and lease liabilities will cause net debt to increase. Depreciation of lease assets and interest on lease liabilities will be recognised in the income statement with marginal impact on the operating surplus. The amounts of cash paid for the principal portion of the lease liability will be presented within financing activities and the amounts paid for the interest portion will be presented within operating activities No change for lessors.
AASB 2014-10 Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture [AASB 10 & AASB 128]	AASB 2014-10 amends *AASB 10 Consolidated Financial Statements* and *AASB 128 Investments in Associates* to ensure consistent treatment in dealing with the sale or contribution of assets between an investor and its associate or joint venture. The · 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 · 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.	1-Jan-16	The assessment has indicated that there is limited impact, as the revisions to AASB 10 and AASB 128 are guidance in nature.

Note 1: Summary of Significant Accounting Policies

AASB 2015-1 Amendments to Australian Accounting Standards – Annual Improvements to Australian Accounting Standards 2012-2014 Cycle [AASB 1, AASB 2, AASB 3, AASB 5, AASB 7, AASB 11, AASB 110, AASB 119, AASB 121, AASB 133, AASB 134, AASB 137 & AASB 140]	Amends the methods of disposal in AASB 5 Non-current assets held for sale and discontinued operations. Amends *AASB 7 Financial Instruments* by including further guidance on servicing contracts.	1-Jan-16	The assessment has indicated that when an asset (or disposal group) is reclassified from 'held to sale' to 'held for distribution', or vice versa, the asset does not have to be reinstated in the financial statements. Entities will be required to disclose all types of continuing involvement the entity still has when transferring a financial asset to a third party under conditions which allow it to derecognise the asset.
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer.	1-Jan-18	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. 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 against the opening returned earnings if there are no former performance obligations outstanding.
AASB 2014-4 *Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation* *[AASB 116 & AASB 138]*	Amends *AASB 116 Property, Plant and Equipment* and *AASB 138 Intangible Assets* to: · 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; · 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.	1-Jan-18	The assessment has indicated that there is no expected impact as the revenue-based method is not used for depreciation and amortisation.
AASB 2015-6 *Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities* *[AASB 10, AASB 124 & AASB 1049]*	The Amendments extend the scope of *AASB 124 Related Party Disclosures* 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-Jul-16	The amending standard will result in extended disclosures on the entity's key management personnel (KMP), and the related party transactions.

Note 1: Summary of Significant Accounting Policies

(t) Category groups

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

Admitted Patient Services (Admitted Patients) comprises all acute and subacute admitted patient services, where services are delivered in public hospitals.

Non Admitted Services comprises acute and subacute non admitted services, where services are delivered in public hospital clinics and provide models of integrated community care, which significantly reduces the demand for hospital beds and supports the transition from hospital to home in a safe and timely manner.

Emergency Department Services comprises all emergency department services.

Aged Care comprises a range of in home, specialist geriatric, residential care and community based programs and support services, such as Home and Community Care (HACC) that are targeted to older people, people with a disability, and their carers.

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

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

(u) Going Concern

The going concern basis was used to prepare the financial statements. DHHS has provided assurances to support the ongoing operations and financial requirements of Northern Health and to provide Northern Health with adequate cash flow support to enable Northern Health to meet its current and future obligations as and when these fall due up to September 2017 should this be required.

Note 2: Analysis of Consolidated Revenue by Source

	Admitted Patients 2016 $'000	Non Admitted Patients 2016 $'000	Emergency Department Services 2016 $'000	Residential Aged Care Services 2016 $'000	Aged Care 2016 $'000	Other 2016 $'000	Total Consol'd 2016 $'000
Government Grants	311,072	29,641	29,401	2,511	10,532	-	383,157
Indirect contributions by DHHS*	6,739	-	-	-	-	-	6,739
Patient and Resident Fees	15,313	131	4	574	92	-	16,113
Commercial Activities	-	-	-	-	-	10,757	10,757
Other Revenue from Operating Activities**	3,953	123	276	28	43	-	4,423
Total Revenue from Operating Activities	**337,077**	**29,895**	**29,680**	**3,114**	**10,667**	**10,757**	**421,189**
Interest	576	-	-	-	-	57	633
Other Revenue from Non-Operating Activities	-	-	-	-	-	7,421	7,421
Total Revenue from Non-Operating Activities	**576**	**-**	**-**	**-**	**-**	**7,478**	**8,054**
Capital Purpose Income (excluding interest)	-	-	-	196	-	1,760	1,956
Government Grants	-	-	-	-	-	25,699	25,699
Capital Interest	-	-	-	-	-	285	285
Total Capital Purpose Income	**-**	**-**	**-**	**196**	**-**	**27,744**	**27,940**
Proceeds from Disposals of Non-Current Assets (see Note 2a) ***	-	-	-	-	-	14	14
Total Other Economic Flows Included in Net Result	**-**	**-**	**-**	**-**	**-**	**14**	**14**
Total Revenue	**337,653**	**29,895**	**29,680**	**3,310**	**10,667**	**45,993**	**457,197**

* DHHS makes certain makes certain payments on behalf of Northern Health such a Medical Indemnity Insurance (known as Indirect Contributions). These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

* During 2015-16 Northern Health transitioned to the DHHS Long Service Leave (LSL) model, which resulted in a $4.8 million revaluation of the present value of the Long Service Leave liability. The remeasurement includes the associated impact of bond rate changes. The increase in the LSL expense is largely offset by an equivalent increase in DHHS Long Service Leave revenue (shown above against Indirect contributions by DHHS).

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

*** Proceeds from Disposal of Non-Current Assets is reported under Net Gain/(Loss) on Non-financial Assets on the Operating Statement

Note 2: Analysis of Consolidated Revenue by Source (Continued)

	Admitted Patients 2015 $'000	Non Admitted Patients 2015 $'000	Emergency Department Services 2015 $'000	Residential Aged Care Services 2015 $'000	Aged Care 2015 $'000	Other 2015 $'000	Total Consol'd 2015 $'000
Government Grants	278,278	28,400	27,364	2,297	10,697	-	347,036
Indirect contributions by DHHS*	996	-	-	-	-	-	996
Patient and Resident Fees	14,943	119	5	540	88	-	15,695
Commercial Activities and Specific Purpose Funds	-	-	-	-	-	9,499	9,499
Other Revenue from Operating Activities	3,934	113	345	-	51	-	4,443
Total Revenue from Operating Activities	**298,151**	**28,632**	**27,714**	**2,837**	**10,836**	**9,499**	**377,669**
Interest	527	-	-	-	-	137	664
Other Revenue from Non-Operating Activities	-	-	-	-	-	6,323	6,323
Total Revenue from Non-Operating Activities	**527**	**-**	**-**	**-**	**-**	**6,460**	**6,987**
Capital Purpose Income (excluding interest)	-	-	-	161	-	431	592
Government Grants	-	-	-	-	-	12,343	12,343
Capital Interest	-	-	-	-	-	269	269
Total Capital Purpose Income	**-**	**-**	**-**	**161**	**-**	**13,043**	**13,204**
Proceeds from Disposals of Non-Current Assets (see Note 2a) ***	-	-	-	-	-	1	1
Total Other Economic Flows Included in Net Result	**-**	**-**	**-**	**-**	**-**	**1**	**1**
Total Revenue	**298,678**	**28,632**	**27,714**	**2,998**	**10,836**	**29,003**	**397,861**

* DHHS makes certain makes certain payments on behalf of Northern Health such a Medical Indemnity Insurance (known as Indirect Contributions). These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

* During 2015-16 Northern Health transitioned to the DHHS Long Service Leave (LSL) model, which resulted in a $4.8 million revaluation of the present value of the Long Service Leave liability. The remeasurement includes the associated impact of bond rate changes. The increase in the LSL expense is largely offset by an equivalent increase in DHHS Long Service Leave revenue (shown above against Indirect contributions by DHHS).

