ANNUAL REPORT 2019

RDHS
Values Driven Care

CONTENTS

Responsible Bodies Declaration

In accordance with the *Financial Management Act 1994*, I am pleased to present the Report of Operations for Robinvale District Health Services for the year ending 30th June 2019.

Mr Quentin Norton
Board Chair

Robinvale
30 July 2019

Annual Report

Robinvale District Health Service reports on its annual performance in two separate documents. The Annual Report of Operations fulfils the statutory reporting requirements to Government and the Quality Account Report reports on quality, risk management and performance improvement matters. Both documents are distributed to the community.

These reports are available on our website:
www.rdhs.com.au

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The responsible Ministers during the reporting period were:		
The Hon. Jill Hennessy MP	Minister for Health and Minister for Ambulance Services	01/01/2018 – 29/11/2019
The Hon. Jenny Mikakos MLC	Minister for Health and Minister for Ambulance Services	29/11/2018 – 30/06/2019
The Hon. Martin Foley MP	Minister for Mental Health	01/07/2018 – 30/06/2019

OUR VISION, MISSION AND VALUES

VISION

Through leadership and innovation RDHS will improve the health, wellbeing and strength of our communities.

MISSION

To be accessible, build strong relationships, understand and meet people's needs and use resources wisely.

VALUES

Respect	We interact with others as we would expect them to interact with us.
Professionalism	We deliver services with integrity, honesty and competence.
Care	We provide a standard of service and support which we would expect for ourselves.
Commitment	We are dedicated to the promotion and ongoing success of the organisation.
Collaboration	We work together in a positive, supportive manner.

2018/19 HEALTH SERVICE SNAPSHOT

412
Renal Dialysis Episodes

21,977
Primary Health Individual Occasions of Service

86%
of Staff vaccinated for Influenza

6,363
Speech Therapy occasions of service across Robinvale, Manangatang, and Ouyen in Victoria and Wentworth, Dareton, Gol Gol , Buronga and Balranald in New South Wales

60
Women at any given time are receiving Pre and Post-Natal Care

1,830
Urgent Care Presentations

OOSH
(Out Of School Hours Program)
was open
100%
of the Victorian school term days - collecting children from all three local schools and being open until 6:00pm nightly.

ABOUT US

RDHS is a multi-campus facility with our main campus located in Robinvale and further locations with Riverside Campus and Manangatang Campus.

In 1998, RDHS was established as a Multi-Purpose Service (MPS) incorporated under the Health Services Act 1988 and in 2009 expanded to incorporate the then former Manangatang & District Hospital. RDHS MPS is one of seven MPS's operating in Victoria and one of 146 Nationally and funded under the MPS Program, a joint initiative of the Australian Government and state and territory governments. This program provides integrated health and aged care services for some small regional and remote communities. It allows services to exist in regions that could not viably support stand-alone hospitals or aged care homes. RDHS receives Australian Government funding to deliver aged care services with the Victorian Government providing block funding for health services.

Under the MPS model RDHS provides a range of services, 20 acute beds, 24 residential aged care places and provide urgent care services to both Robinvale and Manangatang communities. A comprehensive range of additional services includes renal dialysis, medical imaging, midwifery, visiting nursing, allied health and early years' services (playgroups, support for complex need families).

In 1999 the Robinvale Committee for the Ageing; Riverside Hostel - Residential Aged Care Facility, transferred ownership of the Residential Aged Care business to RDHS for management outside of the MPS model. Riverside Campus, as it is now known, consists of 30 beds and is funded by both the Australian Government and contributions from residents. The basic care subsidy for each permanent resident is calculated using the Aged Care Funding Instrument (ACFI). The ACFI is a tool that the provider uses to assess the care needs of a resident. Riverside Campus is required to meet the Australian Aged Care Quality Standards.

In addition to service delivery in its immediate area, RDHS provides outreach services to the communities of Ouyen, Boundary Bend and Manangatang in Victoria and Dareton, Wentworth and Balranald in New South Wales. Overall a catchment area of approximately 60,000 square kilometres.

Our Services

Hospital (acute)

- 20 acute medical beds
- Stabilisation and resuscitation
- Urgent Care Centre
- Maternity Program - Ante and Post Natal Care
- Palliative care
- Post Acute Care
- Medical Imaging
- Renal Dialysis

Aged Care

- Riverside Campus - 30 Low Care Residential Aged Care beds
- Main MPS site - 14 High Care Residential Aged Care Beds
- Manangatang Campus - 10 High Care Residential Aged Care Beds
- Respite Care
- Adult Day Activity and Support Service

Primary Care Services

- Aboriginal Liaison Officer
- Access & Support Worker
- Early Years program
- Aged and Disability Support
- Asthma Education
- Counselling
- Diabetes Education
- Exercise Physiology
- Health Promotion / Education
- Immunisation Program
- Men's Programs
- Dietetics
- Occupational Therapy
- Pap Smear Screening/Women's Health
- Physiotherapy
- Podiatry
- Social Work
- Speech Pathology

Home Nursing Service

- Visiting Nurse Service
- Palliative Care Nursing
- Post Acute Care

Support Services

- Administration
- Customer Services
- Employer Training Programs
- Graduate Nurse Program
- Hospitality and Facilities Management Services
- Information Technology
- Meals on Wheels
- Occupational Health and Safety
- Public Relations
- Supply
- RDHS Linen Service
- Volunteer Services

A wide range of specialist services over a vast area!

STRATEGIC PLAN 2019 – 2024

DIRECTION 01
Become a provider of in-home aged care services

DIRECTION 02
Become a provider of disability support programs and services under the NDIS

DIRECTION 03
Increase focus on community mental health needs, concentrating on mental health promotion and timely referral

DIRECTION 04
Increase capacity to deliver telehealth services

DIRECTION 05
Expand the delivery of health and wellness promotion programs to address chronic disease prevalence

DIRECTION 06
Enhance health care and residential aged care infrastructure at RDHS campuses

DIRECTION 07
Stabilise funding for early childhood care and education services

DIRECTION 08
Increase workforce capacity and develop a leadership program to promote a sustainable middle management workforce

DIRECTION 09
Enhance partnerships with other regional health service organisations providing support to the catchment population including: Mildura Base Hospital (MBH), Murray Valley Aboriginal Co-operative (MVAC), Mallee Track Health & Community Service (MTHCS), Swan Hill District Health (SHDH), Sunraysia Community Health, The Primary Health Networks and Mallee Family Care

DIRECTION 10
Increase community engagement exploring new ways to deliver key health messages, initiatives and events

DIRECTION 11
Promote innovation, scanning the environment for new approaches to health service delivery

Through leadership and innovation RDHS will improve the health, wellbeing and strength of our communities.

The piece of artwork shown represents the health, wellbeing and strength of our RDHS Communities. It is a collaborative design completed with our partners Murray Valley Aboriginal Co-operative and Robinvale College. RDHS would like to acknowledge the Traditional Custodians of the land we work upon and pay our respects to Elders past, present and emerging.

BOARD CHAIR AND CHIEF EXECUTIVE OFFICER'S REPORT

Board Chair

On behalf of the Robinvale District Health Service (RDHS) Board, I am proud to present the Annual Report for the year ending 30th June 2019. This report is prepared in accordance with the *Financial Management Act 1994*.

I would like to acknowledge the traditional owners of the country on which our campuses are located. I wish to pay respect to Elders past, present and emerging. I would also like to make special mention of the vast and varying cultures that make our area such a diverse and wonderful place in which to live.

This year we were unceasing in our passion for continuous improvement. This enabled RDHS to further improve the health, wellbeing and strength of our community as evidenced through our accreditation with the 10 National Safety Quality Health Services Standards (NSQHS).

At this point I would like to point out one particular standard - Standard 2 '*Partnering with Consumers*'. It is this standard where YOU have the opportunity to get involved, have YOUR say and make a difference to YOUR local Health Service!

As I mentioned in last year's report, the Board has formed a Community Advisory Committee (CAC). If you are available to provide feedback, please register your interest in the RDHS CAC as this is a valuable tool for Partnering with our Consumers.

RDHS was fortunate enough this year to participate in the 2018 Study Tour of America and Canada, hosted by the Victorian Healthcare Association (VHA). This was a fantastic opportunity to gain insight into healthcare issues and solutions for Indigenous and vulnerable communities including undocumented clients. VHA hold small study group tours for CEO's, Board Members and Executives on an annual basis.

Delegates had the opportunity to meet with high achieving CEO's and Executives from other health organisations in North America, learn, compare experiences and forge business relationships. To give an example of opportunities, on one occasion we met with Kaiser Permanente which would normally cost visitors around $13k.

Highlights included ICHOM, Dana-Farber Cancer Institute, Anishnawbe Health Toronto for indigenous health care, Intermountain Healthcare and Kaiser Permanente for data and systems innovation.

All organisations have been wrestling with an integrated system for client information. Not one organisation has completely resolved the challenge of collecting patient information and sharing across multiple organisations for holistic care of clients. Some organisations are making inroads into the use of technology and e-health to deliver healthcare in homes, particularly for remote communities.

What is clear is that e-health and an electronic record is the cornerstone of care delivery across all the organisations visited. It is the basis for which information can be gained and used to measure and improve care.

That being said one quote of note was; 'you can't fatten a cow by weighing it' It is clear that Canada and USA are moving towards value-based health care which is all about measuring the health outcomes for each client rather than measuring service hours or numbers of clients.

I am pleased to report that RDHS was invited to present a paper at the Biennial 15th National Rural Health conference held in Hobart, March of this year (2019).

The paper, titled, "TREE; The Ripple Effect of Ethnicities" was jointly presented by Mara Richards, Chief Executive Officer and Ray Gentle, Director of People & Culture. The presentation, was warmly received by a very enthusiastic audience that included Freule Jones, Board Member and provided a snapshot of one of our award winning and innovative projects at a national level.

The Board again held their inaugural Board Planning and Development weekend with great success. This weekend focused on bringing in guest speakers that motivated our thinking around our strategic directions. Again, all of the Board and the Senior Management Team were involved in this innovative weekend. I would like to thank the various speakers, Board and staff for making this such a worthwhile annual event.

This leads me to the most important piece of work that was finalised this year, from a Board perspective, our Strategic Plan. We are very pleased with the end result and excited to present it to staff and the community. Moreover we look forward to the implementation of our 'road map' for the future!

The Board membership has evolved this year as we said goodbye to Jane Neyland and Michael Krasna. I thank them for their contribution throughout their time on the Board. We welcomed Kady Moore, Jack Dang, Abby White and Glenn Stewart to our Board and appreciate the skills and experience they bring with them.

Major capital improvements this year saw the completion of the construction ofthe four bedroom house mentioned in last year's report. This house is now utilised for staff accommodation. We also completed an upgrade to the facade of our Riverside campus, constructing a new canopy to allow for shelter at the main entrance.

Once again RDHS has benefited from outstanding support from community volunteers, both groups and individuals, who selflessly gave both time and financial assistance. As we all know, communities like ours and specifically RDHS would not be able to achieve what they have if not for the many volunteers that support our service. To these special people I say thank you.

In conclusion, on behalf of the Board, I would like to thank our CEO Mara Richards for her ongoing stewardship of our thriving health service. RDHS has a lot to be proud of this past year, and this would not be possible without our staff. As a Board, we are continually impressed at how our staff embrace change and strive for continuous improvement. As always, I believe it's fitting that my final words are a tremendous thank you to all staff!

Quentin Norton
Board Chair

Chief Executive Officer

It is again my very great privilege and pleasure to present our health services operational highlights for the 2019 Annual Report on behalf of the senior management team and staff of Robinvale District Health Services. It is the hard work and efforts of our staff through the various services and programs that we manage that result in success and the well-being of our communities we serve. RDHS is an integral part of the diverse and multicultural community we, as individuals and groups provide for the health and well-being needs of our community as and when required 24 hours a day, 7 days a week.

This year we have welcomed a number of new staff however I would like to acknowledge two staff who have taken on senior positions;

- Emmanuelle (Manny) Geri, Director of Nursing, Manangatang campus.
- Poorani Balasundaram, Manager Primary Care.

RDHS welcomes you both and look forward to your contribution to the health service and its ongoing development into the future.

RDHS has also seen some individuals leave and I would like to acknowledge their contribution and in particular, the outstanding care they afforded to our community through the positions they held;

- Sandra Cocks, Registered Nurse, 17 years.
- Darlene Stevens, Grounds person/ general Maintenance duties, 9 years.
- Pieter Uys, Podiatrist and Manager Primary Care, 8 years.
- Caitlin Duryea, Receptionist, 8 years.
- Jessy Varghese, Registered Nurse, 8 years.
- Sarah Beattie, Enrolled Nurse, 6 years.
- Reshma Vaniya Kandiyil, Registered Nurse, 6 years.
- Rinti Raphael Pullokaran, 5 years.

RDHS sincerely thank you all for your contribution to our patients, residents and clients that you have both individually and collectively, cared for, over significant periods of employment times. You are all proudly acknowledged, for providing your expertise in your various areas of employment and will be remembered with great respect and admiration from all.

This past year has also been one of a focus on our aged care services and we developed an aged care plan with the assistance of Dementia Australia, known as the "Birch" project. Our thanks to Gail Robinson, Nurse Unit Manager of Riverside Campus who continues to lead the project with the assistance of her "champions";

- Lorraine Connell
- Michelle Geran
- Renay Handley
- Heather McPherson
- Leticia Marabito
- Sue Mattschoss
- Teresa Mezzatesta
- Alison Watts
- Josh Loy

Results achieved thus far have been significant and provide RDHS with a framework of aged care of which we can be proud. Thank you to all that have renewed our focus on residential care delivery.

RDHS undertook a formal review of our aged care services by consultant Janet Farrow and sought guidance on a way forward in the provision of care. The report afforded RDHS with eight (8) Recommendations for the Board to consider and the senior management team to implement. From an operational perspective there were changes to the organisational structure which has resulted in one senior position incorporated to be responsible for all aspects of our residential aged care. Emmanuel Geri has accepted this portfolio with great enthusiasm and will ensure we enhance the experiences of the residents across all three campuses.

I should also mention that we have now established our first "joint" position with Mallee Track Health and Community Services in Ouyen. Ray Gentle formerly our Manager of People and Culture is now Director of People and Culture over the two organisations. Ray had provided both organisations with a service that ensures the optimum stewardship of all things human resource!

The Aboriginal Artwork project has become a reality spanning MVAC, RDHS and Robinvale College! At each site, a celebration was held to commemorate this significant achievement and recognition of this valuable partnership within our community. The three campuses now display with great pride artwork that acknowledges the partnership between us.

RDHS has maintained its accreditation status successfully across all of its mandated requirements and this includes the following;

1 Quality ISO 9001:2015
2 Australian Aged Care Quality Agency Standards
3 National Safety Quality Health Services Standards

RDHS would like to acknowledge the GP's we have worked closely with during the time of this report, whom include Dr Sean White and our newest GP, Dr Jane Neyland! Dr Jane has continued in the space vacated by Dr Luigi Lucca who after many years has retired to enjoy other activities in his life. Our sincere Welcome to you Jane and your Family "back" to Robinvale. Our sincere thanks to Dr Luigi who was a great support and friend to all, not just the health service but to the community he loved and cared for. Our fondest farewell to you and we all wish you great happiness in your well-deserved retirement. Thank you all for your dedication as our care and service is not complete without you.

I would now like to conclude this introduction and take the opportunity to thank all of the staff that work at RDHS across all three campuses on behalf of the senior management team. I am very proud and privileged to be your CEO as it is all of you that make RDHS the special place that it is. It is a wonderful place to work and each of you contribute to the success that, it is. Your ongoing commitment, dedication, energy and care that you demonstrate is appreciated and you should all be very proud of your efforts. We cannot stand still for long though as we have a journey to continue on for the betterment of the health of our community. Some of you work within the walls of the health services and some of you in the community, no matter where you are you make a difference to the lives of the individuals that make up our communities. Remember what you are here to do and the reason why you do it. Your efforts and care are not only appreciated by the Board of Directors and myself, but by the ones you interact with during your day....

I would like to acknowledge and thank the ongoing support and efforts of our Board of Directors lead by Quentin Norton. Our Board is energetic and forward thinking, guiding all of us to a future of exciting times and challenges. The journey is based upon our shared Vision and Values and how we develop together for our health service to be relevant to our communities and to ensure the wellbeing of all that come to us. Thank you to my senior management team, you all constantly challenge my thinking and how we can do things better in a safe and quality focused framework! You are my heroes and greatest support and together with your teams' we can only strive for excellence though innovation, innovation, innovation!

Mara Richards
Chief Executive Officer

CLINICAL SERVICES REPORT

Acute Services

Robinvale District Health Services has participated in the whole of State health initiative – Strengthening Hospitals Response to Family Violence (SHRFV). Achievements to date include:

- Staff training
- Community awareness
- Policy supporting the implementation of SHRFV for both community and our own staff
- Participating in the 16 days of Activism

The response to our campaign has been extraordinary. Staff photos with slogans posted daily on Facebook during the 16 days of Activism reached in excess of 1,000 hits daily. Promoting respect towards women is a key message as Family Violence starts with disrespect. The aim of the project is to reassure the community that RDHS is a safe place and can support them in escaping Family Violence with appropriate referrals. It is also delivering the message to men that it is not ok to perpetuate violence towards women. Whilst violence is acknowledged to occur woman to man, the statistics demonstrate most violence is against women. Recognising Family Violence as a health issue has enabled us to implement strategies to address the problem and work towards reducing the impact to the individual, the family and the community. Further training is planned for our frontline staff to hone their skills in sensitive listening to support victims of Family Violence.

RDHS continues to face challenges with afterhours support to the Urgent Care Centre (UCC) and are currently reviewing possibilities to lessen the burden on our local Doctors. The daily average of 5 presentations is similar to the previous year with the majority being classified Category 4 and 5. RDHS staff have been commended on their clinical skills when managing the stabilisation of 21 Category 1 and 2 presentations over the past year. Many of these are stabilised and airlifted out for further management. Manangatang campus is fortunate to now have a MICA Ambulance Victoria Officer stationed locally. This role also offers education for all our nursing staff – a fabulous initiative to boost our skills and confidence in managing critical presentations.

With the introduction of Victorian legislation - Voluntary Assisted Dying Act 2017, RDHS is reviewing our capacity as to which pathway we will introduce. It is anticipated that only a small number of Victorians will be impacted with the very strict criteria required to be eligible.

After 14 years of dedicated service to Robinvale, we farewelled Dr Luigi Lucca. Dr Lucca has been a great support to RDHS carrying a majority of the on call load for many years. To work hours beyond those in his very busy clinic is a testament to Dr Lucca's caring approach to our community. We are very happy to welcome Dr Jane Neyland and Dr Sean White as Visiting Medical Officers' and we look forward to a long-term working relationship with them both.

Residential Aged Care

Turnover of staff has been a challenge in delivering services across our three sites in the past year and has seen a reliance on Agency staff being utilised. Staff have been up to the challenge and ensured quality care is maintained for the residents.

The Birch Leadership team launched their project at Riverside with the support of Dementia Australia. The project has identified the goals and values important to the residents with several small teams currently working on projects to enhance the living experiences of our residents. This has included visits from mothers and their babies to enrich intergenerational relationships and support connections to community. Plans are underway to create a space for residents to entertain their own visitors beyond the communal areas or their own bedrooms. For some residents the opportunity to again "cook" and provide delicious food has been a positive experience. These concepts have had a flow on effect and similar projects are underway at the main site nursing home with the most noted being the improvements to the outdoor area being more inviting for residents and families to enjoy. Manangatang campus have also been the recipients of an improved outdoor area. Both high care facilities are enjoying new large screen SMART televisions.

RDHS has fully cooperated with requests made for the current Royal Commission in Aged Care. We have undertaken a review of past incidents over 7 years and did not identify any systemic concerns. RDHS has embedded a strong belief in our incident reporting process and the "no blame" approach to ensure we capture all incidents and appropriately manage them with a focus on person centred care and best practice.

Regular reviews with Geri Connect (Geriatrician appointments via video conference) is embedded into practice for all residents. This has successfully overcome our isolation from Specialists such as the Geriatrician. Their involvement improves outcomes by supporting the GP in providing care. Several referrals have seen an increased use of the resources offered by Dementia Australia.

Dialysis

Dialysis clinics are conducted every Monday, Wednesday and Friday with 412 episodes of care attended. Under the auspice of Royal Melbourne Hospital, Robinvale staff provide a high quality service to the local community as well as to short-term patients waiting for permanent placement elsewhere and also the occasional holiday visitor to the area. Our staff, ably led by Nurse Unit Manager Binu Joy are commended for their dedication to the clinic, especially without the medical support that larger facilities receive. Telephone support is greatly appreciated from Royal Melbourne staff and the local GP's to assist in managing our high-risk patients. Patients and staff were very happy to receive new dialysis machines this past year.

RDHS provide consulting rooms for the visiting Nephrology team every 6 to 8 weeks. The team is from Royal Melbourne Hospital so the same Doctors' our dialysis patients see when they first commence on dialysis.

The clinic also have appointments with community members suffering kidney disease or failure. The aim is to prevent or delay the need for dialysis by monitoring and treating them accordingly.

Midwifery Services

Our community is fortunate for the ongoing support for expectant mothers by offering a shared care arrangement. This program established in 2007, has continued to provide appropriate care to the community, and reduced the significant impact of travelling to receive care. The main birthing hospital - Mildura Base Hospital is also a beneficiary as there is reduced associated risks in delivery when the birthing mother has received good antenatal care. Midwife Vicki Broad created the program and continues today as the sole midwife servicing the local area, thank you Vicki for your dedication and expertise.

Over the past year, the midwife has:
- Had 488 appointments both ante and post-natal.
- Assisted the visiting Doctor with 607 appointments.
- Conducted 73 booking in episodes to the birthing hospital.
- Attended 64 Pap Smears.
- Held 3 sets of birthing classes for expectant mothers and their partners' afterhours.
- Attended to 118 domiciliary visits to the home.

The busy year has also included support to the visiting Gynaecologist to assist in meeting the needs of our community.

Infection Control

RDHS has well established policies and processes in addressing Infection Control aspects of care delivery. It is recognised that all staff play an important role in preventing Hospital acquired infections. These include:
- Cleaning audits surpassing the expected pass rate of 85% at every audit.
- Hand Hygiene audits surpassing the expected pass rate of 85% at every audit.
- No reports of Hospital acquired infections to VICNISS from our acute sector.
- The reporting and monitoring of antibiotic usage – demonstrating Antimicrobial Stewardship.
- Last winter RDHS staff surpassed the expected pass rate of 80% being immunised with the Influenza vaccine reaching 86%.

Staff are commended on making good infection control practices part of their usual work routine. The general public are also thanked for heeding our organisation requests:
- Not visiting residents or patients if you have a respiratory illness.
- Not visiting residents or patients if you have gastro type symptoms.
- Using the hand hygiene stations available thus promoting good habits and assisting in preventing the spread of germs.

Medical Imaging

Locum support in Medical Imaging has been sporadic over the past year and the position remains vacant currently. With the difficulties experienced in recruiting to the dual operator role, RDHS currently has two nursing staff members undergoing training to be able to perform nurse led basic x-rays as a means of alleviating the local demand in this area. We are continuing to explore viable options that will best suit our community needs.

Clinical Governance

RDHS continues to strengthen our approach to clinical governance by embedding the practice of conducting in depth clinical reviews on all category 1and 2 incidents. Reviews of incidents enables us to identify potential improvements and to implement changes to promote best practice.

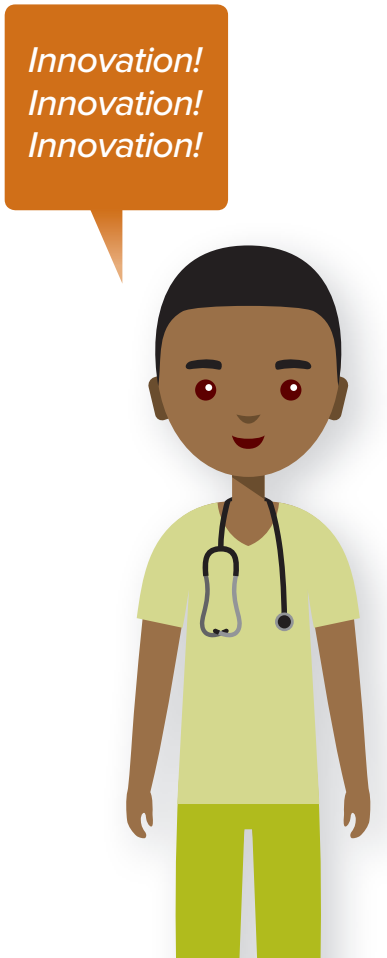
We also conduct reviews on categories 3 and 4 where it is identified there has been more frequent incidents although no injury or minor injury. These reviews have enabled changes to practice to avoid serious injury potentially in the future. In depth clinical reviews are conducted across both the acute and residential care sectors.

The Clinical Governance meetings are well supported by our staff, Board of Management, the Visiting Medical Officers, community Pharmacist and Barratt & Smith Pathology area Manager. The expertise of each stakeholder is appreciated.

Visiting Nurse Service

The Visiting Nurse Service is available to the Robinvale and Manangatang communities. The Manangatang need is relative to the size of the community with a total of 271 visits and the patient list declining from eleven to currently seven clients. Robinvale and district maintains high activity with in excess of 9,500 kilometres travelled over the past financial year for 1,541 occasions of service. Robinvale activity includes:
- 25 post-acute care clients.
- 47 clients requiring specific wound care.
- 2 clients receiving palliative care within their home.
- An average of 16 clients needing long term monitoring and support per month.

The VNS support to community assists in keeping people in their home and avoid unnecessary or prolonged hospitalisations.



CORPORATE SERVICES REPORT

Several Corporate Support Service teams work in clinical areas, including catering and environmental services, while others deliver maintenance, business, administrative, finance, payroll, human resources and IT support.

Highlights

Construction a 4-bedroom residence for staff accommodation on vacant land owned by RDHS.

Management Advantage – Manad Plus (Residential Aged Care software). Implementation commenced late 2018, Riverside Campus and Manangatang Campus are now on board with the main campus scheduled for July 2019.

Implementation of an Asset Management Information System.

Riverside Residential Aged Care campus:
- Entry Canopy project completed
- Exterior of building re rendered

Robinvale campus –Sensory Garden in the Aged Care courtyard completed.

Corporate Services – Finance, ICT and People & Culture support is being provided to Mallee Track Health & Community Services via a contractual arrangement.

Finance

The accepted indicator of performance is the result from continuing operations prior to depreciation and capital purpose income. RDHS did meet all set DHHS performance indicators.

Please refer to the attached Financial Statements for further information.

Funding

In addition to operational funding from the Department of Health and Human Services Victoria and the Commonwealth Department of Health, RDHS secured supplementary grants from the State and Commonwealth Government and other agencies to support the Robinvale community through various programs. Programs such as Best Start, Communities for Children, Early Years; HIPPY (Home Interaction Program for Parents and Youngsters) and Primary Health Services Flexible funding, via the Murray Primary Health Network, Rural Doctors Network and the Western New South Wales Primary Health Network.

Compliance

Assurance with new legislative reform and ongoing compliance remains a high priority.

The Finance & Audit Committee continues to monitor the adequacy of risk management, accounting procedures, financial reporting and compliance with statutory requirements. The internal audit program is undertaken by Audit & Risk Solutions, independent internal auditors contracted by the RDHS Board. Accounting & Audit Solutions Bendigo were also engaged to undertake a specific audit of RDHS compliance with the requirements of the Financial Management Compliance Framework under the Standing Directions 2016 under the Financial Management Act 1994. RDHS was deemed fully compliant.

Asset Management Accountability Framework (AMAF)

The Department of Treasury and Finance AMAF has required extensive updates to our policies and procedures for asset management. The Maintenance team has implemented a number of major changes to our processes including the development of the new Maintenance and Operations Plan and research and implementation plan for the new Assets Management Information System. Compliance to the new requirements has been reviewed through an internal audit process.

Facilities Management

Facilities Management provides the ongoing maintenance of physical facilities to ensure they are reliable, safe and comply with relevant standards. Maintenance of our infrastructure requires planning, coordination of redevelopment and refurbishment programs and

preventative and reactive maintenance for essential plant and equipment at all sites. To assist us we have sourced a facilities management system which enables us to have a more structured asset orientated approach and bring about more consistency and better oversight across the organisation.

The solution will provide robust functionality across critical operational areas such as asset and work order management and contractor and visitor management.

Food Services

Our Catering departments at all campuses continued their quality work in the past year. The team of approximately 20 staff provides more than 50,000 meals each year to patients, residents, visitors and staff. We have recently commenced a review of Catering Services across all campuses. This review will undertake a deep dive into catering staff levels, menu's and current practices.

Hotel/Linen Services

The cleaning staff of approximately 8 people continued their quality work delivering excellent results with external cleaning audits results well above the industry target of 85.

The laundry staff continue to provide a high level of service to both internal and external customers. Our service area extends to Balranald, Ouyen, a local medical clinic, Robinvale & Euston Motels, other accommodation providers and horticultural business in Robinvale.

Resident personal laundry is managed by the linen service with delicate precision.

Community initiative

Robinvale District Health Services is a keen participant in in all areas of community. For many years with financial assistance from Swan Hill Rural City Council, RDHS has managed the operations of the Robinvale / Euston Tourist Information Centre.

12,818 customers accessed the Tourist Information Centre in the 18/19 year and Vline customer's equated to over 60% of the total customers visiting the centre. Vline sales continue to be strong with 3 months this year where sales exceeded all previous years on record. This is an indication of the importance of public transport options in Robinvale.

The sustainability of non-health community units is reviewed annually to ensure that there is no financial impost on the health service.

Procurement

RDHS as a Multi-Purpose service is not mandated under the Health Services Act (1988) Vic to procure through Health Purchasing Victoria (HPV). However, we do wherever possible seek access to relevant HPV contracts to ensure that RDHS achieves best value outcomes when procuring.

RDHS does have a staff member commencing the Certificate IV in Government (PSP40116) pilot program at Bendigo TAFE. This new nationally accredited training course has been developed by Bendigo TAFE in collaboration with Health Purchasing Victoria and advisors from the health services industry. The content is designed to provide the attendee knowledge of public service principles and the specialist skills required to plan, develop and manage procurement within the Victorian public health sector.

2019 heralds the introduction of the RDHS Social Procurement Strategy. This strategy applies to the procurement of all goods, services and construction undertaken by, or on behalf of RDHS post 1 September 2019. For further information on the Social Procurement Framework please refer to the website https://buyingfor.vic.gov.au/social-procurement-framework

Information Technology

The RDHS Information Technology Support team is responsible for providing baseline user support services for ICT systems and infrastructure. The key delivery mechanism for higher level ICT support is via external company Pro Advance Mildura.

RDHS is also a member of the Loddon Mallee Rural Health Alliance (LMRHA). ICT development and software implementation support is provided by LMRHA.

Key areas of focus from a RDHS perspective in the 2018/19 year have been:

- Cyber Security
- Telehealth
- PC Upgrades/replacements
- Management Advantage – Manad Plus (implementation)
- Asset / Facilities Management software (implementation)

Environmental

RDHS strives to continually improve the health of the people in our community by endeavouring to provide health care in an environmentally sound and sustainable manner. We commit to continual improvement in energy to reduce our carbon footprint. Refer to Environmental – RDHS Energy Use graph on page 15.