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

*** Proceeds from Disposal of Non-Current Assets is reported under Net Gain/(Loss) on Non-financial Assets on the Operating Statement

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

	Consol'd 2016 $'000	Consol'd 2015 $'000
Proceeds from Disposals of Non-Current Assets		
Medical Equipment	2	56
Motor Vehicles	12	-
Total Proceeds from Disposal of Non-Current Assets	**14**	**56**
Less: Written Down Value of Non-Current Assets Sold		
Medical Equipment	54	-
Motor Vehicles	27	-
Other	17	1
Total Written Down Value of Non Current Assets Sold	**98**	**1**
Net Gains/(Losses) on Disposal of Non-Current Assets	**(84)**	**55**

Note 2b: Assets received free of charge or for nominal consideration

	Consol'd 2016 $'000	Consol'd 2015 $'000
During the reporting period fair value of assets received free of charge was as follows:		
Medical Equipment	11	-
Total	**11**	**-**

Note 3: Analysis of Consolidated Expenses by Source

	Admitted Patients 2016 $'000	Non Admitted Patients 2016 $'000	Emergency Department Services 2016 $'000	Residential Aged Care Services 2016 $'000	Aged Care 2016 $'000	Other 2016 $'000***	Total Consol'd 2016 $'000
Employee Expenses *	226,947	16,911	38,515	3,940	5,968	5,808	298,089
Non Salary Labour Costs	7,995	351	1,061	86	36	133	9,662
Supplies and Consumables	58,255	2,609	13,462	537	2,742	601	78,206
Other Expenses from Continuing Operations**	31,089	1,600	3,827	713	1,001	4,520	42,750
Total Expenditure from Operating Activities	**324,286**	**21,471**	**56,865**	**5,276**	**9,747**	**11,062**	**428,707**
Expenditure for Capital Purposes	-	-	-	-	-	312	312
Depreciation and Amortisation (refer note 4)	-	-	-	26	-	22,898	22,924
Written Down Value of Assets Sold (refer note 2a)	-	-	-	-	-	98	98
Finance Costs (refer note 5)	-	-	-	-	-	27	27
Specific Expenses (refer to note 3b)	-	-	-	-	-	803	803
Total Other Expenses	**-**	**-**	**-**	**26**	**-**	**24,138**	**24,164**
Total Expenses	**324,286**	**21,471**	**56,865**	**5,302**	**9,747**	**35,200**	**452,871**

* During 2015-16 Northern Health transitioned to the DHHS Long Service Leave (LSL) model, which resulted in a $4.8 million revaluation of the present value of the Long Service Leave liability. The remeasurement includes the associated impact of bond rate changes. The increase in the LSL expense is largely offset by an equivalent increase in DHHS Long Service Leave revenue (refer Note 2).

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

***Refer to Note 3a for further details.

Note 3: Analysis of Consolidated Expenses by Source (Continued)

	Admitted Patients 2015 $'000	Non Admitted Patients 2015 $'000	Emergency Department Services 2015 $'000	Residential Aged Care Services 2015 $'000	Aged Care 2015 $'000	Other 2015 $'000**	Total Consol'd 2015 $'000
Employee Expenses	205,762	15,237	38,540	2,417	5,981	4,815	272,753
Non Salary Labour Costs excl. Consulting	7,711	495	1,928	50	60	389	10,633
Supplies and Consumables	49,658	2,191	11,769	418	2,520	452	67,007
Other Expenses from Continuing Operations *	30,988	1,656	4,297	423	1,042	4,544	42,950
Total Expenditure from Operating Activities	**294,119**	**19,578**	**56,534**	**3,308**	**9,603**	**10,200**	**393,343**
Expenditure for Capital Purposes	-	-	-	-	-	1,079	1,079
Depreciation and Amortisation (refer note 4)	-	-	-	26	-	22,006	22,032
Written Down Value of Assets Sold (refer note 2a)	-	-	-	-	-	1	1
Finance Costs (refer note 5)	-	-	-	-	-	17	17
Total Other Expenses	**-**	**-**	**-**	**26**	**-**	**23,103**	**23,129**
Total Expenses	**294,119**	**19,578**	**56,534**	**3,334**	**9,603**	**33,303**	**416,472**

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

**Refer to Note 3a for further details.

Note 3a: Analysis of Expenses and Revenue by Internally Managed and Restricted Specific Purpose Funds for Services Supported by Hospital and Community Initiatives

	Expense		Revenue	
	Consol'd 2016 $'000	Consol'd 2015 $'000	Consol'd 2016 $'000	Consol'd 2015 $'000
Commercial Activities				
Private Practice and other patient activities	2,783	2,167	3,487	2,851
Car Park	262	260	2,950	2,907
Property Expenses	4,619	4,386	5,831	5,006
Northern Health Foundation : Marketing Expenditure and Capital Donations	510	424	909	748
Salary Packaging	336	543	1,958	1,522
Allied Health and Rehabilitation Supply Store	768	356	988	554
Other Activities				
Fundraising and Community Support	-	14	-	60
Research and Scholarship	1,222	1,058	1,502	1,115
Special and Restricted Purpose Funds	562	992	610	1,196
TOTAL	**11,062**	**10,200**	**18,235**	**15,959**

Note 3b: Specific Expenses

	Consol'd 2016 $'000	Consol'd 2015 $'000
Specific Expenses		
Costs Associated with Organisational Restructure (Disaggregation/Aggregation)	803	-
Total Specific Expenses	**803**	**-**

Note 4: Depreciation and Amortisation

	Consol'd 2016 $'000	Consol'd 2015 $'000
Depreciation		
Buildings	17,806	17,227
Medical Equipment	3,070	3,193
Computers and Communication	968	824
Furniture and Fittings	276	221
Motor Vehicles	145	104
Non Medical Equipment	272	267
Total Depreciation	**22,537**	**21,836**
Amortisation		
Intangible Assets	388	196
Total Amortisation	**388**	**196**
Total Depreciation and Amortisation	**22,925**	**22,032**

Note 5: Finance Costs

	Consol'd 2016	Consol'd 2015
Interest on Long Term Borrowings	27	17
Total Finance Costs	**27**	**17**

Note 6: Cash and Cash Equivalents

Cash and cash equivalents inlcudes Cash On Hand and Cash In Banks and short-term deposits which are readily convertible to cash on hand, and are not subject to any material risks of change in value.
(Note that Northern Health does not maintain an overdraft facility).