The 100kW solar system at the main campus (installed November 2015) continues to generate significant monetary and environmental efficiencies. Monitored data output for the period November 2015 to August 2019 shows a saving of $115,681 through the production of 522.14MW of power generated.

Information and Communication Technology (ICT) expenditure 2018/19

Business As Usual (BAU) ICT expenditure	Non-Business As Usual (non-BAU) ICT expenditure		
Total (excluding GST)	Total=Operational expenditure and Capital Expenditure (excluding GST) (a) + (b)	Operational expenditure (excluding GST) (a)	Capital expenditure (excluding GST) (b)
$445,121	$61,360	$61,360	-

As part of the Greener Government Buildings Program a 20 kW solar system was to be installed at the Manangatang Campus in the 2018/19 year, however the installation has been delayed for reasons outside our control. The anticipated annual saving is up to $5,600.

In addition:

- LED lighting: continue to replace existing globes across the organisation.
- A number of computers were upgraded to dual screens, reducing the need to print a document for working purposes.

Refer to graphs below.

People & Culture

The People & Culture department is responsible for overseeing industrial matters, recruitment and retention, performance management, professional development, employee support, OH&S and payroll.

The role supports the health service through cultural change by creating, implementing and managing change and supporting the Management team in leadership development through performance management systems and constructive feedback.

In January 2019 the Director People & Culture became a shared service with Mallee Track Health and Community Service.

Recruitment

RDHS continues to experience difficulties in the recruitment of Registered and Enrolled Nurses and some disciplines within Allied Health. It is still increasingly difficult for small rural communities to attract health professionals; however, we have implemented an ongoing strategy to seek suitable candidates throughout the year. To supplement our recruitment we engage Agency staff in the interim while we continue to recruit.

Staff Credentialing

RDHS verifies the credentials of all registered practitioners annually though Australian Health Practitioners Regulation Agency (AHPRA) public access web site or directly with presentation of renewed registration.

Clinical Placement/Work Experience

Placements were undertaken by:

- Allied Health Students
- Registered Nurse Students (Acute setting)
- Students from Robinvale College

Traineeships/Apprentices

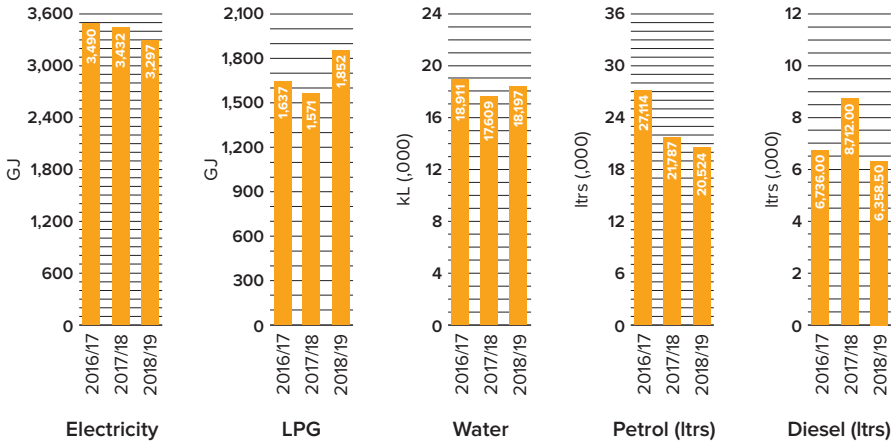
In November 2018 we commenced a Food Service Apprentice working in our Main Campus Kitchen which will be conducted over the next 3 years. The Apprentice will be completing a Certificate III in Commercial Cookery at Sunraysia Institute of Technical and Further Education.

Additionally we commenced a School Based Apprentice in July 2018 for a young Aboriginal man from Robinvale College working in our Grounds and Maintenance team 2 days per week. The Apprentice is completing the Certificate III in Parks and Gardens at Sunraysia Institute of Technical and Further Education.

15th National Rural Health Alliance Conference

The CEO and Director People & Culture presented at the Conference showcasing our TREE Project and Conversational English achievements. The presentations were well received at the conference which we also highlighted our region and RDHS.

Environmental - RDHS Energy Use



Hospital Labour Category	JUNE Current Month FTE*		JUNE YTD FTE**	
	2018	2019	2018	2019
Administration & Clerical	20.53	19.46	20.64	19.86
Ancillary Staff (Allied Health)	21.93	24.57	22.37	23.23
Hospital Medical Officers	0	0	0	0
Hotel & Allied Services	35.95	38.17	35.65	36.27
Medical Officers	0	0	0	0
Medical Support	0	0	0.66	0
Nursing	38.75	39.45	40.49	37.71
Sessional Clinicians	0	0	0	0

The table above *(current month FTE) represents all employees that were paid in the month of June and their FTE for calculation for that month. **(YTD FTE) means all employees employed throughout the financial year i.e. the sum of each month FTE divided by 12.

PRIMARY HEALTH

In the past year, Primary Care has seen an innovative shift towards embracing telecommunications technologies in the delivery of health care. We have also adapted a more active stance in promoting and improving mental health in the community.

One of the biggest projects Primary Care is involved in is the Speech Pathology program in partnership with Royal Flying Doctors Services and Mallee Track Health and Community Service. This program employs telehealth services and a delegated model of care whereby Speech Pathologists and Allied Health Assistants work in collaboration to provide paediatric Speech Pathology services across the Robinvale and Mallee Track catchment areas, including Sea Lake, Underbool, Ouyen and Murrayville. As part of this program, the Speech Pathologists have also delivered education to Early Educators and parents in the Mallee and Robinvale areas on when to refer to Speech Pathology services and the importance of early identification in the treatment process. This has led to an increase in referrals and understanding of the Speech Pathology services in the regions. This program has been running across all sites with very positive feedback from parents and teachers. The program has allowed a significant increase in access to paediatric Speech Pathology services in the Mallee region.

As always Early Years is delighted to see families from all cultures attending playgroups on a weekly basis. We run three playgroups per week, during school terms and see in excess of 100 people attend weekly.

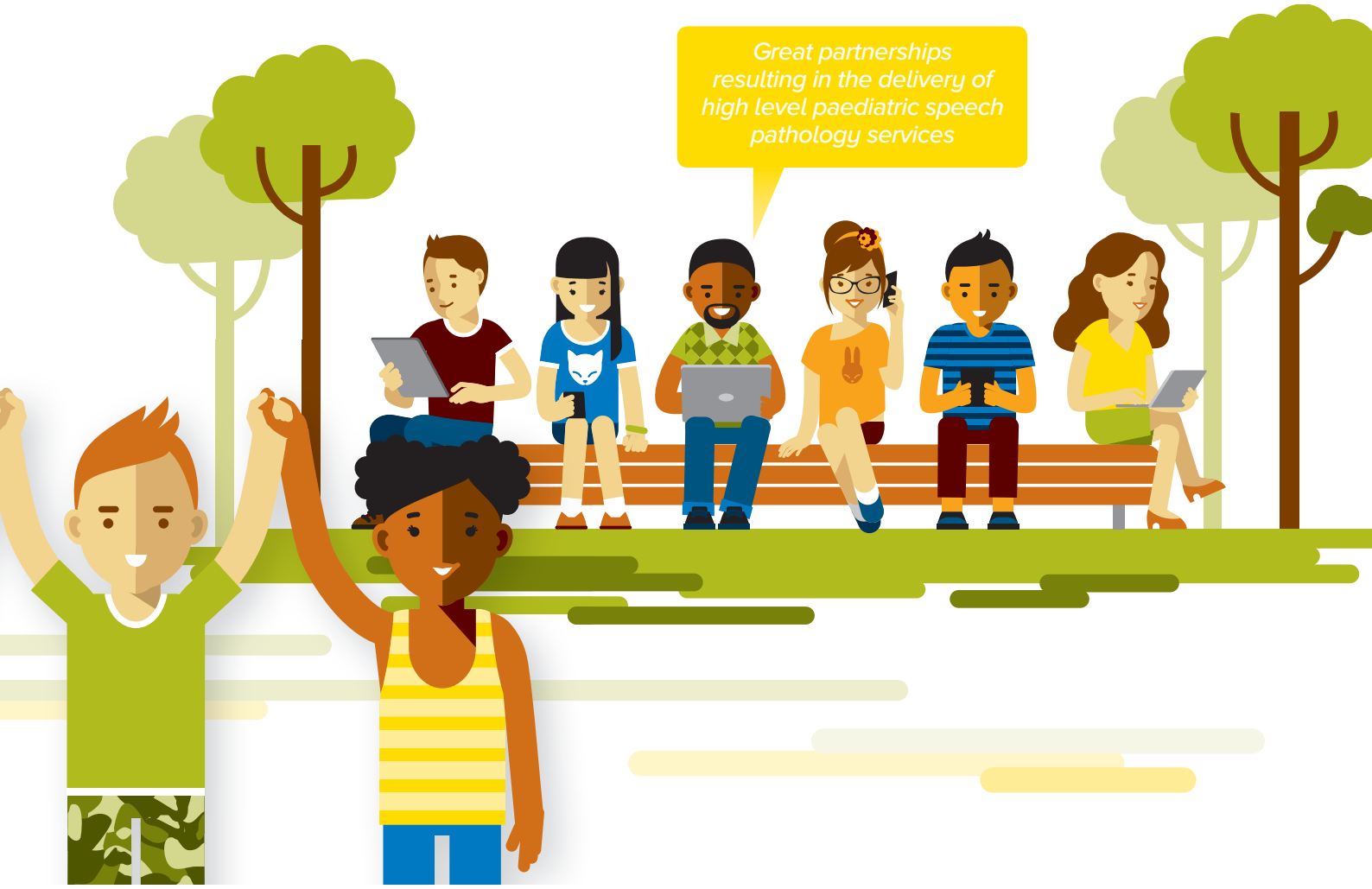
This Year RDHS made a formal partnership with 'Our Place' which is based at Robinvale College, both RDHS, Robinvale College and other local services made a formal agreement to work together on a more targeted approach to helping our children and families thrive.

Continuing on with new partnerships RDHS is part of a new wider Swan Hill Council area based program, Better Together, to again look at ways we can support the families we work with.

The Victorian Government program 'Best Start' has been in Robinvale for a number of years, the work within this program concentrates on connecting and supporting Early Years staff within the community at the Early Learning Centre, Preschools, Playgroups and Primary schools.

In mid-2018, Primary Care began delivering some of Murray PHN Mental Health initiatives in Robinvale, including the Alcohol and Other Drugs program, the Dual Diagnosis program for Aboriginal and Torres Strait Islander clients and Clinical Care Coordination in partnership with Sunraysia Community Health Services. All three of these programs were delivered by our team of Social Workers and the Community Wellbeing Officer to increase the focus on Mental Health needs in the community.

The Health Promotion team continued their hard work to promote a healthy lifestyle in the workplace as well as the community. Quick Hands, a pad-work focused boxing program continues to be a popular and extremely successful program. A 6 week program was run with the community in April 2019 and two Quick Hand sessions were delivered in May 2019 to the Clontarf Academy. These sessions provided all the participants an opportunity to learn the technical and disciplinary aspects of boxing while promoting physical and mental wellbeing.



In May 2019, the Health Promotion team also presented to approximately 50 children in Year 5 and Year 6 from St. Mary's school. The interactive presentation covered topics like healthy eating and the importance of physical activity and was followed by activities for the children to identify and match food groups and sugar content.

Workplace health and wellbeing was also a highlight this year. The Premier's Active April initiative was hosted at RDHS during the month of April. Staff engaged in fun weekly activities such as Frisbee, Finska and football and clocked in over 56 hours of physical activity during the month of April.

The Health Promotion team continues to run the Heart Foundation Walking group, Red 25 Blood Group and the Cancer Council's Biggest Morning Tea all of which have had very positive outcomes.

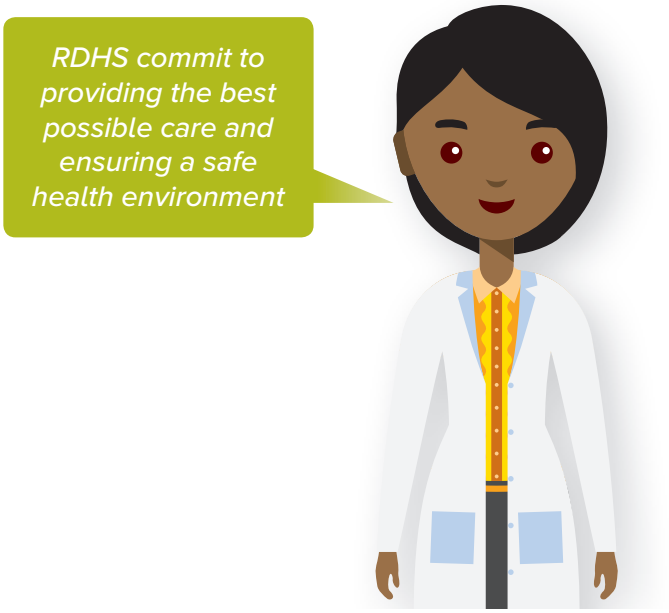
A Cervical Screening clinic was set up at the IGA carpark in the RDHS caravan on the 17th and 18th of June 2019 to provide a culturally appropriate Cervical Screening service to under-screened women from the Culturally and Linguistically Diverse communities in Robinvale and surrounding areas. The screening clinic was a success with women from a variety of cultural backgrounds attending.

Through partnership with the Rural Doctors Network, Balranald Multipurpose Service and Western New South Wales PHN, the Primary Care Allied Health team continues to provide outreach services to Dareton, Wentworth and Balranald.

The Primary Care team is looking forward to lead the next year by expanding the delivery of health and wellness programs through innovation and excellence.

QUALITY AND RISK

RDHS continues to demonstrate ongoing commitment to maintain our Quality Management System (ISO 9001 QMS) and adhere to the National Safety and Quality Health Service (NSQHS) Standards, maintaining certification in all 10 National Standards. We are committed to providing the best possible care and ensuring a safe and healthy environment, the organisation continuously strives to improve our services to identify and eliminate or minimise risk.



Quality

RDHS has a strong commitment to safety and quality and this is reflected in our approach to:

- Ensuring accountability for the safety and quality of care at all levels of the organisation, reporting through to the Board of Management.
- Creating safe environments and systems for consumers and staff
- Reviewing and improving the performance of the patient safety and quality systems
- Assisting our healthcare professionals and Visiting Medical Officers monitor the safety and quality of care they provide, and
- Maintaining an outstanding record in the delivery of quality patient care

As a Multi-Purpose Service (MPS) RDHS provides integrated health and aged care services for our local community. As a joint initiative of the Commonwealth and State Government, RDHS is required to meet an array of relevant standards and accreditation frameworks through the accreditation process.

Accreditation

During 2018-2019, RDHS continuously worked towards meeting and maintaining the required Commonwealth and State Government Standards and in June 2019; the organisation underwent a successful surveillance audit with accrediting body TQCSI, retaining accreditation against ISO 9001:2015 Quality Management Systems.

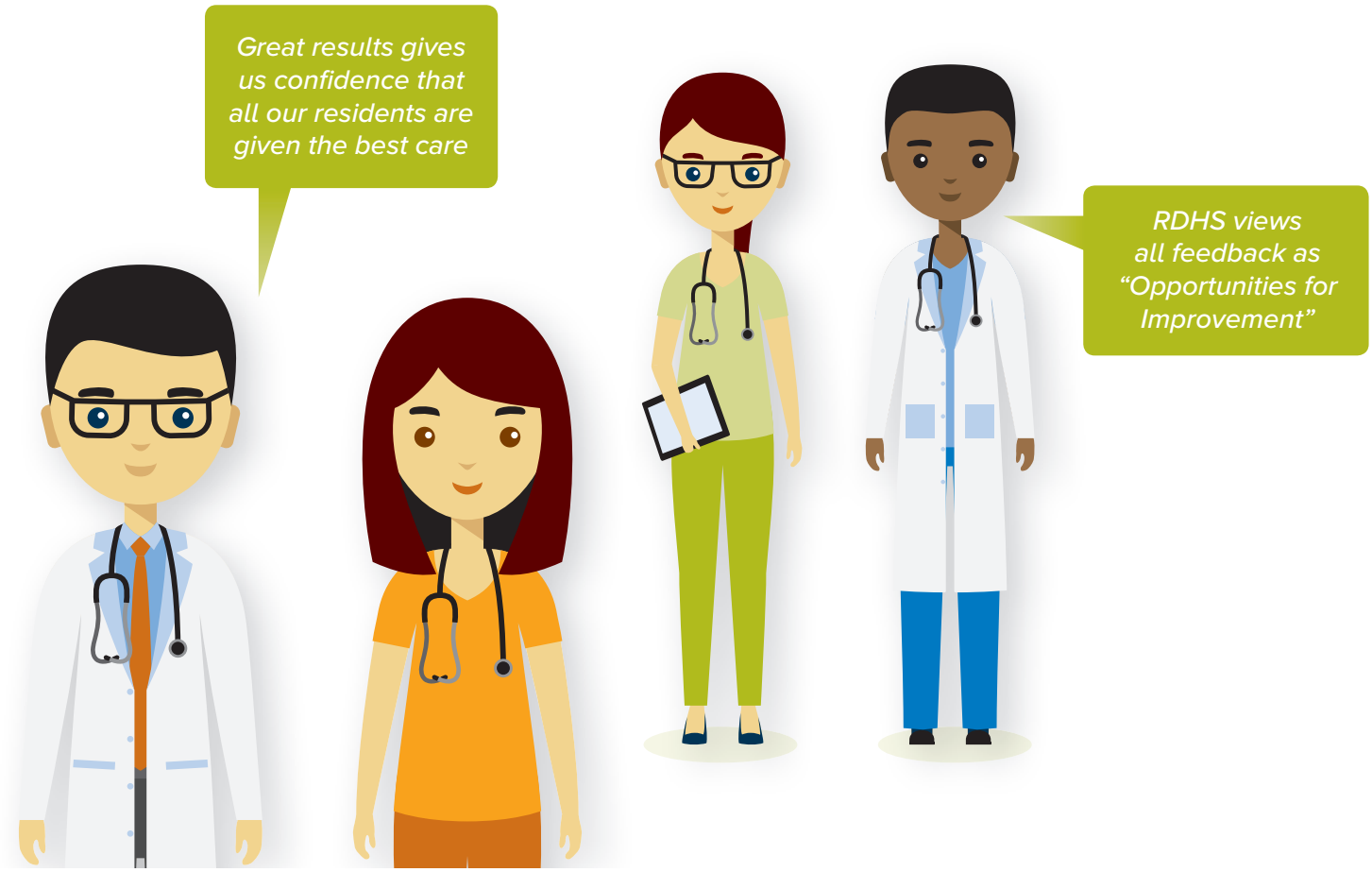
All acute Australian healthcare facilities are to obtain accreditation against the National Safety and Quality Health Service (NSQHS) Standards. These standards provide a clear statement about the level of care consumers can expect from health service organisations, and they play an essential role with the accreditation process. RDHS maintains ongoing accreditation for NSQHS Standards until June 2021, with significant work continuing to strengthen compliance against the standards.

As of 1st January 2019 the compliance to NSQHS Version 2 Standards commenced with all health service organisations informed of transition arrangements. RDHS will undertake full recertification against these standards in 2021.

Riverside Campus is required to participate in one Accreditation audit every three years and one support visit annually. These are now both attended by the Australian Aged Care Quality Agency (AACQA) as “un-announced” visits.

Riverside successfully obtained their re – accredited status against the AACQA Standards in an “Unannounced” Re-Accreditation Audit October 2018. Staff and residents participated in a two-day audit and were compliant against all 44 outcomes. This resulted in Riverside receiving re-accreditation for another 3 years. In March 2019, Riverside participated in a support visit, which also resulted in compliance against standards 2 Health and Personal Care and Standard 3 Care Recipient Lifestyle.

These results give us confidence that all our aged care residents are given the best possible service by our extremely caring staff. The Aged Care areas at Manangatang Campus Aged Care and Robinvale Campus Aged Care do not require external accreditation, however with our



extensive internal auditing process we ensure that the same processes and procedures are followed at all of our Aged Care facilities.

Risk

RDHS continues to utilise the Victorian Health Incident Management System (VHIMS) in collaboration with the Department of Health and Human Services. VHIMS provides the organisation with a standard electronic method (which is used by all Victorian public hospitals) for reporting, recording and monitoring incidents / near misses that occur within the health setting. This ensures that if things go wrong, the organisation has a procedure for reporting and managing adverse events. This ensures that consumer and staff safety is maintained and that any identified issues are addressed to prevent and / or minimise the likelihood of a similar event occurring again.

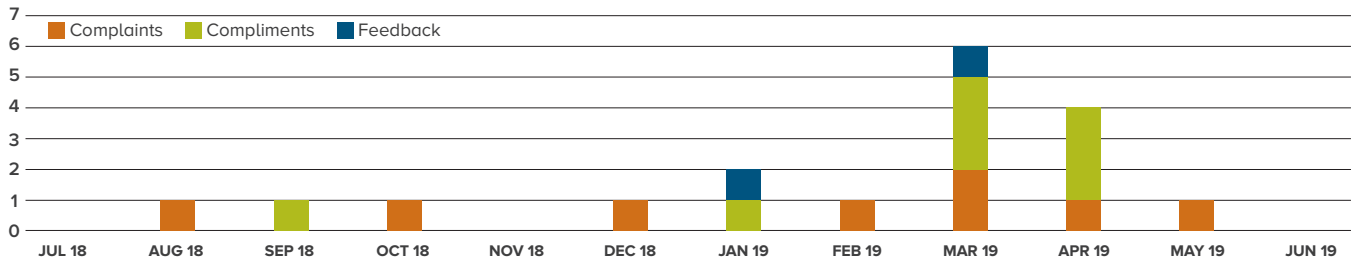
Consumer/Community Feedback

The organisation continually seeks consumer feedback through surveys (internal and external); direct contact and our comments and complaints process.

10 compliments / feedback and 8 complaints have been received during July 2018 – June 2019. Staff also receive compliments in way of unofficial cards and verbal "thank you", praising and highlighting their hard work and commitment to patient centred care. RDHS ensures that staff receive this feedback via staff meetings and general communication.

RDHS views all feedback as 'opportunities for improvement' with the aim of ensuring consumers and community members have an opportunity to participate in the decision making processes relating to the safe and effective delivery of services. All complaints are investigated with the complainant provided with a response within a timely matter.

Registered Complaints, Compliments and Feedback 2018 – 2019



PERFORMANCE

PART A: SERVICE PLAN KEY ACHIEVEMENTS

Key achievements against the RDHS Service Plan for the 2018/19 year are listed below.

1 Consolidating acute care and residential aged care provision

Renal Dialysis

Goal	Outcome
Enhance Renal Dialysis Capability to meet future demand	• MOU with Melbourne Health to provide Renal Dialysis as a satellite program continues. • RN staff continue to be trained to support the Renal Dialysis unit

Maternity Services

Goal	Outcome
Support and maintain the existing maternity service model	• Our Midwife program will host a placement from Cohuna Hospital. Opportunity to share learnings and to create a network of like-minded organisations. • A casual Midwifery position has been established to assist our Midwife during busy periods and to provide support and cover during leave periods.

Specialist Medical Services

Goal	Outcome
Enhance the range of specialist consulting services that can be accessed locally	• Visiting services include Ophthalmology, Mental Health, Psychology, Nephrology, Gynaecology, Obstetrics, Audiology, Cardiology, Endocrinology, Psychiatry, Paediatrics and Continence support. Whilst some services are delivered face to face, others are accessed via telehealth. • Residential care continues to be supported by the Psychiatric Geriatrician services out of Mildura Base Hospital. • Residents in residential care are able to access a geriatrician via the Geri-Connect telehealth program.

Urgent Care

Goal	Outcome
Enhance the existing urgent care capability	• RDHS is participating in a pilot program funded by PHN for afterhours access to a Doctor via the My Emergency Dr App. • RDHS is looking to invest in equipment to better manage emergency presentations, including an ISTAT machine and cardiac monitor.

2 Enhancing community based health services

Primary & Community Health - General Practitioners

Goal
Enhance the capacity and availability of local GPs

Outcome
- Manangatang Campus residential aged residents are supported by a locum GP service provided by Mallee Track Health & Community Service.
- RDHS Urgent Care Centre and patient care is supported by Dr Jane Neyland and Dr Sean White
- RDHS continues to explore opportunities to support local GP workload, including current negotiations with the Royal Flying Doctor Service on a GP supported service.

Community Mental Health – Collaboration and Integration

Goal
Improve service delivery outcomes through collaboration and partnerships

Outcome
- Partnership continues with Sunraysia Community Health Services to expand Mental Health Services into Robinvale (funded by Murray Primary Health Network)
- RDHS continues to support Mental Health visiting services provided by Mildura Base Hospital.
- Community Wellbeing Officer position has a strong emphasis on mental health awareness and community wellbeing
- Community Wellbeing Officer has broadened Mental Health First Aid training and can facilitate adult sessions and co-facilitate youth/teen sessions. 104 individuals from various organisations completed the MFHA course throughout the year.
- Community Wellbeing Officer commenced the ATSI Dual Diagnosis program at MVAC which has increased referrals and psychoeducation to staff. This program is funded by the Murray Primary Health Network.
- Social Workers and Community Wellbeing Officer are partnering with Mildura Mental Health Services to run a Dialectic Behaviour Therapy group

Primary & Community Health – Alcohol and Other Drugs

Goal
Enhance the service capability for AOD services

Outcome
- In partnership with the Murray Primary Health Network, Community Wellbeing Officer is delivering AOD & Mental Health services to Murray Valley Aboriginal Coop.
- Needle Syringe Program continues to operate from the Health & Wellbeing Centre to support community need.
- Alcohol and Drug Services delivered by external providers is supported by the provision of consulting rooms by RDHS

Primary & Community Health – Chronic Disease Management

Goal
Develop a Service Framework that improves CDM service delivery

Outcome
- RDHS has employed a chronic care model in the primary care setting to focus on care for chronic conditions that is early, evidence based, has a team approach, facilitates self-management, is goal directed, health promoting and encourages health literacy. This model of care has been embedded into the policies and procedure of RDHS' service delivery in order for employees to be guided by this framework in CDM service delivery.
- Several projects are delivered at RDHS under the chronic care model and these include:
- The Heart Time and Better Breathing programs are two cardiac and pulmonary rehabilitation programs delivered by a range of health professionals to improve the health outcomes of people with or at risk of heart and lung conditions. (funded by Murray Primary Health Network)
- The Workplace Achievement program that is embedded across the organisation. This program is an initiative of Healthy Together Victoria and supports a healthy workplace environment.
- Support visiting Nephrology services from Royal Melbourne Hospital continue to reach community members at pre-dialysis stage.
- Preventive health groups include groups such as warm water exercise classes, Strength & Balance, HEAL and Quick Hands (Boxing)
- Through partnership with the Rural Doctor's Network, Balranald Multipurpose Service and Western New South Wales PHN, the Primary Care Allied Health team continues to provide chronic disease management services to Dareton, Wentworth and Balranald.
- Regular meetings are held with the Robinvale "Elders" to discuss current issues relating to the indigenous community.

Primary & Community Health – Integration

Goal	Outcome
Improve service integration within RDHS and between service providers	• Argus and My Aged Care continue as the main platforms for referral management. • Robinvale Early Years Network (REYN) continues to meet and bring together service providers of early childhood and adolescence. • Safety Committee meets quarterly for information sharing and project discussion. Attendees represent providers that service or outreach to Robinvale.

Primary & Community Health – Other Services

Goal	Outcome
Consolidate and incrementally improve a range of community based services	• Preventive health groups offered include warm water exercise classes, Strength & Balance, Healthy Eating and Active Living, walking groups, Quick Hands Boxing, M45 Women's, Heart Time and Better Breathing and moderate intensity exercise groups which respond to the needs of the community. • A Toy Library has been established and is open twice per week. • Jump and Jive, Vacation Care Programs and Mobile Visiting Play Groups are provided to the children in the community by Early Years.

3 Achieving sustainability

Sustainability – Rural Primary Health Service Program

Goal	Outcome
Maintain the Commonwealth Flexible Funding (under Primary Health Network)	• Contracts were again secured with the NSW Rural Doctors Network, Western New South Wales PHN, Murray PHN and Far West Local Health District, Balranald Multipurpose Service to provide allied health services to the communities of Robinvale, Manangatang and Ouyen in Victoria and Wentworth, Dareton and Balranald in New South Wales. • RDHS continues to seek alternate funding opportunities to provide allied health services beyond the contracted periods. • In addition to Commonwealth (PHN, RDN) funding we were successful in securing funding from the NSW Department of Industry to employ a Social Worker to support both problem gambling and other co-morbidities

Sustainability – Financial Management

Goal	Outcome
Improve understanding of the costs of service streams to better manage the service	• Comprehensive budgets are developed each year for individual service contracts. • Magiq - Power Budget has again undergone a major upgrade. This has enabled budget management processes to be refined, with a view to department Managers being more specifically engaged in the process of managing their departmental budget.

4 Enhancing performance management

Enhancing Performance Management - Monitoring and Reporting

Goal	Outcome
Ensure a robust basis for performance monitoring	• Contracted external accountant continues to provide the BoM with informative advice and monthly and annual financial reports. • Through the internal auditors the Board and Finance & Audit Committee monitor the Health Services risk management, financial systems and reporting and compliance with statutory requirements. The internal audit program is undertaken by Audit & Risk Solutions and Accounting & Audit Solutions Bendigo under independent contracts as appointed by the RDHS Board. Activities undertaken by the internal auditors during the year included reviews focusing on Asset Management, Fraud, Human Resources and the Financial Management Compliance Framework. • Continue to meet all DHHS financial performance KPI's

5 Developing partnerships

Partnerships and Alliances

Goal
Focus on the development of priority partnerships and alliances

Outcome

- **Dementia Australia (Victoria)** - Facilitation and completion of the BIRCH project to identify and establish an Aged Model of Care.
- **Mallee Track Health and Community Services & Royal Flying Doctor Service** – Tripartite agreement to expand the delivery of Speech Pathology services.
- **Murray Valley Aboriginal Cooperative & Robinvale College** – RDHS has lead the partnership to finalise the Aboriginal Artwork Project. The project has unified all 3 community service providers in Robinvale. (see photo of RDHS artwork in the annual report of operations)
- **Murray Valley Aboriginal Cooperative** – Continue to promote relationships and agreed practices to better engage with the indigenous community.
- A strong partnership continues with the Aboriginal Elders and Senior Management staff. The Aboriginal Health Liaison Officer coordinates these conversations as required.
- **Mildura Base Hospital** – Continue to promote dialogue to enhance the referral to and discharge from MBH processes.
- **Robinvale College** – partnership continues with the Robinvale College to utilise heated pool facilities so that water exercise classes can be run all year round. RDHS provided Speech Pathology, Occupational Therapy and Social Work to the College.
- **Commenced a joint project Robinvale College "Our Place"** which supports the education needs of our lower socio-economic demographic. We share the RDHS Early Year Co-ordinator in a joint role to support this project.
- **Mallee Track Health & Community Service** – partnership continues with the sharing of the Director of People & Culture role and the contracted serviced of the RDHS Director of Corporate Services.
- **Mallee Local Area Health Partnership** – commenced partnership workshops with Mildura Base Hospital, Swan Hill District Health and Mallee Track Health & Community Service. Aspirations for the partnership is to build deeper trust, mutual understanding, and more relationships.
- **Southern Mallee Primary Care Partnership** – Developed a new agreement to include the RDHS main campus in SMPCP health promotion activities.
- **Euston Club** – RDHS acknowledges this first time grant from the NSW Department of Industry to employ a Social Worker to support both problem gambling and other co-morbidities. The grant was made possible through our partnership with the Euston Club and NSW Club Grants program.