	Consol'd 2016 $'000	Consol'd 2015 $'000
Cash on Hand	29	28
Cash at Bank	17,631	8,033
Cash in Short-term Deposits	2,000	-
Total Cash and Cash Equivalents	**19,660**	**8,061**
Represented by:		
Cash for Health Service Operations (as per Cash Flow Statement)	19,653	8,055
Cash held in Trust	7	6
Total Cash and Cash Equivalents	**19,660**	**8,061**

Note 7: Receivables

	Consol'd 2016 $'000	Consol'd 2015 $'000
CURRENT		
Contractual		
Trade Debtors	3,068	1,390
Patient Fees	4,012	4,665
Accrued Revenue - Other	1,969	1,960
Less Allowance for Doubtful Debts		
Trade Debtors	(38)	(85)
Patient Fees	(1,231)	(742)
	7,780	**7,188**
Statutory		
GST Receivable	1,693	1,662
	1,693	**1,662**
TOTAL CURRENT RECEIVABLES	**9,473**	**8,850**
NON CURRENT		
Statutory		
Long Service Leave - DHHS	7,417	5,008
TOTAL NON-CURRENT RECEIVABLES	**7,417**	**5,008**
TOTAL RECEIVABLES	**16,890**	**13,858**

(a) Movement in the Allowance for Doubtful Debts	Consol'd 2016 $'000	Consol'd 2015 $'000
Balance at beginning of year	827	627
Amounts written off during the year	(679)	(466)
Increase in allowance recognised in net results	1,121	666
Balance at end of year	**1,269**	**827**

(b) Ageing analysis of receivables
Please refer to Note 19(c) for the ageing analysis of contractual receivables

(c) Nature and extent of risk arising from receivables
Please refer to Note 19(c) for the nature and extent of credit risk arising from contractual receivables.

Note 8: Inventories

	Consol'd 2016 $'000	Consol'd 2015 $'000
Medical and Surgical Supplies (at cost)	1,340	1,060
Pharmaceuticals (at cost)	1,033	890
TOTAL INVENTORIES	**2,373**	**1,950**

Note 9: Prepayments and other Assets

CURRENT	Consol'd 2016 $'000	Consol'd 2015 $'000
Prepayments	1,465	872
TOTAL OTHER ASSETS	**1,465**	**872**

Note 10: Property, Plant and Equipment

(a) Gross carrying amount and accumulated depreciation

	Consol'd 2016 $'000	Consol'd 2015 $'000
Land		
Land at Fair Value	47,348	47,348
Total Land	**47,348**	**47,348**
Buildings at cost	81,727	50,203
Less Accumulated Depreciation	2,967	1,194
	78,760	49,009
Buildings at Fair Value	277,806	277,806
Less Accumulated Depreciation	32,064	16,032
Total Buildings	**324,502**	**310,783**
Assets under Construction		
Assets under construction at cost	725	11,352
Total Assets Under Construction	**725**	**11,352**
Medical Equipment at Fair Value	34,234	33,570
Less Accumulated Depreciation	19,934	17,230
Total Medical Equipment	**14,300**	**16,340**
Computers and Communication		
Computers and Communication	7,805	7,363
Less Accumulated Depreciation	6,247	5,433
Total Computers and Communication	**1,558**	**1,930**
Furniture and Fittings		
Furniture and Fittings	2,933	2,851
Less Accumulated Depreciation	1,403	1,139
Other Expenses from Continuing Operations	**1,530**	**1,712**
Non-Medical Equipment		
Non-Medical Equipment	2,676	2,487
Less Accumulated Depreciation	1,177	913
Total Non Medical Equipment	**1,499**	**1,574**
Motor Vehicles		
Motor Vehicles	1,619	1,598
Less Accumulated Depreciation	1,263	1,178
Total Motor Vehicles	**356**	**420**
Artworks		
Artworks at valuation	468	468
Total Artworks	**468**	**468**
TOTAL	**392,286**	**391,927**

Note 10: Property, Plant and Equipment (continued)

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

	Land	Buildings	Medical Equipment	Assets Under Construction	Computers and Communication	Furniture and Fittings	Non Medical Equipment	Motor Vehicles	Artworks	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2014	**47,348**	**296,124**	**17,127**	**27,146**	**1,542**	**1,361**	**1,397**	**295**	**468**	**392,808**
Additions	-	6,885	2,394	9,339	1,201	572	334	229	-	20,954
Disposals	-	-	-	-	-	-	(1)	-	-	(1)
Revaluation increments/(decrements)	-	-	-	-	-	-	-	-	-	-
Net Transfers between classes	-	25,000	12	(25,133)	11	-	110	-	-	-
Depreciation (note 4)	-	(17,226)	(3,193)	-	(824)	(221)	(266)	(104)	-	(21,834)
Restated Balance at 1 July 2015	**47,348**	**310,783**	**16,340**	**11,352**	**1,930**	**1,712**	**1,574**	**420**	**468**	**391,927**
Additions	-	20,224	1,075	725	561	94	207	107	-	22,994
Disposals	-	-	(54)	-	(4)	-	(13)	(27)	-	(98)
Net Transfers between classes	-	11,301	9	(11,352)	39	-	3	1	-	-
Depreciation (note 4)	-	(17,806)	(3,070)	-	(968)	(276)	(272)	(145)	-	(22,537)
Balance at 30 June 2016	**47,348**	**324,502**	**14,300**	**725**	**1,558**	**1,530**	**1,499**	**356**	**468**	**392,286**

Land and buildings carried at valuation

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

Plant and all other equipment

Plant and all other equipment are reported at fair value as assessed by Northern Health Management in accordance with FRD 103F Non-current Physical Assets.

Note 10: Property, Plant and Equipment (continued)

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

	Carrying amount as at 30 June 2016	Fair value measurement at end of reporting period using: Level 1 (1)	Level 2 (1)	Level 3 (1)
Land at fair value				
Non-specialised land (ii)	1,538	-	1,538	-
Specialised land (i)	45,810	-	-	45,810
Total of land at fair value	47,348	-	1,538	45,810
Buildings at fair value				
Non-specialised buildings				
Specialised buildings	324,502	-	78,760	245,742
Total of building at fair value	324,502	-	78,760	245,742
Computer and Communication at fair value				
Computer and Communication at fair value	1,558	-	-	1,558
Total of computer and communication at fair value	1,558	-	-	1,558
Furniture and Fitting at fair value				
Furniture and Fitting at fair value	1,530	-	-	1,530
Total of furniture and fitting at fair value	1,530	-	-	1,530
Non Medical equipment at fair value				
Non medical Equipment at fair value	1,499	-	-	1,499
Total of Non Medical Equipment at fair value	1,499	-	-	1,499
Motor Vehicles at fair value				
Motor Vehicles at fair value(ii)	356	-	-	356
Total motor vehicles at fair value	356	-	-	356
Medical equipment at fair value				
Medical equipment at fair value (iii)	14,300	-	-	14,300
Total Medical equipment at fair value	14,300	-	-	14,300
Artworks at fair value				
Artworks (iv)	468	-	468	-
Total Artworks at fair value	468	-	468	-
Assets under construction at fair value				
Assets under construction	725	-	-	725
Total assets under construction at fair value	725	-	-	725
	392,286	**-**	**80,766**	**311,520**

Specialised land

(i) Classified in accordance with the fair value hierarchy, see Note 1(b).

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

Non-specialised land

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

Vehicles

(ii) The process of vehicle acquisition, use and disposal is managed by Northern Health which sets the relevant depreciation rates during use to reflect the utilisation of the vehicles. The book value of the vehicles is considered a reasonable valuation of the fair value of the vehicle assets.