6 Enabling people

Enabling People – Innovative Workforce Models

Goal
Ensure development of innovative and flexible staffing and workforce models to enhance future service delivery

Outcome

- Director People & Culture has supported the health service through organisational/cultural change by supporting the Management team in leadership development through performance management systems and constructive feedback.
- Skills based Commercial Cook Apprenticeship taken up by local person
- Traineeships continue to be offered in many areas across the organisation.

Enabling People – Staff Engagement

Goal
Further develop effective staff engagement

Outcome

- RDHS continues to assist with the cost of professional development for all staff, ensuring that skills are maintained.
- Embedded robust Employee Assistance Program.
- Staff training continues through the Reshen e-learning modules.
- Mental Health First Aid training for staff has been a focus throughout the year.
- Quarterly "CEO Conversations" with staff have been held at all campuses to support employee engagement.
- Team sporting activities arranged by the Workplace Achievement Program.

7 Supporting quality

Quality

Goal	Outcome
Develop and sustain a comprehensive clinical governance framework	• The health service wide Triennial Audit conducted in 2018 demonstrated a high level of achievement against all 10 National Safety and Quality Health Service Standards (NSQHSS). RDHS awarded 6 “met with merit” in our Governance and Partnership arrangements. • Accreditation against ISO 9001:2015 Quality Management Systems has been maintained post the audit in June 2019 • Riverside maintained accreditation against the Australian Aged Care Quality Agency Standards (AACQA) • Director of Medical Services continues to support our GP’s and provide an overarching view of Clinical Governance. • CEO and Board Chair participation in the Regional Clinical Governance Committee & Loddon Mallee Clinical Council. • Internal Clinical Review Working Group continues to review incidents as required. Results are tabled at the Clinical Governance Committee. • Strengthened Board Governance by encouraging attendance by all BoM at the newly titled Clinical Governance Committee Meeting (formerly Clinical Risk Management).

8 Developing infrastructure

Infrastructure – Information Communication Technology

Goal	Outcome
Improve ICT within RDHS to address the technical and functional capability of the organisation (in collaboration with LMRHA)	• RDHS continues to participate in regional and LMRHA initiatives including ICT strategic planning for the Loddon Mallee Region. • Geri-Connect • Telehealth • Telehealth – successful use of telehealth when dealing with adult retrieval team in the Urgent Care Centre • RDHS is participating in a pilot program funded by PHN for afterhours access to a Doctor via the My Emergency Dr App • Key areas of focus areas in 2018/19: - Cyber Security - Telehealth - PC Upgrades/replacements - Residential Aged Care management software Management Advantage – Manad Plus implementation - Asset / Facilities Management software implementation

PART B: PERFORMANCE PRIORITIES

Quality and Safety

Key Performance Indicator	Target	Result
Health Service Accreditation	Full compliance	Achieved
Compliance with cleaning standards	Full compliance	Achieved
Compliance with the Hand Hygiene Australia Program	80%	94%
Percentage of healthcare workers immunised for influenza	80%	86%
Victorian Healthcare Experience Survey – discharge care Quarter 1, 2, 3	Full compliance	*Achieved

* Less than 42 responses were received for the period due to relative size of the Health Service.

Funded Flexible Aged Care Places

Campus	Number
Flexible High Care	
Robinvale	14
Manangatang	10

Utilisation of Aged Care Places

Campus	Number of bed days	Occupancy Level %
Flexible High Care		
Robinvale - Permanent	4104	85%
Robinvale - Respite	262	
Manangatang - Permanent	2302	69%
Manangatang - Respite	202	
Riverside		
Riverside - Permanent	5858	59%
Riverside - Respite	568	
Convalescent Care		
Riverside	0	
Manangatang	37	
Robinvale	0	

Occupational Violence

Occupational Violence Statistics	2018/19
Workcover accepted claims with an occupational violence cause per 100 FTE.	0
Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	0
Number of occupational violence incidents reported.	2
Number of occupational violence incidents reported per 100 FTE.	1.5
Percentage of occupational violence incidents resulting in a staff injury, illness or condition.	0

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 – an event or circumstance that could have resulted in, or did result in, harm to an employee. Incidents of all severity rating must be included. Code Grey reporting is not included, however, if an incident occurs during the course of a planned or unplanned Code Grey, the incident must be included.
Accepted Workcover claims – Accepted Workcover claims that were lodged in 2018-19.
Lost time – is defined as greater than one day.
Injury, illness or condition – This includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.
FTE figures required in the above table should be calculated consistent with the Workforce information FTE calculation (refer to page 12 of the Health Service Model Annual Report guidelines).

Acute Care

Service	Campus	Type of Activity	Actual
Medical inpatients	Robinvale	Bed days	493
	Manangatang	Bed days	0
Urgent care	Robinvale	Presentations	1830
	Manangatang	Presentations	174
Non-admitted patients	Robinvale	Occasions of service	4030
Radiology	Robinvale	Number of clients	407
Palliative care	Robinvale	Number of clients	NA
District nursing	Robinvale	Occasions of service	1343
	Manangatang	Occasions of service	271
Maternity	Robinvale	Occasions of service	1262
Renal Dialysis	Robinvale	Episodes	412

Primary Health Care

Service	Activity levels (e.g. occasions/hours of service. By campus)	
Access and Support Worker*	Individual Occasions of Service	570
	Group Attendees	0
Allied Health Assistant*	Individual Occasions of Service	191
	Group Attendees	2449
Community Health Nursing*	Individual Occasions of Service	845
	Group Attendees	115
Cultural Officer*	Individual Occasions of Service	620
	Group Attendees	514
Dietetics*	Individual Occasions of Service	2567
	Group Attendees	15
Early Years*	Group Attendees	5109
Exercise Physiologist*	Individual Occasions of Service	1722
	Group Attendees	641
Health Promotion*	Group Attendees	1311
Occupational Therapy*	Individual Occasions of Service	1138
	Group Attendees	355
Physiotherapy*	Individual Occasions of Service	1717
	Group Attendees	109
Planned Activity Group*	Number of Group Sessions	175
	Group Attendees	453
Podiatry*	Individual Occasions of Service	3650
	Group Attendees	0
Social Work*	Individual Occasions of Service	2418
	Group Attendees	19
Speech Pathology*	Individual Occasions of Service	6364
	Group Attendees	1342

* Services which are not funded or only part funded through the MPS Tripartite Agreement.

Governance and Leadership

Key Performance Indicator	Target	Result
People Matter Survey - percentage of staff with a positive response to safety culture questions	80%	84%

Financial Sustainability

Key Performance Indicator	Target	Result
Operating result ($m)	Update	Refer to FS
Trade creditors	60 days	34 Days
Patient fee debtors	60 days	22 Days
Adjusted current asset ratio	0.7	1.76
Number of days available cash	14	189

STATUTORY COMPLIANCE

Occupational Health and Safety

Robinvale District Health Services (RDHS) is committed to enthusiastically working to provide a safe, "environmentally friendly" work environment for all staff and for residents that meet regulatory requirements.

RDHS monitor and maintain the safety and wellbeing of staff, patients, residents, consumers, visitors and contractors through Occupational Health, Safety and Environmental (OHSE) procedures. A major component to ensure RDHS remains a safe working environment is through the OHSE committee. The OHSE committee meet on a bi-monthly basis (every two months) to report and resolve any issue that may arise or have arisen as a result of OHSE. This meeting is minuted and available for viewing by all staff, Managers and Directors.

Robinvale District Health Services (RDHS) standard Work Cover claims

RDHS had no claims submitted for the 2018/19 year.

There are no outstanding claims.

Freedom of Information

Access to documents and records held by RDHS may be requested under the *Freedom of Information Act 1982*. Consumers wishing to access documents should apply in writing to the FOI Officer at RDHS.

This year 14 FOI requests were received. No requests were denied. All requests were processed within the required timeframes.

Competitive Neutrality

Robinvale District Health Services complied with all the government policies regarding competitive neutrality.

Statement on Compliance with the Building and Maintenance Provisions of the *Building Act 1993*

In accordance with the Building Regulations 2006, made under the *Building Act 1993*, all buildings within the Service are classified according to their functions.

Each campus has a planned preventative maintenance program to ensure ongoing building safety and compliance with regulations.

An Essential Safety Measures Report is prepared annually for each campus and confirms the safety of buildings including fire safety, entry and egress.

Summary of major changes or factors which have affected the achievement of the operational objectives for the year

During the 2018-2019 financial year there were no major changes or factors which materially affected the achievement of the operational objectives.

Events subsequent to balance date which may have a significant effect on the operations of the entity in subsequent years

There were no events subsequent to balance date that may have a significant effect on the operations of the entity in subsequent years.

Local Jobs First Act 2003

In 2018/19 there were no contractors requiring disclosure under the Local Jobs First Policy.

Safe Patient Care Act 2015

RDHS has no matters to report in relation to its obligations under section 40 of the *Safe Patient Care Act 2015*.

Fees and Charges

All fees and charges charged by RDHS are regulated by the Australian Department of Health and Ageing and the Hospital & Charities (Fees) Regulations 1986, as amended and as other determined by the Department of Human Services, Victoria.

Policies and procedures are in place for the effective collection of fees owing to the service.

Publications

Publications such as the Annual Report, Quality Account Report, Strategic Plan and a multiplicity of Patient Information Brochures are available from RDHS.

Information on RDHS is also available on our website - www.rdhs.com.au

The *Protected Disclosure Act 2012*

RDHS has policies and guidelines in place to protect people against detrimental action that might betaken against them if they choose to make a protected disclosure. No disclosures have been made in the year ended 30th June 2019.

Protected Disclosures are to be reported directly to:
Independent Broad-Based Anti-Corruption Commission (ibac)
P 1300 735 135 | **F** 03 8635 6444
Street address Level 1, North Tower, 459 Collins Street, Melbourne VIC 3000
Postal address GPO Box 24234, Melbourne VIC 3001
Web www.ibac.vic.gov.au/contact-us

Health Records Act 2001 and *Information Privacy Act 2000*

The Acts preserve the privacy and confidentiality of information held by our agency.

All patients, residents and clients receive a brochure explaining how their health information will be used and who will have access to such information

All staff are required to undertake privacy and confidentiality training on a regular basis and there are documented policy and protocols relating to privacy and confidentiality within our organisation

The Chief Executive Officer is the designated Privacy Officer and deals with enquiries and complaints relating to the Health Records and Information Privacy Acts.

In 2018/19 there were no written complaints with respect to breaches of privacy or confidentiality.

Carers Recognition Act 2012

RDHS is an agency subject to the *Carers Recognition Act 2012*. The *Carers Recognition Act 2012* formally recognises and values the role of carers and the importance of care relationships in the Victorian community.

The Act includes a set of principles about the significance of care relationships, and specifies obligations for State Government agencies, Local Councils, and other organisations that interact with people in care relationships.

RDHS has:
- Taken all practical measures to comply with its obligations under the Act;
- Promoted the principles of the Act to people in care relationships receiving our services and also to the broader community; and
- Reviewed our staff employment policies to include flexible working arrangements and leave provision ensuring compliance with the statement of principles in the Act.

There were no disclosures in 2018/19.

Employment and conduct principles

Robinvale District Health Services ensures a fair and transparent process for recruitment, selection, transfer and promotion of staff. It bases its employment selection on merit and complies with the relevant legislation. Policies and procedures are in place to ensure staff are treated fairly, respected and provided with avenues for grievance and complaints.

National Competition Policy

Robinvale District Health Services complied with all Government policies regarding neutrality requirements with regards to all tender applications.

Consultancies

Details of consultancies (under $10,000)
In 2018/19, there was 1 consultancy where the total fees payable to the consultants were less than $10,000. The total expenditure incurred during 2018/19 in relation to these consultancies is $2,680 (excl. GST).

Details of consultancies (valued at $10,000 or greater)
In 2018/19, there was 1 consultancy where the total fees payable to the consultant were $10,000 or greater. The total expenditure incurred during 2018/19 in relation to this consultancy was $12,600 (excl. GST). See table below for further details.

Consultancies fees valued >$10,000

Consultant	Purpose of consultancy	Start Date	End Date	Total approved project fee (excluding GST)	Expenditure 2018/19 (excluding GST)	Future expenditure (excluding GST)
Healthcare Management Advisors Pty Ltd	Facilitation of RDHS 2018-2022 Strategic Plan	January 2018	January 2019	$26,800	$2,680	0
Janet Farrow	Aged Care Review	February 2019	March 2019	$12,600	$12,600	0

Additional Information (FRD 22H APPENDIX)

In compliance with the requirements of the Standing Directions of the Minister for Finance, details in respect of the items listed below have been retained by the RDHS 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) a statement that declarations of pecuniary interests have been duly completed by all relevant officers of the Department;
(b) details of shares held by senior officers as nominee or held beneficially in a statutory authority or subsidiary;
(c) details of publications produced by the Department about the activities of the Health Service and where they 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 in respect of the operation of the Health Service
(f) details of any other research and development activities undertaken by the Health Service that are not otherwise covered either in the report of operations or in a document which contains the financial statement 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 services provided by the Health Service;
(i) details of assessments and measures undertaken to improve the occupational health and safety of employees, not otherwise detailed in the report of operations;
(j) a general statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes, which are 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 the purposes have been achieved; and
(l) details of all consultancies and contractors including consultants/ contractors engaged, services provided and expenditure committed for each engagement.

Attestations

Data Integrity

I, Mara Richards, certify that Robinvale District Health Services has put it place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Robinvale District Health Services has critically reviewed these controls and processes during the year.

Mara Richards
Chief Executive Officer

Integrity, fraud and corruption

I, Mara Richards, certify that Robinvale District Health Services has put in place appropriate internal controls and processes to ensure integrity, fraud and corruption risks have been reviewed and addressed at Robinvale District Health Services during the year.

Mara Richards
Chief Executive Officer

Conflict of Interest

I, Mara Richards, certify that Robinvale District Health Services has put in place appropriate internal controls and processes to ensure that it has complied with the requirements of hospital circular 07/2017 Compliance reporting in health portfolio entities (Revised) and has implemented a 'Conflict of Interest' policy consistent with the minimum accountabilities required by the VPSC. Declaration of private interest forms have been completed by all executive staff within Robinvale District Health Services and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive board meeting.

Mara Richards
Chief Executive Officer

Financial Management Compliance attestation

I, Quentin Norton, on behalf of the Responsible Body, certify that Robinvale District Health Services has complied with the applicable Standing Directions 2018 under the *Financial Management Act 1994* and Instructions.

Quentin Norton
Board Chair

OUR GOVERNANCE

The Board of Management

The Health Service is governed by the Board of Management (BOM), appointed by the Governor in Council upon recommendation of the Minister for Health. The BOM oversees the clinical and corporate governance of the health service and ensures that services provided comply with *Health Act 1988* requirements and RDHS By-Laws.

The Board of Management meets on the last Tuesday of each month to deal with a formal agenda and the Chief Executive Officer reports on the health service's performance.