Note 10: Property, Plant and Equipment (continued)

Medical and Non Medical Equipment

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

Artworks

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

There were no changes in valuation techniques throughout the period to 30 June 2016.

There have been no transfers between levels during the period.

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

(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 (1)	Level 2 (1)	Level 3 (1)
Land at fair value				
Non-specialised land	1,538	-	1,538	-
Specialised land	45,810	-	-	45,810
Total of land at fair value	47,348	-	1,538	45,810
Buildings at fair value				
Specialised buildings	310,783	-	49,009	261,774
Total of building at fair value	310,783	-	49,009	261,774
Computer and Communication at fair value				
Computer and Communication at fair value	1,930	-	-	1,930
Total of computer and communication at fair value	1,930	-	-	1,930
Furniture and Fitting at fair value				
Furniture and Fitting at fair value	1,712	-	-	1,712
Total of furniture and fitting at fair value	1,712	-	-	1,712
Non Medical equipment at fair value				
Non medical Equipment at fair value	1,574	-	-	1,574
Total of Non Medical Equipment at fair value	1,574	-	-	1,574
Motor Vehicles at fair value				
Motor Vehicles at fair value(ii)	420	-	-	420
Total motor vehicles at fair value	420	-	-	420
Medical equipment at fair value				
Medical equipment at fair value (iii)	16,340	-	-	16,340
Total Medical equipment at fair value	16,340	-	-	16,340
Artworks at fair value				
Artworks (iv)	468	-	468	-
Total Artwork at fair value	468	-	468	-
Assets under construction at fair value				
Assets under construction	11,352	-	-	11,352
Total assets under construction at fair value	11,352	-	-	11,352
	391,927	**-**	**51,015**	**340,912**

Note 10: Property, Plant and Equipment (continued)

(d) Reconciliation of Level 3 fair value

30 June 2016

	Land	Buildings	Computers & Communication	Furniture & Fittings	Non Medical Equipment	Motor Vehicles	Medical equipment	Assets under construction	Total
Restated Opening Balance	**45,810**	**261,774**	**1,930**	**1,712**	**1,574**	**420**	**16,340**	**11,352**	**340,912**
Purchases / (Disposals)	-	-	596	93	199	81	1,030	(10,627)	(8,628)
Transfers In / (Out) of Level 3	-	-	-			-	-	-	-
- Depreciation	-	(16,032)	(969)	(276)	(272)	(145)	(3,070)	-	(20,764)
		-							
Subtotal	**45,810**	**245,742**	**1,557**	**1,529**	**1,501**	**356**	**14,300**	**725**	**311,520**
Items recognised in other comprehensive income									
- Revaluation	-	-	-			-	-	-	-
Closing Balance	**45,810**	**245,742**	**1,557**	**1,529**	**1,501**	**356**	**14,300**	**725**	**311,520**

There have been no transfers between levels during the period.

(d) Reconciliation of Level 3 fair value

30 June 2015

	Land	Buildings	Computers & Communication	Furniture & Fittings	Non Medical Equipment	Motor Vehicles	Medical equipment	Assets under construction	Total
Opening Balance	**45,810**	**277,806**	**17,127**	**1,542**	**1,361**	**1,397**	**295**	**27,146**	**372,484**
Purchases / (Disposals)	-	-	**2,406**	**1,212**	**572**	**443**	229	(16,270)	(11,408)
Restatement		-	-	-			-	476	476
Transfers In / (Out) of Level 3									
Gains or losses recognised in net result									
- Depreciation	-	(16,032)	(3,193)	(824)	(221)	(266)	(104)	-	(20,640)
Subtotal	**45,810**	**261,774**	**16,340**	**1,930**	**1,712**	**1,574**	**420**	**11,352**	**340,912**
Items recognised in other comprehensive income									
- Revaluation	-	-	-			-	-	-	-
Subtotal									
Restated Closing Balance	**45,810**	**261,774**	**16,340**	**1,930**	**1,712**	**1,574**	**420**	**11,352**	**340,912**

There have been no transfers between levels during the period.

Note 10: Property, Plant and Equipment (continued)

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

	Valuation technique	Significant unobservable inputs	Range (weighted average)	Sensitivity of fair value measurement to changes in significant unobservable inputs
Specialised land	Market approach	Community Service Obligation (CSO) adjustment	10 - 25% (19%) (i)	A significant increase or decrease in the CSO adjustment would result in a significantly lower (higher) fair value
Non - specialised land	Market approach	N/A	$1,033 - $2,291/m2 ($1,750)	A significant increase or decrease in direct cost per square meter adjustment would result in a significantly higher or lower fair value
Specialised buildings	Depreciated replacement cost	Direct cost per square metre	$477 - $888/m2 ($583)	A significant increase or decrease in direct cost per square meter adjustment would result in a significantly higher or lower fair value
		Useful life of specialised buildings	5 - 53 years (29 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Medical equipment at fair value	Depreciated replacement cost	Cost per unit	$1,000 - $1,116,000 ($9,300)	Increase (decrease) in gross replacement cost would result in a significantly higher (lower) fair value
		Useful life of medical equipment	7-10 years (8 years)	Increase (decrease) in useful life would result in a significantly higher (lower) fair value
Computer & Communication at fair value	Depreciated replacement cost	Cost per unit	$800 - $277,800 ($3,000)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value
		Useful life of PPE	3 years	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Furniture and Fitting at fair value	Depreciated replacement cost	Cost per unit	$1,000 - $13,400 ($9,000)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value
		Useful life of PPE	7-10 years (8 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Non-Medical equipment at fair value	Depreciated replacement cost	Cost per unit	$1,000 - $484,000 ($6,900)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value
		Useful life of PPE	7-10 years (8 years)	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.
Vehicles	Depreciated replacement cost	Cost per unit	$12,300-$57,800 per unit ($24,900 per unit)	A significant increase or decrease in cost per unit would result in a significantly higher or lower fair value
		Useful life of vehicles	4 years	A significant increase or decrease in the estimated useful life of the asset would result in a significantly higher or lower valuation.

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

The significant unobservable inputs have remained unchanged from 2016.

Note 11: Intangible Assets

	Consol'd 2016 $'000	Consol'd 2015 $'000
Development Costs Capitalised	4,687	4,356
Less Accumulated Amortisation	4,311	3,924
	376	432
Computer Software - Work in Progress	-	173
Total Intangible Assets	**376**	**605**

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

	Development Costs $'000	Total $'000
Balance at 1 July 2014	447	**447**
Additions	181	181
Net Transfers between classes	173	173
Amortisation (note 4)	(196)	(196)
Balance at 1 July 2015	**605**	**605**
Additions	159	159
Amortisation (note 4)	(388)	(388)
Balance at 30 June 2016	**376**	**376**

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

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

Note 12: Payables

	Consol'd 2016 $'000	Consol'd 2015 $'000
CURRENT		
Contractual		
Trade Creditors [(i)]	4,041	4,559
Accrued Expenses	10,024	8,242
Salaries and Wages Related Creditors	4,993	6,994
Inter Health Services	5,081	3,971
Other	445	470
Statutory		
DHHS [(ii)]	1,187	2,359
	1,187	2,359
TOTAL CURRENT	**25,771**	**26,595**
TOTAL PAYABLES	**25,771**	**26,595**

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

(ii) Terms and conditions of amounts payable to DHHS vary according to the particular agreement with the Department.

(a) Maturity analysis of Payables
Please refer to Note 19d for analysis of the ageing of payables.

(b) Nature and extent of risk arising from Payables
Please refer to Note 19d and Note 19e for analysis on the nature and extent of risks arising from payables.

Note 13: Borrowings

	Consol'd 2016 $'000	Consol'd 2015 $'000
CURRENT		
Upfront capital funding associated with security and car parking service contracts	281	283
Total Australian Dollar Borrowings	**281**	**283**
TOTAL CURRENT	**281**	**283**
Upfront capital funding associated with security and car parking service contracts	181	487
Total Australian Dollar Borrowings	**181**	**487**
TOTAL NON CURRENT	**181**	**487**
TOTAL BORROWINGS	**462**	**770**

(a) Maturity analysis of Borrowings
Please refer to Note 19d for analysis on the ageing of borrowings.

(b) Nature and extent of risk arising from Borrowings
Please refer to Note 19d and Note19e for analysis on the nature and extent of risks arising from borrowings.

(c) Defaults and breaches

During the current and prior year, there were no defaults nor breaches of any of the borrowings.

Note 14: Provisions

	Consol'd 2016 $'000	Consol'd 2015 $'000
Current Provisions		
Employee Benefits (Note 14(a))		
Annual Leave (Note 14(a))		
- Unconditional and expected to be settled within 12 months (ii)	18,637	17,676
- Unconditional and expected to be settled after 12 months (ii)	3,078	3,011
Long Service Leave		
- Unconditional and expected to be settled within 12 months (ii)	3,966	3,377
- Unconditional and expected to be settled after 12 months (ii)	26,784	21,010
Accrued Salaries and Wages	9,040	5,611
	61,506	**50,685**
Provisions related to employee benefit on-costs		
- Unconditional and expected to be settled within 12 months (nominal value) (ii)	2,297	2,147
- Unconditional and expected to be settled after 12 months (present value) (ii)	3,129	2,450
	5,427	4,597
Total Current Provisions	**66,932**	**55,282**
Non-Current Provisions		
Employee Benefits (i) (Note 14(a))	9,384	8,492
Provisions related to employee benefit on-costs (Note 14(a) and Note 14(b))	984	866
Total Non-Current Provisions	**10,368**	**9,358**
TOTAL PROVISIONS	**77,300**	**64,640**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and Related On-costs		
Unconditional LSL entitlements	33,975	26,874
Annual leave entitlements	23,917	22,797
Accrued Salaries and Wages	8,599	5,204
Accrued Days Off	441	407
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave entitlements (present value)	10,368	9,358
Total Employee Benefits and Related On-Costs	**77,300**	**64,640**

Note 14: Provisions

	Consol'd 2016 $'000	Consol'd 2015 $'000
(b) Movements in provisions		
Movement in Long Service Leave (Current and Non-Current):		
Balance at start of year	**36,231**	**33,453**
Provision made during the year		
- Revaluations	5,861	790
- Expense recognising employee service	6,462	5,710
Settlement made during the year	(4,211)	(3,722)
Balance at end of year	**44,343**	**36,231**

(i) Employee benefits consist of Annual Leave and Long Service Leave accrued by employees as well as accrued Salaries and Wages as at 30 June 2016. On-costs such as payroll tax and worker's compensation insurance are not employee benefits and are reflected as a separate provision.

(ii) The amounts disclosed are at present values.

Note 15: Superannuation

	Paid Contribution for the year		Contribution Outstanding at	
	Consol'd 2016 $'000	Consol'd 2015 $'000	Consol'd 2016 $'000	Consol'd 2015 $'000
(i) Defined benefit plans:				
First State Super (formerly Health Super)	288	348	22	13
Defined contribution plans:				
First State Super (formerly Health Super)	12,796	13,560	1,352	647
HESTA	7,194	6,725	817	601
Other	420	430	27	27
	20,697	**21,063**	**2,218**	**1,288**

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

Note 16: Other Liabilities

	Consol'd 2016 $'000	Consol'd 2015 $'000
CURRENT		
Patient Monies Held in Trust (Held in Cash)	7	6
Income in Advance	1,741	931
TOTAL CURRENT OTHER LIABILITIES	**1,748**	**937**
NON CURRENT		
Income in Advance	14,552	15,438
TOTAL NON CURRENT OTHER LIABILITIES	**14,552**	**15,438**
TOTAL OTHER LIABILITIES	**16,300**	**16,375**

Note 17: Equity

	Consol'd 2016 $'000	Consol'd 2015 $'000
(a) Surpluses		
Property, Plant and Equipment Revaluation Surplus		
Balance at the beginning of the reporting period	200,146	200,146
Revaluation Increment/(Decrements) during the period		
- Land	-	-
- Buildings	-	-
Balance at the end of the reporting period*	**200,146**	**200,146**
* Represented by:		
- Land	39,004	39,004
- Buildings	161,142	161,142
	200,146	**200,146**
Restricted Specific Purpose Surplus		
Balance at the beginning of the reporting period	4,532	3,935
Transfer to and from Restricted Specific Purpose Surplus	409	597
Balance at the end of the reporting period	**4,941**	**4,532**
Capital Projects Reserve Surplus		
Balance at the beginning of the reporting period	-	3,300
Transfer to and from Capital Projects Reserve Surplus	-	(3,300)
Balance at the end of the reporting period	**-**	**-**
Total Surpluses	**205,087**	**204,678**
(b) Contributed Capital		
Balance at the beginning of the reporting period	161,634	161,634
Capital contribution received from Victorian Government	-	-
Balance at the end of the reporting period	**161,634**	**161,634**
(c) Accumulated Deficits		
Balance at the beginning of the reporting period	(57,420)	(41,512)
Net Result for the Year	4,325	(18,611)
Transfer to and from Capital Projects Reserve Surplus	-	3,300
Transfer to and from Restricted Specific Purpose Surplus	(409)	(597)
Balance at the end of the reporting period	**(53,504)**	**(57,420)**
Total Equity at end of financial year	**313,217**	**308,893**

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

Note 18: Reconciliation of Net Result for the Year to Net Cash Inflow/(Outflow) from Operating Activities

	Consol'd 2016 $'000	Consol'd 2015 $'000
Net Result for the period	4,325	(18,611)
Non-cash movements		
Depreciation and Amortisation	22,925	22,032
Provision for Doubtful Debts	1,121	666
Amortisation of Prepaid Rent	(629)	(342)
Change in Inventories	(426)	(549)
Resources/Assets Provided/(Received) Free of Charge	(12)	-
Movements included in investing and financing activities		
Net (Gain)/Loss from Sale of Plant and Equipment	84	(56)
Movements in assets and liabilities		
Change in Operating Assets and Liabilities		
Decrease in Current Receivables	(2,373)	277
(Increase) in Non Current Receivables	(2,410)	(700)
(Increase)/Decrease in Other Assets	(617)	(761)
(Decrease) / Increase in Payables	3,057	(305)
Increase in Employee Benefits	9,771	2,548
(Decrease) / Increase in Other Liabilities	216	1,886
NET CASH INFLOW FROM OPERATING ACTIVITIES	**35,032**	**6,085**

Note 19: Financial Instruments

(a) Financial Risk Management Objectives and Policies

Northern Health's principal financial instruments comprise of:

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

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

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

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

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

Categorisation of financial instruments

	Note	Contractual financial assets - receivables 2016 $'000	Contractual financial assets - receivables 2015 $'000
Contractual Financial Assets			
Cash and cash equivalents (including monies held in trust)	6	19,660	8,061
Receivables			
- Trade Debtors	7	3,030	1,305
- Other Receivables	7	4,750	5,883
Total Receivables		**7,780**	**7,188**
Total Financial Assets [(i)]		**27,440**	**15,249**

	Note	Contractual financial liabilities at amortised cost 2016 $'000	Contractual financial liabilities at amortised cost 2015 $'000
Financial Liabilities			
Payables	12	24,584	24,236
Borrowings	13	462	770
Other Liabilities	16		
- Monies Held in Trust		7	6
- Income in Advance		16,293	16,369
Total Other Liabilities		**16,300**	**16,375**
Total Financial Liabilities [(ii)]		**41,346**	**41,381**

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

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

Note 19: Financial Instruments (continued)

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

	Total Interest Income / (expense) 2016 $'000	Total Interest Income / (expense) 2015 $'000
Financial Assets		
Cash and cash equivalents [(i)]	918	933
Total Financial Assets	**918**	**933**
Financial Liabilities		
Borrowings [(ii)]	27	17
Total Financial Liabilities	**27**	**17**

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

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

Note 19: Financial Instruments (continued)

(c) Credit Risk

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

Credit risk associated with Northern Health's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, it is Northern Health'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, Northern Health does not engage in hedging for its contractual financial assets and mainly obtains contractual financial assets that are on fixed interest, except for cash assets, which are mainly cash at bank. As with the policy for debtors, Northern Health'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 Northern Health 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 Northern Health's maximum exposure to credit risk without taking account of the value of any collateral obtained.

Credit quality of contractual financial assets that are neither past due nor impaired

2016	Financial Institutions (A1+ Credit Rating) $'000	Government Agencies (AAA Credit Rating) $'000	Government Agencies (BBB Credit Rating) $'000	Other Institutions (min BB Credit Rating)	Other Financial Assets $'000	Total $'000
Financial Assets						
Cash and Cash Equivalents	19,631	-	-		29	19,660
Receivables (i)						
- Trade debtors	-	-	-		3,030	3,030
- Other receivables	-	-	-		4,750	4,750
Total Financial Assets	**19,631**	**-**	**-**		**7,809**	**27,440**
		-				
		-				
2015						
Financial Assets						
Cash and Cash Equivalents	8,033	-	-		28	8,061
Receivables (i)						
- Trade debtors	-	-	-		1,305	1,305
- Other receivables	-	-	-		5,883	5,883
Total Financial Assets	**8,033**	**-**	**-**		**7,216**	**15,249**

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

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

Note 19: Financial Instruments (continued)

(c) Credit Risk (continued)
Ageing analysis of financial assets as at 30 June

2016	Consol'd Carrying Amount $'000	Not Past Due and Not Impaired $'000	Past Due But Not Impaired				Impaired Financial Assets $'000
			Less than 1 Month $'000	1-3 Months $'000	3 months - 1 Year $'000	1-5 Years $'000	
Financial Assets							
Cash and Cash Equivalents	19,660	19,660	-	-	-	-	-
Receivables (i)							
- Trade debtors	3,030	2,163	739	79	49	-	-
- Other receivables	4,750	2,005	1,929	740	31	45	-
Total Financial Assets	**27,440**	**23,828**	**2,668**	**819**	**80**	**45**	**-**
2015							
Financial Assets							
Cash and Cash Equivalents	8,061	8,061	-	-	-	-	-
Receivables (i)							
- Trade debtors	1,305	1,047	140	118	-	-	-
- Other receivables	5,883	3,453	1,209	1,057	101	64	-
Total Financial Assets	**15,249**	**12,561**	**1,349**	**1,175**	**101**	**64**	**-**

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

Contractual financial assets that are either past due or impaired

There are no material financial assets which are individually determined to be impaired. Currently Northern Health does not hold any collateral as security nor credit enhancements relating to any of its financial assets.

There are no financial assets that have had their terms renegotiated so as to prevent them from being past due or impaired, and they are stated at the carrying amounts as indicated. The ageing analysis table above discloses the ageing only of contractual financial assets that are past due but not impaired.

Note 19: Financial Instruments (continued)

(d) Liquidity Risk

Liquidity risk is the risk that Northern Health would be unable to meet its financial obligations as and when they fall due. Average Northern Health payment terms are 45 days.

Northern Health's maximum exposure to liquidity risk is the carrying amounts of financial liabilities as disclosed on the balance sheet.
The following table discloses the contractual maturity analysis for Northern Health's financial liabilities. For interest rates applicable to each class of liability refer to individual notes to the financial statements.

Maturity analysis of financial liabilities as at 30 June

			Maturity Dates			
2016	**Carrying Amount $'000**	**Nominal Amount $'000**	**Less than 1 Month $'000**	**1-3 Months $'000**	**3 months - 1 Year $'000**	**1-5 Years $'000**
Financial Liabilities						
Payables	24,584	24,584	18,196	5,975	411	-
Borrowings	462	462	23	47	211	181
Other Financial Liabilities (i)	16,300	16,300	838	189	714	14,559
Total Financial Liabilities	**41,346**	**41,346**	**19,057**	**6,211**	**1,336**	**14,740**
2015						
Financial Liabilities		-				
Payables	24,236	24,236	17,897	6,338	-	-
Borrowings	770	770	25	49	222	474
Other Financial Liabilities (i)	16,375	16,375	-	123	816	15,436
Total Financial Liabilities	**41,381**	**41,381**	**17,922**	**6,511**	**1,038**	**15,910**

Note 19: Financial Instruments (continued)

(e) Market Risk

Northern Health's exposures to market risk are primarily through interest rate risk with only insignificant exposure to foreign currency and other price risks. Objectives, policies and processes used to manage each of these risks are disclosed in the paragraph below.

Currency Risk

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

Interest Rate Risk

Exposure to interest rate risk might arise primarily through Northern Health's interest bearing liabilities. Minimisation of risk is achieved by mainly undertaking fixed rate or non-interest bearing financial instruments. For financial liabilities, Northern Health mainly undertake financial liabilities with relatively even maturity profiles.