Board of Management Members 2018–2019

Mr Quentin Norton –Chair
Mr Bruce Myers – Vice Chair
Mrs Freule Jones
Mrs Yvonne Brown
Mr Glenn Stewart
Miss Kady Moore
Mrs Abby White
Mr Trung (Jack) Dang

Finance And Audit Committee

Mr Bruce Ginn – Chair (Independent Member)
Mr Quentin Norton
Mrs Yvonne Brown
Mrs Lisa Murray (Independent Member)
Mrs Ginette Chirchiglia (Independent Member)
Mr John Bond (Independent Member)

Executive Committee (Including Capital Works and Projects)

Mr Quentin Norton
Mrs Freule Jones
Mr Bruce Myers

Senior Management Team

Mrs Mara Richards
Chief Executive Officer

The Chief Executive Officer responsible to the Board of Management for the efficient and effective management of Robinvale District Health Services. Major responsibilities include the development and implementation of operational and strategic planning, maximising service efficiency and quality improvement and minimising risk.

Mrs Leanne Adcock
Director of Clinical Services

The Director of Clinical Services manages the clinical operations of RDHS including; Acute Nursing, Residential Aged Care, Visiting Nurse Services, Midwifery, Clinical Education and Radiology.

Mrs Vicki Shawcross
Director Corporate Services

The Director Corporate Services has operational responsibility for the majority of corporate support services provided to support the organisation. Financial Services, Health Information Systems, Information Communication Technology, Capital Projects, Hospitality Services, Hotel Services, Procurement, Maintenance, Fleet, Administration/Customer Services, Corporate Reporting & Publications, Robinvale/Euston Tourist Information Centre.

Departmental Managers

Manager Primary Care
Miss Poorani Balasundaram

Manager Supply & Maintenance
Mr Peter Rickard

Director People & Culture
Mr Ray Gentle

Director of Aged Care – Manangatang, Riverside and Main Campus
Emmanuel Geri

Nurse Unit Manager (Riverside Campus)
Ms Gail Robinson

Nurse Unit Manager (Robinvale Campus)
Mrs Binu Joy

Visiting Medical Officers

Dr Jane Neyland
MBBS
Monash University (Australia) 2009

Dr Sean White
MBBS
University of Newcastle/University of New England (Australia) 2010

Director of Medical Services

Dr Peter Sloan
MBBS
University of Melbourne (Australia) 1984

Organisational Structure

DISCLOSURE INDEX

The Annual Report of Robinvale District Health Services is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of Robinvale District Health Services compliance with statutory disclosure requirements.

Legislation	Requirement	Page Reference
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FRD 22H	Workforce data / employment and conduct principles	15
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FRD 22H	Subsequent events	26
FRD 22H	Details of consultancies under $10,000	27
FRD 22H	Details of consultancies over $10,000	27
FRD 22H	Disclosure of ICT expenditure	14
Legislation		
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Other reporting requirements		
- Occupational Violence reporting		25
- Reporting obligations under the Safe Patient Care Act 2015		26

FS - Refers to Financial Statements
IFC - Refers to Inside Front Cover

FINANCE REPORT 2018–2019

Robinvale District Health Services (RDHS) financial goal is to deliver high quality cost efficient health services to our communities in Victoria and New South Wales.

Financial Performance

The Department of Health and Human Services (DHHS) benchmark indicator for financial performance is the Operating Result. For the 2018/19 financial year the Operating Result was a surplus of $72,000 compared to a budgeted deficit of $471,000. The Net Result from Transactions which includes capital and specific items was a deficit of $1,026,000 increasing from $613,000 in the previous financial year.

Revenue decreased by $288,000 for the year with the loss of Primary Health Network funding, a reduction in residential aged care occupancy and a decline in acute inpatient, renal dialysis and medical imaging activity. New revenue streams included $250,000 from the NSW Department of Industry – Office of Responsible Gambling for a gambling social work initiative and an increase in allied health brokered services to the Royal Flying Doctors and NSW Rural Doctors Network.

Expenses increased in 2018/19 by $125,000 predominantly due to nursing EBA pay rates which increased by 9-15% depending upon award classification. The long service leave provision increased by $231,000 for the year, $167,000 of that was due to probability rates issued by the Department of Treasury and Finance with the remainder, a combination of pay increases and limited long service leave taken. Software charges increased by over $80,000 on 2017/18 with the implementation of PULSE asset management system and Management Advantage (Manad Plus) for Residential Aged Care. The use of agency staff increased by $50,000 for the year and there was almost $60,000 extra in recruitment costs compared to the previous financial year.

Liquidity Position

Total assets have increased significantly due to the 5 year land and building revaluation carried out by the Valuer General. Health services now have to comply with Department of Treasury and Finance's Centralised Banking system (CBS) where any excess cash (surplus to working capital) must be held in accordance with the State's CBS arrangements hence the reduction in investments and investment revenue. Liabilities increased in 2018/19 with an additional $525,000 of Refundable Accommodation Deposits (RAD) received.

Financial Position

Robinvale District Health Service's (RDHS) financial position is one of strength with $7.36M of untied funds which equates to199 days' cash available (DHHS target 14 days). The RDHS Adjusted current asset ratio of 1.98 is well above the Department of Health and Human Services Adjusted current ratio indicator (0.70) along with trade debtor and creditor turnover days (Less than 60 days).

The Future

RDHS will continue to work with our partners to develop, deliver sustainable high quality, cost efficient health services to meet our community need.

5 Year Comparison

For the Financial Year ended 30 June 2019

	2019 $000	2018 $000	2017 $000	2016 $000	2015 $000
OPERATING RESULT*	73	309	684	749	1,200
Total Revenue	13,660	13,948	14,128	14,423	16,725
Total Expenses	14,686	14,561	14,521	14,824	15,043
Net Result from Transactions	**-1,026**	**-613**	**-393**	**-401**	**1,682**
Total Other Economic Flows	-113	141	90	13	0
Net Result	**-1,139**	**-472**	**-303**	**-388**	**1,682**
Total Assets	31,455	27,171	27,220	27,554	27,661
Total Liabilities	6,971	6,129	6,055	6,086	5,805
Net Assets / Total Equity	**24,484**	**21,042**	**21,165**	**21,468**	**21,856**

* The Operating result is the result for which the health service is monitored in its Statement of Priorities.

	2019 $000	2018 $000	2017 $000	2016 $000	2015 $000
Net Operating Result	73	309	684	749	1,200
Capital and Specific Items					
Capital Purpose Income	129	218	92	69	103
Specific Income	0	0	0	0	0
Assets Provided Free of Charge	0	0	0	0	0
Assets Received Free of Charge	0	0	0	0	1,867
Expenditure for Capital Purpose	134	93	35	108	0
Depreciation and Amortisation	1,094	1,047	1,134	1,111	1,121
Impairment of Non-Financial Assets	0	0	0	0	394
Finance Costs (Other)	0	0	0	0	0
Net Result from Transactions	**-1,026**	**-613**	**-393**	**-401**	**1,655**

Independent Auditor's Report

VAGO
Victorian Auditor-General's Office

To the Board of Robinvale District Health Services

Opinion	I have audited the financial report of Robinvale District Health Services (the health service) which comprises the: • balance sheet as at 30 June 2019 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including significant accounting policies • board member's, accountable officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2019 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
10 September 2019

Travis Derricott
as delegate for the Auditor-General of Victoria

ROBINVALE DISTRICT HEALTH SERVICES

BOARD MEMBER'S, ACCOUNTABLE OFFICER'S AND CHIEF FINANCE & ACCOUNTING OFFICER'S DECLARATION

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2019 and the financial position of Robinvale District Health Services at 30 June 2019.

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

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

Quentin Norton	Mara Richards	Andrew Arundell
Board Chair	Accountable Officer	Chief Finance & Accounting Officer (Contract)
Robinvale	Robinvale	Robinvale
5th September 2019	5th September 2019	5th September 2019

ROBINVALE DISTRICT HEALTH SERVICES
COMPREHENSIVE OPERATING STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2019

	Note	2019 $000	2018 $000
Income from Transactions			
Operating Activities	2.1	13,440	13,732
Non-operating Activities	2.1	220	216
Total Income from Transactions		**13,660**	**13,948**
Expenses from Transactions			
Employee Expenses	3.1	10,637	10,507
Supplies and Consumables	3.1	537	604
Depreciation and Amortisation	4.3	1,094	1,047
Other Operating Expenses	3.1	2,418	2,403
Total Expenses from Transactions		**14,686**	**14,561**
Net Result from Transactions - Net Operating Balance		**(1,026)**	**(613)**
Other Economic Flows Included in Net Result			
Net gain/(loss) on Non-Financial Assets	3.2	0	86
Other Gain/(Loss) from Other Economic Flows	3.2	(113)	55
Total Other Economic Flows Included in Net Result		(113)	141
Net Result for the year		**(1,139)**	**(472)**
Other Comprehensive Income			
Items that will not be classified to Net Result			
Changes in Property, Plant & Equipment Revaluation Surplus	4.2 (f)	4,930	0
Total Other Comprehensive Income		4,930	0
Comprehensive Result for the year		**3,791**	**(472)**

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

ROBINVALE DISTRICT HEALTH SERVICES
BALANCE SHEET
AS AT 30 JUNE 2019

	Note	2019 $000	2018 $000
ASSETS			
Current Assets			
Cash and Cash Equivalents	6.1	9,904	2,340
Receivables	5.1	253	343
Investments and Other Financial Assets	4.1	1,000	8,620
Inventories		58	71
Prepayments and Other Assets		178	145
Total Current Assets		**11,393**	**11,519**
Non-Current Assets			
Receivables	5.1	348	372
Property, Plant and Equipment	4.2	19,714	15,280
Total Non-Current Assets		**20,062**	**15,652**
TOTAL ASSETS		**31,455**	**27,171**
LIABILITIES			
Current Liabilities			
Payables	5.3	1,001	1,252
Provisions	3.3	2,039	1,861
Other Liabilities	5.2	3,541	3,016
Total Current Liabilities		**6,581**	**6,129**
Non-Current Liabilities			
Provisions	3.3	390	349
Total Non-Current Liabilities		**390**	**349**
TOTAL LIABILITIES		**6,971**	**6,478**
NET ASSETS		**24,484**	**20,693**
EQUITY			
Property, Plant and Equipment Revaluation Surplus	4.2 (f)	4,956	26
Contributed Capital		22,352	22,352
Accumulated Surpluses		(2,824)	(1,685)
TOTAL EQUITY		**24,484**	**20,693**

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

ROBINVALE DISTRICT HEALTH SERVICES
STATEMENT OF CHANGES IN EQUITY
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2019

	Property, Plant and Equipment Revaluation Surplus	Contributed Capital	Accumulated Surpluses/ (Deficits)	Total
	$000	$000	$000	$000
Balance at 1 July 2017	26	22,352	(1,213)	21,165
Net result for the year	0	0	(472)	(472)
Other comprehensive income for the year	0	0	0	0
Balance at 30 June 2018	**26**	**22,352**	**(1,685)**	**20,693**
Net result for the year	0	0	(1,139)	(1,139)
Other comprehensive income for the year	4,930	0	0	4,930
Balance at 30 June 2019	**4,956**	**22,352**	**(2,824)**	**24,484**

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

ROBINVALE DISTRICT HEALTH SERVICES
CASH FLOW STATEMENT
FOR THE FINANCIAL YEAR ENDED 30 JUNE 2019

	Note	2019 $000	2018 $000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		10,880	11,186
Capital Grants from Government		41	23
Other Capital Receipts		9	0
Patient and Resident Fees Received		1,041	1,064
Donations and Bequests Received		9	3
GST (Paid to)/received from ATO		56	(67)
Interest Received		220	136
Other Receipts		1,468	1,120
Total Receipts		***13,724***	***13,465***
Employee Expenses Paid		(10,531)	(10,545)
Payments for Supplies and Consumables		(524)	(627)
Payments for Medical Indemnity Insurance		(51)	(66)
Payments for Repairs and Maintenance		(281)	(321)
Other Payments		(2,320)	(1,434)
Total Payments		***(13,707)***	***(12,993)***
NET CASH FLOW FROM OPERATING ACTIVITIES	8.1	**17**	**472**
CASH FLOWS FROM INVESTING ACTIVITIES			
(Purchase) / Proceeds of Investments		7,620	(569)
Purchase of Non-Financial Asset		(698)	(1,650)
Proceeds from Sale of Non-Financial Assets		100	242
NET CASH FLOW FROM / (USED IN) INVESTING ACTIVITIES		**7,022**	**(1,977)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Receipt of Accommodation Deposits		2,063	1,618
Repayment of Accommodation Deposits		(1,538)	(1,160)
NET CASH FLOW FROM FINANCING ACTIVITIES		**525**	**458**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		**7,564**	**(1,047)**
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		2,340	3,387
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.1	**9,904**	**2,340**

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

BASIS OF PRESENTATION

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

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

NOTE 1 : SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Robinvale District Health Services (ABN 58 413 230 512) for the year ended 30 June 2019. The report provides users with information about the Health Services' stewardship of resources entrusted to it.

(a) Statement of compliance

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

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

(b) Reporting Entity

The financial statements represent the activities of Robinvale District Health Services as a single entity.

Its principal address is:
128-132 Latje Road
Robinvale VIC 3549

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

BASIS OF PRESENTATION (Continued)

(c) Basis of accounting preparation and measurement

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

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2019, and the comparative information presented in these financial statements for the year ended 30 June 2018.

The financial statements are prepared on a going concern basis.

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

All amounts shown in the financial statements have been rounded to the nearest thousand dollars, unless otherwise stated. Minor discrepancies in tables between totals and sum of components are due to rounding.

The Health Service operates on a fund accounting basis and maintains three funds: Operating, Specific Purpose and Capital Funds.

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.

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 underlying assumptions are reviewed on an ongoing basis. The estimates and associated assumptions are based on professional judgements derived from historical experience and various experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

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

- The fair value of land, buildings, infrastructure, plant and equipment, (refer to Note 4.2);
- Defined benefit superannuation expense (refer to Note 3.4);
- Employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.3); and

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 Australian Taxation Office (ATO). 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 ATO is included with other receivables or payables in the Balance Sheet.

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

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

(d) Intersegment Transactions

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

BASIS OF PRESENTATION (Continued)

(e) Jointly Controlled Operation

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.

In respect of any interest in joint operations, the Health Service recognises in the financial statements:
- its assets, including its share of any assets held jointly;
- any liabilities including its share of liabilities that it had incurred;
- its revenue from the sale of its share of the output from the joint venture operation;
- its share of the revenue from the sale of the output by the operation; and
- its expenses, including its share of any expenses incurred jointly.

Robinvale District Health Services is a Member of the Loddon Mallee Rural Health Alliance Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.7 Jointly Controlled Operations and Assets).

(f) Equity

Contributed Capital

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

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

Other transfers that are in the nature of contributions or distributions or that have been designated as contributed capital are also treated as contributed capital.

Note 2: FUNDING DELIVERY OF OUR SERVICES

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

The health service is predominantly funded by accrual based grant funding for the provision of outputs. The health service also receives income from the supply of services.

Structure
2.1 Income from Transactions

Note 2.1: INCOME FROM TRANSACTIONS

	TOTAL 2019 $000	TOTAL 2018 $000
Government Grants - Operating	10,915	11,320
Government Grants - Capital	41	23
Other Capital Purpose Income	9	3
Patient and Resident Fees	1,021	1,223
Commercial Activities	316	332
Other Revenue from Operating Activities (Including Non-Capital Donations)	1,138	831
Total Income from Operating Activities	**13,440**	**13,732**
Interest	220	216
Total Revenue from Non-Operating Activities	**220**	**216**
Total Revenue	**13,660**	**13,948**

Revenue Recognition
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 Robinvale District Health Services and the income can be reliably measured at fair value.
Unearned income at reporting date is reported as income received in advance.