Cash flow interest rate risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

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

Northern Health manages this risk by mainly undertaking fixed rate or non-interest bearing financial instruments with relatively even maturity profiles, with only insignificant amounts of financial instruments at floating rate. Management has concluded for cash at bank as financial assets that can be left at floating rate without necessarily exposing Northern Health to significant 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 Rate (%)	Carrying Amount	Interest Rate Exposure		
			Fixed Interest Rate $'000	Variable Interest Rate $'000	Non-Interest Bearing $'000
2016					
Financial Assets					
Cash and Cash Equivalents	2.46	19,660	-	19,631	29
Receivables[(i)]					
- Trade debtors	0.00	3,030	-	-	3,030
- Other receivables	0.00	4,750	-	-	4,750
Other financial assets	0.00	-	-	-	-
		27,440	**-**	**19,631**	**7,809**
Financial Liabilities					
Payables[(i)]	0.00	24,584	-	-	24,584
Borrowings	4.39	462	462	-	-
Other financial liabilities	0.00	16,300	-	-	16,300
		41,346	**462**	**-**	**40,884**
2015					
Financial Assets					
Cash and Cash Equivalents	2.86	8,061	-	8,033	28
Receivables[(i)]					
- Trade Debtors	0.00	1,305	-	-	1,305
- Other Receivables	0.00	5,883	-	-	5,883
		15,249	**-**	**8,033**	**7,216**
Financial Liabilities					
Payables[(i)]	0.00	24,236	-	-	24,236
Borrowings	4.39	770	770	-	-
Other financial liabilities	0.00	16,375	-	-	16,375
		41,381	**770**	**-**	**40,611**

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

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

Note 19: Financial Instruments (continued)

(e) Market Risk (cont)

Sensitivity Disclosure Analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, Northern Health believes the following movements are 'reasonably possible' over the next 12 months (Base rates are sourced from the Reserve Bank of Australia)
- A shift of +1% and -1% in market interest rates (AUD) from year-end rates of 1.75%
- A parallel shift of +1% and 1% in inflation rate from year-end rates of 1.30%

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

	Carrying Amount	Interest Rate Risk				Other Price Risk			
		-1%		+1%		-5%		+10%	
2016		$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial Assets		-							
Cash and Cash Equivalents[(i)]	19,660	(196)	(196)	196	196	-	-	-	-
Receivables									
- Trade debtors	3,030	-	-	-	-	-	-	-	-
- Other receivables	4,750	-	-	-	-	-	-	-	-
Financial Liabilities		-							
Payables	24,584	-	-	-	-	-	-	-	-
Borrowings	462	-	-	-	-				
Other Financial Liabilities	16,300	-	-	-	-	-	-	-	-
		(196)	**(196)**	**196**	**196**	**-**	**-**	**-**	**-**
2015									
Financial Assets									
Cash and Cash Equivalents[(i)]	8,061	(80)	(80)	80	80	-	-	-	-
Receivables									
- Trade debtors	1,305	-	-	-	-	-	-	-	-
- Other receivables	5,883	-	-	-	-	-	-	-	-
Financial Liabilities									
Payables	24,236	-	-	-	-	-	-	-	-
Borrowings	770								
Other Financial Liabilities	16,375	-	-	-	-	-	-	-	-
		(80)	**(80)**	**80**	**80**	**-**	**-**	**-**	**-**

(i) e.g. Sensitivity of cash and cash equivalents to +1% movement in interest rates: [$19,660*0.0246]-[$19,660*0.0146] = $196k Similarly -1% movement in interest rate impact = $(196k)

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

(f) Fair Value

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

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

Note 20: Commitments for Expenditure

	Consol'd 2016 $'000	Consol'd 2015 $'000
(a) Commitments other than public private partnerships		
Capital Expenditure Commitments		
Payable:		
Land and Buildings	3,141	22,093
Plant and Equipment	2,799	3,523
Intangible Assets	16	27
Total Capital Expenditure Commitments	**5,956**	**25,643**
Not later than one year	3,141	22,093
Later than 1 year and not later than 5 years	-	-
Total	**3,141**	**22,093**
Plant and Equipment		
Not later than one year	2,799	3,523
Later than 1 year and not later than 5 years	-	-
Total	**2,799**	**3,523**
Intangible Assets		
Not later than one year	16	27
Total	**16**	**27**

Note 20: Commitments for Expenditure (continued)

	Consol'd 2016 $'000	Consol'd 2015 $'000
Other Expenditure Commitments		
Payable:		
Pathology Services	6,164	11,095
Radiology Services	51,245	11,091
Food Services	20,789	7,241
Laundry Services	536	2,187
Cleaning Services	12,544	4,939
Patient Transport	1,000	1,637
Waste Services	816	1,347
Maintenance Services	3,037	1,150
Security Services	4,487	6,719
Shared Services	12,449	10,872
Total Other Expenditure Commitments	**113,067**	**58,278**
Not later than one year	39,556	38,257
Later than 1 year and not later than 5 years	73,511	20,022
TOTAL	**113,067**	**58,278**
Lease Commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	918	1,350
Total Lease Commitments	**918**	**1,350**
Operating Leases		
Non-cancellable		
Not later than one year	447	460
Later than 1 year and not later than 5 years	471	890
Sub Total	**918**	**1,350**
TOTAL	**918**	**1,350**
Total Commitments for expenditure (inclusive of GST)	**119,941**	**85,271**
less GST recoverable from the Australian Tax Office	(10,904)	(7,752)
Total commitments for expenditure (exclusive of GST)	**109,037**	**77,519**

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

Note 21: Contingent Assets and Contingent Liabilities

Northern Health is not aware of any contingent assets (2015: Nil).

Northern Health is not aware of any contingent liabilities (2015: Nil).

Note 22: Operating Segments

	Residential Aged Care Services		Other		Consol'd	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000
REVENUE						
External Segment Revenue	3,310	2,998	452,969	393,930	456,279	396,928
Total Revenue	**3,310**	**2,998**	**452,969**	**393,930**	**456,279**	**396,928**
EXPENSES		-				
External Segment Expenses	(5,302)	(3,334)	(447,544)	(413,138)	(452,846)	(416,472)
Intersegment Expenses	-	-	-	-	-	-
Total Expenses	**(5,302)**	**(3,334)**	**(447,544)**	**(413,138)**	**(452,846)**	**(416,472)**
Net Result from Ordinary Activities	**(1,992)**	**(336)**	**5,425**	**(19,208)**	**3,433**	**(19,544)**
Interest Expense	-	-	(25)	-	(25)	-
Interest Income	-	-	918	933	918	933
Net Result for Year	**(1,992)**	**(336)**	**6,318**	**(18,275)**	**4,326**	**(18,611)**
OTHER INFORMATION						
Segment Assets	127	146	392,159	391,781	392,286	391,927
Unallocated Assets	-	-	40,764	25,346	40,764	25,346
Total Assets	**127**	**146**	**432,923**	**417,127**	**433,050**	**417,273**
Unallocated Liabilities	-	-	119,833	108,380	119,833	108,380
Total Liabilities	**-**	**-**	**119,833**	**108,380**	**119,833**	**108,380**
Acquisition of Property, Plant and Equipment and Intangible Assets	8	41	23,145	20,618	23,153	20,659
Depreciation and Amortisation expense	26	23	22,899	22,008	22,925	22,031

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

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

All inter-segment transactions are carried at cost.

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

Note 23a: Responsible Persons Disclosures

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

	Period
Responsible Ministers	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services	01/07/2015 - 30/06/2016
The Honourable Martin Foley, Minister for Housing, Disability and Ageing, Minister for Mental Health	01/07/2015 - 30/06/2016
Governing Board	
Ms Jennifer Williams (Chair)	01/07/2015 - 30/06/2016
Ms Sabine Phillips	01/07/2015 - 30/06/2016
Mr Brian Joyce	01/07/2015 - 30/06/2016
Mr Peter McWilliam	01/07/2015 - 30/06/2016
Associate Professor John Fitzgerald	01/07/2015 - 30/06/2016
Dr Alison Lilley	01/07/2015 - 30/06/2016
Mr James Bailey	01/07/2015 - 30/06/2016
Ms Juliann Byron	08/12/2015 - 30/06/2016
Accountable Officers:	
Ms Janet Compton	01/07/2015 - 10/08/2015
Mr Robert Burnham	11/08/2015 - 16/08/2015
Mr Siva Sivarajah	17/08/2015 - 30/06/2016

Remuneration of Responsible Persons

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

	Consol'd	
Income Band	**2016 No.**	**2015 No.**
$0 - $9,999	-	1
$10,000 - $19,999	2	-
$20,000 - $29,999	3	6
$30,000 - $39,999	3	1
$40,000 - $49,999	-	1
$200,000 - $209,999	1	-
$230,000 - $239,999	1	
$280,000 - $289,999	1	-
$300,000 - $309,999	-	1
Total Numbers	11	10
Total remuneration comprising all money, consideration and benefits received or receivable by Responsible Persons from the reporting entity amounted to:	**$935,776**	**$558,108**

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

Other Transactions of Responsible Persons and their Related Parties.

J Williams serves as a Member of the Latrobe University Council. Latrobe University transacts with Northern Health on normal commercial terms and conditions. In 2016 Northern Health received $1.24M from Latrobe (2015: $0.38M) and made $0.05M in payments (2015: $0.04M).
Northern Health is not aware of any other material business arrangements in 2015-16 involving Northern Health and Related Parties.

Note 23b: Executive Officer Disclosures

Executive Officers' Remuneration

The numbers of Executive Officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the schedule below in their relevant income bands.

The total remuneration of Executive Officers is shown in the first and second columns. It comprises all money, consideration and benefits received or receivable by the Executive Officers. The base remuneration of Executive Officers is shown in the third and fourth columns. Base remuneration comprises salaries, superannuation and the grossed-up reportable fringe benefits to Executive Officers from salary packaging. Base remuneration is exclusive of bonus payments, long-service leave payments, redundancy payments and retirement benefits. Executive Officers with remuneration packages in excess of $100,000 who have commenced or ceased employment with Northern Health during the year have been included in the following details.

Under Northern Health's Executive structure there are six Clinical Divisional Directors. While these Directors do not form part of the Executive a lead Director is appointed on a rolling basis to participate in Executive Officer meetings.

	Consolidated			
	Total Remuneration		Base Remuneration	
	2016 No.	2015 No.	2016 No.	2015 No.
$110,000 – $119,999	1	-	-	-
$180,000 – $189,999	1	-	1	-
$190,000 – $199,999	-	1	-	-
$200,000 – $209,999	-	-	-	1
$210,000 – $219,999	2	-	2	-
$220,000 – $229,999	1	2	1	1
$230,000 – $239,999	1	2	2	2
$240,000 – $249,999	-	1	-	1
$250,000 – $259,999	-	-	-	-
$260,000 – $269,999	1	-	1	1
$380,000 – $389,999	-	-	-	-
$390,000 – $399,999	-	1	-	1
Total Number of Executives (b)	7	7	7	7
Total annualised employee equivalent (AEE) [(a)]	12	7	12	7
Total Remuneration	**$ 2,024,279**	**$ 1,898,865**	**$ 2,016,371**	**$ 1,826,042**

(a) Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period. During the year 4 Executive Officers retired, resigned or were retrenched. As they did not work a full year, their remuneration for 2015-16 was below $100,000 and has not been reported in the income table above. A new replacement Executive Director was appointed during 2016 however as their income is below $100,000 their reumeration has not been show in the table above.

Note 24: Events Occurring after the Balance Sheet Date

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

Note 25: Remuneration of Auditors

	Consol'd 2016 $'000	Consol'd 2015 $'000
Victorian Auditor-General's Office		
Audit and review of financial statement	77	73
Total Remuneration of Auditors	**77**	**73**

Note 26: Ex-gratia Expenses

	Consol'd 2016 $'000	Consol'd 2015 $'000
Northern Health has made the following ex-gratia expenses :		
Payments associated with employee departure separation arrangements	162	313
Total ex-gratia expenses	**162**	**313**

(i) The total for ex-gratia expenses in also presented in Note 3 Expenses

Note 27: Controlled Entities

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

Note 28: Economic Dependency

The financial performance and position of Northern Health has improved since the prior year. Northern Health has reported a net surplus before capital and specific items of $0.54 million (2015: net deficit of $8.85 million), a current asset ratio of 0.34 (2015: 0.24) and net cash flow operations of $35.03 million (2015: $6.08 million).

While there has been improvement across all three indicators Northern Health's financial sustainability is still materially below the level that would enable management and the Board to form a view that the health service has adequate cash flow to meets its obligations. As a consequence Northern Health has obtained a Letter of Comfort from the State Government, namely DHHS confirming that they will continue to provide Northern Health adequate cash flow to meet its current and future obligations up to September 2017. A letter was also obtained for the previous financial year. On this basis, the financial statements have been prepared on a going concern basis.

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

Note 29: Alternative Presentation of Comprehensive Operating Statement

	Parent Entity 2016 $'000	Parent Entity 2015 $'000	Consol'd 2016 $'000	Consoled 2015 $'000
Interest	902	868	918	933
Sales of goods and services	35,141	30,900	35,218	30,926
Grants	415,625	360,375	415,625	360,375
Other Income	4,923	8,282	5,418	5,570
Total Revenue	**456,591**	**400,425**	**457,179**	**397,804**
Employee expenses	298,841	273,056	299,054	273,056
Depreciation	22,925	22,032	22,925	22,032
Interest expense	57	50	58	51
Other operating expenses	130,439	120,885	130,735	121,332
Total Expenses	**452,262**	**416,023**	**452,772**	**416,471**
Net Result from transactions - Net operating balance	**4,329**	**(15,598)**	**4,407**	**(18,667)**
Net gain/(loss) on non-financial assets	(83)	57	(83)	57
Total other economic flows included in net result	**(83)**	**57**	**(83)**	**57**
Net result	**4,246**	**(15,541)**	**4,324**	**(18,610)**

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INDEPENDENT AUDITOR'S REPORT

To the Board Members, Northern Health

The Financial Report

I have audited the accompanying financial report for the year ended 30 June 2016 of Northern Health which comprises comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the Board Member's, Accountable Officer's and Chief Finance and Accounting Officer's declaration of Northern Health and the consolidated entity. The consolidated entity comprises Northern Health and the entities it controlled at the year's end or from time to time during the financial year as disclosed in note 27 to the financial statements

The Board Members' Responsibility for the Financial Report

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used, and the reasonableness of accounting estimates made by the Board Members, as well as evaluating the overall presentation of the financial report.

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

Independent Auditor's Report (continued)

Independence

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

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of Northern Health and the consolidated entity as at 30 June 2016 and their financial performance and cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Financial Management Act 1994*.

MELBOURNE
19 August 2016

Dr Peter Frost
Acting Auditor-General

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35 Johnstone Street Broadmeadows Vic 3074
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Bundoora Extended Care Centre
1231 Plenty Road Bundoora Vic 3083
T. (03) 9495 3100 F. (03) 9467 4365

Craigieburn Health Service
274-304 Craigieburn Road Craigieburn Vic 3064
T. (03) 8338 3000 F. (03) 8338 3110

Panch Health Service
300 Bell Street Preston Vic 3072
T. (03) 9485 9000 F. (03) 9485 9010

The Northern Hospital
185 Cooper Street Epping Vic 3076
T. (03) 8405 8000 F. (03) 8405 8524

Northern Health