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

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

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

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

Non-cash contributions from the Department of Health and Human Services
The Department of Health and Human Services makes some payments on behalf of health services as follows:

- The Victorian Managed Insurance Authority non-medical indemnity insurance payments are recognised as revenue following advice from the Department of Health and Human Services
- Long Service Leave (LSL) - revenue is recognised upon finalisation of movements in LSL liability in line with the arrangements set out in the Metropolitan Health and Aged Care Services Division Hospital Circular

Patient and Resident Fees
Patient and resident fees are recognised as revenue on an accrual basis.

Private Practice Fees
Private Practice fees are recognised as revenue at the time invoices are raised, and include recoupments from private practice for use of Hospital facilities.

Revenue from commercial activities
Revenue from commercial activities such as medical clinic and property rental are recognised on an accrual basis.

Note 2.1: INCOME FROM TRANSACTIONS (Continued)

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 reserve, such as specific restricted purpose reserve.

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

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 services would have been purchased if not donated.

Note 3: THE COST OF DELIVERING OUR SERVICES

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

Structure

3.1 Expenses from Transactions
3.2 Other Economic Flows
3.3 Employee benefits in the Balance Sheet
3.4 Superannuation

Note 3.1: EXPENSES FROM TRANSACTIONS

	TOTAL 2019 $000	TOTAL 2018 $000
Salaries and Wages	8,029	7,906
On-Costs	781	768
Agency Expenses	571	518
Fee for Service Medical Officer Expenses	1,063	1,116
WorkCover Premium	193	199
Total Employee Expenses	**10,637**	**10,507**
Drug Supplies	23	33
Medical and Surgical Supplies	152	201
Diagnostic and Radiology Supplies	92	117
Other Supplies and Consumables	270	253
Total Supplies and Consumables	**537**	**604**
Fuel, Light, Power and Water	333	307
Repairs and Maintenance	180	223
Maintenance Contracts	101	98
Medical Indemnity Insurance	51	66
Other Administrative Expenses	1,619	1,613
Expenditure for Capital Purposes	134	96
Total Other Operating Expenses	**2,418**	**2,403**
Depreciation (refer Note 4.3)	1,094	1,047
Total Other Non-Operating Expenses	**1,094**	**1,047**
Total Expenses from Transactions	**14,686**	**14,561**

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

Employee expenses
Employee expenses include:

- Salaries and wages (including fringe benefits tax, leave entitlements, termination payments)
- On-Costs
- Agency Expenses
- Fee for Service Medical Officer Expenses
- WorkCover Premium

Supplies and Consumables
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 3.1: EXPENSES FROM TRANSACTIONS (Continued)

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

- Fuel, Light and Power
- Repairs and maintenance
- Other administrative expenses
- Expenditure for capital purposes (represents expenditure related to the purchase of assets that are below the capitalisation threshold).

The Department of Health and Human Services also makes certain payments on behalf of Robinvale District Health Services. These amounts have been brought to account as grants in determining the operating result for the year by recording them as revenue and also recording the related expense.

Non-Operating expenses
Other non-operating expenses generally represent expenditure for outside the normal operations such as depreciation and assets and services provided free of charge or for nominal consideration.

NOTE 3.2: OTHER ECONOMIC FLOWS	**TOTAL**	**TOTAL**
	2019 $000	**2018 $000**
Net gain/(loss) on sale of non-financial assets		
Net gain on disposal of property plant and equipment	0	86
Total net gain/(loss) on non-financial assets	0	86
Other gains/(losses) from other economic flows		
Net gain/(loss) arising from revaluation of long service liability	(113)	55
Total other gains/(losses) from other economic flows	(113)	55
Total other gains/(losses) from economic flows	(113)	141

Other economic flows are changes in the volume or value of an asset or liability that do not result from transactions.
Other gains/(losses) from other economic flows include the gains or losses from:

- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates; and
- reclassified amounts relating to available-for-sale financial instruments from the reserves to net result due to a disposal or derecognition of the financial instrument. This does not include reclassification between equity accounts due to machinery of government changes or 'other transfers' of assets.

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 gain/ (losses) of non-financial physical assets (Refer to Note 4.2 Property, Plant and Equipment)
- Net gain/(loss) on disposal of Non-Financial Assets

Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal.

Other gains/(losses) from other economic flows
Other gains/(losses) include:

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

Note 3.3 EMPLOYEE BENEFITS IN THE BALANCE SHEET	2019	2018
Current Provisions	**$000**	**$000**
Employee Benefits (i)		
Annual Leave and Wages and Accrued Days Off		
- unconditional and expected to be settled wholly within 12 months (ii)	805	806
- unconditional and expected to be settled wholly after 12 months (iii)	0	0
Long Service Leave		
- unconditional and expected to be settled wholly within 12 months (ii)	162	240
- unconditional and expected to be settled wholly after 12 months (iii)	839	592
	1,806	1,638
Provisions related to employee benefit on-costs		
- unconditional and expected to be settled within 12 months (ii)	125	147
- unconditional and expected to be settled after 12 months (iii)	108	76
	233	223
Total Current Provisions	**2,039**	**1,861**
Non-Current Provisions		
Conditional Long Service Leave (iii)	346	272
Provisions related to employee benefit on-costs	44	77
Total Non-Current Provisions	**390**	**349**
Total Provisions	**2,429**	**2,210**
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Annual Leave Entitlements	847	870
Accrued Days Off	62	52
Unconditional Long Service Leave Entitlements	1,130	939
Non-Current Employee Benefits and related on-costs		
Conditional Long Service Leave Entitlements	390	349
Total Employee Benefits and Related On-Costs	**2,429**	**2,210**

Notes:
(i) Employee benefits consist of amounts for accrued days off, annual leave and long service leave accrued by employees, not including on-costs.
(ii) The amounts disclosed are nominal values.
(iii) The amounts disclosed are discounted to present values.

b) Movements in Provisions	2019 $000	2018 $000
Movement in Long Service Leave:		
Balance at start of year	1,288	1,384
Provision made during the year		
- Revaluations	(113)	(55)
- Expense Recognising Employee Service	417	211
Settlement made during the year	(72)	(252)
Balance at end of year	**1,520**	**1,288**

Note 3.3: EMPLOYEE BENEFITS IN THE BALANCE SHEET (Continued)

Employee Benefit Recognition

Provision is made for benefits accruing to employees in respect of accrued days off, annual leave and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

Provisions

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

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation.

Employee Benefits

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

Annual Leave and Accrued Days Off

Liabilities for 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:

- Nominal 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)

The liability for LSL is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:

- Nominal value – if the health service expects to wholly settle within 12 months; or
- Present value – if the health service does not expect to settle a component of this current liability within 12 months

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

Termination Benefits

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

On-Costs related to employee expense

Provision for on-costs, such as workers compensation and superannuation are recognised separately from provisions for employee benefits.

Note 3.4: SUPERANNUATION

Fund	Paid Contributions for the year		Outstanding Contributions at Year End	
	2019 $000	**2018 $000**	**2019 $000**	**2018 $000**
Defined Benefit Plans: (i)				
First State Super	25	27	0	0
Defined Contribution Plans:				
First State Super	613	689	0	0
Hesta	131	89	0	0
Other	71	32	0	0
Total	**840**	**837**	**0**	**0**

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

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

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

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

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

Note 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

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

Structure
4.1 Investments and other financial assets
4.2 Property, plant & equipment
4.3 Depreciation

Note 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS	Operating Fund		Total	
	2019	2018	2019	2018
CURRENT	$000	$000	$000	$000
Loans and Receivables				
Term Deposit				
Aust. Dollar Term Deposits > 3 Months (i)	1,000	8,620	1,000	8,620
TOTAL CURRENT OTHER FINANCIAL ASSETS	**1,000**	**8,620**	**1,000**	**8,620**
Represented by:				
Investments - Health Service	0	5,650	0	5,650
Investments - Joint Operation	0	170	0	170
Investments - Monies Held in Trust	1,000	2,800	1,000	2,800
TOTAL INVESTMENTS AND OTHER FINANCIAL ASSETS	**1,000**	**8,620**	**1,000**	**8,620**

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

Investment Recognition
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 as loans and receivables or available-for-sale financial assets.

Robinvale District Health Services classifies its other financial assets between current and non-current assets based on the Board of Management's intention at balance date with respect to the timing of disposal of each asset. The Health Service assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

Robinvale District Health Services' investments must comply with Standing Direction 3.7.2 - Treasury and Investment Risk Management.

All financial assets, except those measured at fair value through the Comprehensive Operating Statement are subject to annual review for impairment.

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

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

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

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

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

In order to determine an appropriate fair value as at 30 June 2019 for its portfolio of financial assets, the Health Service used the market value of investments held provided by the portfolio managers.

The above valuation process was used to quantify the level of impairment (if any) on the portfolio of financial assets as at year end.

Note 4.2: PROPERTY, PLANT AND EQUIPMENT (a) Gross carrying amount and accumulated depreciation	2019 $000	2018 $000
Land		
- Land at Fair Value	1,010	721
Total Land	**1,010**	**721**
Buildings		
- Buildings at Fair Value	17,806	16,595
Less Accumulated Depreciation	0	3,116
	17,806	13,479
- Buildings Work in Progress at Cost	14	60
Total Buildings	**17,820**	**13,539**
Plant and Equipment		
- Plant and Equipment at Fair Value	2,512	2,457
Less Accumulated Depreciation	1,903	1,733
	609	724
- Joint Operation Plant and Equipment at Fair Value	57	58
Less Accumulated Depreciation	32	33
	25	25
Total Plant and Equipment	**634**	**749**
Motor Vehicles		
- Motor Vehicles at Fair Value	633	621
Less Accumulated Depreciation	383	350
Total Motor Vehicles	**250**	**271**
TOTAL	**19,714**	**15,280**

Note 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(b) Reconciliation of the carrying amounts of each class of asset

	Land	Buildings	Plant & Equipment	Motor Vehicles	Total
	$000	$000	$000	$000	$000
Balance at 1 July 2017	761	14,245	811	274	16,091
Additions	0	152	96	123	371
LMRHA Movement	0	0	21	0	21
Disposals	(40)	(67)	0	(49)	(156)
Depreciation (note 4.3)	0	(791)	(179)	(77)	(1,047)
Balance at 1 July 2018	**721**	**13,539**	**749**	**271**	**15,280**
Additions	0	466	64	168	698
LMRHA Movement	0	0	0	0	0
Asset Revaluation	289	4,641	0	0	4,930
Disposals	0	0	0	(100)	(100)
Depreciation (note 4.3)	0	(826)	(179)	(89)	(1,094)
Balance at 30 June 2019	**1,010**	**17,820**	**634**	**250**	**19,714**

Land and Buildings Carried at Valuation
The Valuer-General Victoria undertook to re-value all of Robinvale District Health Services' owned and leased land and buildings to determine the fair value. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments.
The effective date of the valuation is 30 June 2019.

(c) Fair value measurement hierarchy for assets

	Carrying amount as at 30 June 2019	Fair value measurement at end of reporting period using: Level 1 (i)	Level 2 (i)	Level 3 (i)
	$000	$000	$000	$000
Land at fair value				
Non-Specialised land	343	0	343	0
Specialised land	667	0	0	667
Total of land at fair value	1,010	0	343	667
Buildings at fair value				
Non-Specialised buildings	1,558	0	1,558	0
Specialised buildings	16,248	0	0	16,248
Total of buildings at fair value	17,806	0	1,558	16,248
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles	250	0	250	0
- Plant and equipment	634	0	0	634
Total of plant, equipment and vehicles at fair value	884	0	250	634

Note
(i) Classified in accordance with the fair value hierarchy

There have been no transfers between levels during the period.

Note 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(c) Fair value measurement hierarchy for assets (Continued)

	Carrying amount as at 30 June 2018	Fair value measurement at end of reporting period using: Level 1 (i)	Level 2 (i)	Level 3 (i)
	$000	$000	$000	$000
Land at fair value				
Non-Specialised land	245	0	245	0
Specialised land	476	0	0	476
Total of land at fair value	721	0	245	476
Buildings at fair value				
Non-Specialised buildings	1,067	0	1,067	0
Specialised buildings	12,412	0	0	12,412
Total of buildings at fair value	13,479	0	1,067	12,412
Plant and equipment at fair value				
Plant equipment and vehicles at fair value				
- Vehicles (ii)	271	0	271	0
- Plant and equipment	749	0	0	749
Total of plant, equipment and vehicles at fair value	1,020	0	271	749

Note
(i) Classified in accordance with the fair value hierarchy
There have been no transfers between levels during the period.

Note 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(d) Reconciliation of Level 3 fair value

30-Jun-19	Land	Buildings	Plant and equipment
	$000	**$000**	**$000**
Opening Balance	476	12,412	749
Purchases (sales) & reclassifications	0	466	64
Transfers in (out) of Level 3	0	0	0
Gains or losses recognised in net result			
- Depreciation	0	(769)	(179)
Subtotal	476	12,109	634
Items recognised in other comprehensive income			
- Revaluation	191	4,139	0
Subtotal	191	4,139	0
Closing Balance	667	16,248	634
Unrealised gains/(losses) on non-financial assets	0	0	0
	667	16,248	634

There have been no transfers between levels during the period.

30-Jun-18	Land	Buildings	Plant and equipment
	$000	**$000**	**$000**
Opening Balance	476	13,099	801
Purchases (sales) & reclassifications	0	0	0
Transfers in (out) of Level 3	0	0	0
Gains or losses recognised in net result			
- Depreciation	0	(687)	(52)
Subtotal	476	12,412	749
Items recognised in other comprehensive income			
- Revaluation	0	0	0
Subtotal	0	0	0
Closing Balance	476	12,412	749
Unrealised gains/(losses) on non-financial assets	0	0	0
	476	12,412	749

There have been no transfers between levels during the period.

(e) Fair Value Determination

Asset Class	Likely Valuation Approach	Significant Inputs (Level 3 Only)
Specialised Land (Crown / Freehold)	Market approach	Community Service Obligation Adjustment 30%
Specialised Buildings	Market approach	- Cost per square metre - Useful Life
Vehicles	Market approach	- n.a
Plant and Equipment	Depreciated Replacement Cost	- Cost per unit - Useful Life

Note 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
(f) Property, Plant and Equipment Revaluation Surplus

Property, Plant and Equipment Revaluation Surplus	**2019 $000**	**2018 $000**
Balance at the beginning of the reporting period	26	26
Transfer to Accumulated Deficits		
- Land	0	0
Revaluation Increment		
- Land	289	0
- Buildings	4,641	0
Balance at the end of the reporting period*	4,956	26
***Represented by:**		
- Land	289	0
- Buildings	4,667	26
	4,956	26

Initial Recognition
Items of property, plant and equipment are measured initially at cost and subsequently revalued at fair value less accumulated
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 change are transferred at their carrying amounts.

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

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

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

Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

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

Revaluations of non-current physical assets
Non-Current physical assets are measured at fair value and are revalued in accordance with FRD 103H 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 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 the 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 transferred to accumulated funds on derecognition of the relevant asset.

In accordance with FRD 103H Robinvale District Health Services' non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

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

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

Note 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)
Fair value measurement (Continued)

In addition, Robinvale and District Health Services determines whether transfers have occurred between levels in the hierarchy by reassessing 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 Robinvale and District Health Services independent valuation agency.

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

Valuation hierarchy
In determining fair values a number of inputs are used. To increase consistency and comparability in the financial statements, these inputs are categorised into three levels, also known as the fair value hierarchy. The levels are as follows:

- 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; and
- Level 3 - valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

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

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

Consideration of highest and best use (HBU) for non-financial physical assets
Judgements about highest and best use must take into account the characteristics of the assets concerned, including restrictions on the use and disposal of assets arising from the asset's physical nature and any applicable legislative/contractual arrangements.
In considering the HBU for non-financial physical assets, valuers are probably best placed to determine highest and best use (HBU) in consultation with Health Services. Health Services and their valuers therefore need to have a shared understanding of the circumstances of the assets. A Health Service has to form its own view about a valuer's determination, as it is ultimately responsible for what is presented in its audited financial statements.

In accordance with paragraph AASB 13.29, Health Services can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.

Non specialised land and specialised buildings
Non-specialised land, non-specialised buildings and cultural assets are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value.
For non-specialised land and non-specialised buildings, an independent valuation was performed by the Valuer-General to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 2019.

Specialised land and specialised buildings
Specialised land includes Crown Land which 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 assets 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 use.

During the reporting period, the Health Service held Crown Land. The nature of this asset means that there are certain limitations and restrictions imposed on its use and/or disposal that may impact their fair value.

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

Note 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Specialised land and specialised buildings (Continued)

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

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

An independent valuation of the Health Service's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2019.

Vehicles

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

Plant and equipment

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

There were no changes in valuation techniques throughout the period to 30 June 2019.

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

Note 4.3: DEPRECIATION

	2019 $000	2018 $000
Depreciation		
Buildings	826	791
Plant and Equipment		
- Plant	103	103
- Major Medical	71	73
- Motor Vehicles	89	77
- Joint Operation	5	3
TOTAL DEPRECIATION	**1,094**	**1,047**

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 is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life (refer AASB 116 *Property, Plant and Equipment*).

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

	2019	2018
Buildings		
- Structure Shell Building Fabric	7 to 40 Years	7 to 40 Years
- Site Engineering Services and Central Plant	6 to 25 Years	6 to 25 Years
Central Plant		
- Fit Out	5 to 40 Years	5 to 40 Years
- Trunk Reticulated Building Systems	5 to 17 Years	5 to 17 Years
Plant and Equipment	5 to 10 years	5 to 10 years
Medical Equipment	5 to 20 years	5 to 20 years
Computers and Communication	2.5 to 4 years	2.5 to 4 years
Furniture and Fittings	5 years	5 years
Motor Vehicles	5 to 10 years	5 to 10 years

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

Note 5: OTHER ASSETS AND LIABILITIES

This section sets out those assets and liabilities that arose from the health services operations.

Structure
5.1 Receivables
5.2 Other liabilities
5.3 Payables

Note 5.1: RECEIVABLES	2019 $000	2018 $000
CURRENT		
Contractual		
Trade Debtors - Health Service	111	96
Patient / Resident Debtors	9	27
Accrued Revenue	27	87
Joint Operations - Receivables	22	19
Less Allowance for Impairment Losses of Contractual Receivables	(2)	0
	167	229
Statutory		
Joint Operations - GST Receivable	3	7
GST Receivable - Health Service	83	107
	86	114
TOTAL CURRENT RECEIVABLES	**253**	**343**
NON CURRENT		
Statutory		
Long Service Leave - Department of Health and Human Services	348	372
TOTAL NON-CURRENT RECEIVABLES	**348**	**372**
TOTAL RECEIVABLES	**601**	**715**

(a) Movement in the Allowance for Impairment Losses of Contractual Receivables	2019 $000	2018 $000
Balance at beginning of year	0	(5)
Amounts written off during the year	0	5
Increase in allowance recognised on the net result	(2)	0
Balance at end of year	(2)	0

Note 5.1: RECEIVABLES (Continued)

Receivables Recognition

Receivables consist of:

- Contractual receivables, which consists of debtors in relation to goods and services and accrued investment income. These receivables are classified as financial instruments and categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. The Health Service holds the contractual receivables with the objective to collect the contractual cash flows and therefore subsequently measured at amortised cost using the effective interest method, less any impairment.
- Statutory receivables, which predominantly includes amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. The Health Service applies AASB 9 for initial measurement of the statutory receivables and as a result statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition.

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.

The Health Service is not exposed to any significant credit risk exposure to any single counterparty or any group of counterparties having similar characteristics. Trade receivables consist of a large number of customers in various geographical areas. Based on historical information about customer default rates, management consider the credit quality of trade receivables that are not past due or impaired to be good.

Impairment losses of contractual receivables

Refer to Note 7.1 (c) Contractual receivables at amortised costs for the Health Service's contractual impairment losses.

Receivables are subject to impairment loss assessment in accordance with AASB 9's expected credit loss model and the impairment loss allowance is increased accordingly with the impairment expense recognised in the net result as an 'other economic flow'. However, when it becomes mutually agreed between debtor and creditor that the receivable has become uncollectible, the carrying amount of the receivable needs to be reduced, and a bad debt expense for the write-off recognised in the net result as a transaction. Accordingly at the same time, the amount in the provision together with its related impairment expense initially recognised as an 'other economic flow' will need to be reversed.

Where the bad debt is written off following a unilateral decision, the carrying amount of the receivable needs to be reduced, and a bad debt expense for the write-off recognised in the net result as an 'other economic flow'. Accordingly at the same time, the amount in the provision together with its related impairment expense will need to be reversed.

However, the initial fair value measurement requirements of AASB 9 are the most appropriate for the types of receivables under consideration as the economic substance of contractual receivables and receivables arising from statutory requirements is similar at initial recognition and therefore AAB 9 should be applied at the initial measurement of such receivables. Although these assets are similar to financials instruments, they are not in the scope of AASB 7 Financial Instruments: Disclosures.

Note 5.2: OTHER LIABILITIES	**2019 $000**	**2018 $000**
CURRENT		
Monies Held in Trust*		
- Resident Monies Held in Trust	14	13
- Refundable Accommodation Deposits	3,524	2,999
- Auspiced Funds	3	4
TOTAL CURRENT	**3,541**	**3,016**
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets (refer to Note 6.1)	2,541	216
Investment and other Financial Assets (refer to Note 4.1)	1,000	2,800
TOTAL OTHER LIABILITIES	**3,541**	**3,016**

Note 5.3: PAYABLES	2019 $000	2018 $000
CURRENT		
Contractual		
Trade Creditors	224	467
Joint Operation - Payables	68	69
Other Accrued Expenditure	503	473
Income in Advance	4	23
	799	**1,032**
Statutory		
Department of Health and Human Services	134	184
GST Payable (ii)	68	36
	202	**220**
TOTAL PAYABLES	**1,001**	**1,252**

Payables Recognition

Payables consist of:

- contractual payables, classified as financial instruments and measured at amortised cost. Accounts payable represents liabilities for goods and services provided to the Department prior to the end of the financial year that are unpaid; and
- statutory payables, that 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 contracts.

Maturity analysis of payables

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

Note 6: HOW WE FINANCE OUR OPERATIONS

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

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

Structure
6.1 Cash and cash equivalents
6.2 Commitments for expenditure

Note 6.1: CASH AND CASH EQUIVALENTS

	2019 $000	2018 $000
Cash on Hand	1	1
Cash at Bank	9,903	2,339
TOTAL CASH AND CASH EQUIVALENTS	**9,904**	**2,340**
Represented by:		
Cash for Health Service Operations	7,184	2,097
Joint Operation - Cash	196	44
Cash for Monies Held in Trust	2,524	199
TOTAL CASH AND CASH EQUIVALENTS	**9,904**	**2,340**

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 and are subject to insignificant risk of changes in value.

For cash flow statement presentation purposes, cash and cash equivalents include bank overdrafts, which are included as liabilities on the balance sheet. The cash flow statement includes monies held in trust.

Note 6.2: COMMITMENTS FOR EXPENDITURE

	2019 $000	2018 $000
a) Commitments		
Lease commitments		
Commitments in relation to leases contracted for at the reporting date:		
Operating Leases	4	0
Total lease commitments	4	0
Total Commitments	4	0
b) Commitments payable		
Lease commitments payable		
Rental Property		
Less than 1 year	4	0
Longer than 1 year but not longer than 5 years	0	0
Total lease commitments	4	0
Total commitments (inclusive of GST)	4	0
Less GST recoverable from the Australian Taxation Office	0	0
Total commitments (exclusive of GST)	4	0

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

Note 7: RISKS, CONTINGENCIES & VALUATION UNCERTAINTIES

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

Structure
7.1 Financial instruments

Note 7.1: 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 Robinvale District Health Service's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation.*

(a) Financial Instruments: Categorisation

2019	Financial assets at amortised cost $000	Financial liabilities at amortised cost $000	Total $000
Contractual Financial Assets			
Cash and cash equivalents	9,904	0	9,904
Receivables	167	0	167
Investments and Other Financial Assets	1,000	0	1,000
Total Financial Assets (i)	11,071	0	11,071
Financial Liabilities			
At amortised cost			
- Payables	0	799	799
- Other Liabilities	0	3,541	3,541
Total Financial Liabilities(ii)	0	4,340	4,340

2018	Contractual financial assets - loans and receivables $000	Contractual financial liabilities at amortised cost $000	Total $000
Contractual Financial Assets			
Cash and cash equivalents	2,340	0	2,340
Receivables	229	0	229
Investments and Other Financial Assets	8,620	0	8,620
Total Financial Assets (i)	11,189	0	11,189
Financial Liabilities			
At amortised cost			
- Payables	0	1,032	1,032
- Other Liabilities	0	3,016	3,016
Total Financial Liabilities(ii)	0	4,048	4,048

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

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)
(a) Financial Instruments: Categorisation (Continued)

From 1 July 2018, the Health Service applies AASB 9 and classifies all of its financial assets based on the business model for managing the assets and the asset's contractual terms.

Categories of financial assets under AASB 9

Financial assets at amortised cost
Financial assets are measured at amortised costs if both of the following criteria are met and the assets are not designated as fair value through net result:
- the assets are held by the Health Service to collect the contractual cash flows, and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interests.

These assets are initially recognised at fair value plus any directly attributable transaction costs and subsequently measured at amortised cost using the effective interest method less any impairment.
The Department recognises the following assets in this category:
- cash and deposits;
- receivables (excluding statutory receivables);
- term deposits; and
- certain debt securities.

Categories of financial assets previously under AASB 139
Loans and receivables and cash 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 (and for assets, less any impairment).

Loans and receivables category includes cash and deposits (refer to Note 6.1), term deposits with maturity greater than three months, trade receivables, loans and other receivables, but not statutory receivables.

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

Derecognition of financial assets: A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is derecognised when the rights to receive cash flows from the asset have expired.

Derecognition of financial liabilities: A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

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

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

Note 7.1: FINANCIAL INSTRUMENTS (Continued)

Note 7.1 (b) Maturity analysis of financial liabilities as at 30 June

The following table discloses the contractual maturity analysis for Robinvale District Health Services' 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			
2019	**Total 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						
At amortised cost						
Payables	799	799	798	1	0	0
Other Financial Liabilities (i)						
- Monies Held in Trust	3,541	3,541	3,541	0	0	0
Total Financial Liabilities	**4,340**	**4,340**	**4,339**	**1**	**0**	**0**
2018						
Financial Liabilities						
At amortised cost						
Payables	1,032	1,032	1,003	23	6	0
Other Financial Liabilities (i)						
- Monies Held in Trust	3,016	3,016	3,016	0	0	0
Total Financial Liabilities	**4,048**	**4,048**	**4,019**	**23**	**6**	**0**

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

Note 7.1: FINANCIAL INSTRUMENTS (Continued)
Note 7.1 (c): Contractual receivables at amortised costs

01-Jul-18	Current	Less than 1 month	1-3 months	3 months - 1 year	1-5 years	Total
Expected loss rate	0%	0%	0%	0%	100%	
Gross carrying amount of contractual receivables	204	23	2	0	0	229
Loss allowance	0	0	0	0	0	0

30-Jun-19	Current	Less than 1 month	1-3 months	3 months - 1 year	1-5 years	Total
Expected loss rate	0%	0%	0%	0%	100%	
Gross carrying amount of contractual receivables	153	7	3	2	2	167
Loss allowance	0	0	0	0	2	2

Impairment of financial assets under AASB 9 – applicable from 1 July 2018
From 1 July 2018, the Health Service has been recording the allowance for expected credit loss for the relevant financial instruments, replacing AASB 139's incurred loss approach with AASB 9's Expected Credit Loss approach. Subject to AASB 9 impairment assessment include the Health Service's contractual receivables, statutory receivables and its investment in debt instruments.

Equity instruments are not subject to impairment under AASB 9. Other financial assets mandatorily measured or designated at fair value through net result are not subject to impairment assessment under AASB 9. While cash and cash equivalents are also subject to the impairment requirements of AASB 9, the identified impairment loss was immaterial.

Contractual receivables at amortised cost
The Health Service applies AASB 9 simplified approach for all contractual receivables to measure expected credit losses using a lifetime expected loss allowance based on the assumptions about risk of default and expected loss rates. The Health Service has grouped contractual receivables on shared credit risk characteristics and days past due and select the expected credit loss rate based on the Department's past history, existing market conditions, as well as forward‑looking estimates at the end of the financial year.

On this basis, the Health Service determines the opening loss allowance on initial application date of AASB 9 and the closing loss allowance at end of the financial year as disclosed above.

Reconciliation of the movement in the loss allowance for contractual receivables

	2019	*2018*
Balance at the beginning of the year	0	5
Opening retained earnings adjustment on adoption of AASB 9	0	0
Opening Loss Allowance	0	5
Modification of contractual cash flows on financial assets	0	0
Increase in provision recognised in the net result	2	0
Reversal of provision of receivables written off during the year as uncollectible	0	(5)
Reversal of unused provision recognised in the net result	0	0
Balance at end of the year	2	0

Credit loss allowance is classified as other economic flows in the net result. Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

In prior years, 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. A provision is made for estimated irrecoverable amounts from the sale of goods when there is objective evidence that an individual receivable is impaired. Bad debts considered as written off by mutual consent.

Statutory receivables and debt investments at amortised cost [AASB2016-8.4]
The Health Service's non-contractual receivables arising from statutory requirements are not financial instruments. However, they are nevertheless recognised and measured in accordance with AASB 9 requirements as if those receivables are financial instruments.

The statutory receivables are considered to have low credit risk, taking into account the counterparty's credit rating, risk of default and capacity to meet contractual cash flow obligations in the near term.

NOTE 8: OTHER DISCLOSURES

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

Structure

8.1 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities
8.2 Responsible persons disclosures
8.3 Executive officer disclosures
8.4 Related parties
8.5 Remuneration of auditors
8.6 Events occurring after the balance sheet date
8.7 Jointly controlled operations and assets
8.8 Economic dependency
8.9 AASBs issued that are not yet effective

Note 8.1: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW / (OUTFLOW) FROM OPERATING ACTIVITIES	2019 $000	2018 $000
NET RESULT FOR THE YEAR	(1,139)	(472)
Non-cash movements		
Depreciation	1,094	1,044
Share of Net Result from Joint Ventures	0	7
Movements included in investing and financing activities		
Net (Gain)/Loss from Disposal of Plant and Equipment	0	(86)
Movements in assets and liabilities		
Change in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	114	51
(Increase)/Decrease in Prepayments	(33)	(23)
Increase/(Decrease) in Payables	(251)	45
Increase/(Decrease) in Provisions	219	(94)
Change in Inventories	13	0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**17**	**472**

Note 8.2: RESPONSIBLE PERSON DISCLOSURES

In accordance with the Ministerial Directions issued by the Assistant Treasurer 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 and Minister for Ambulance Services	01/07/2018 - 29/11/2018
The Honourable Jenny Mikakos, Minister for Health and Minister for Ambulance Services	29/11/2018 - 30/06/2019
The Honourable Martin Foley, Minister for Mental Health	01/07/2018 - 30/06/2019
The Honourable Martin Foley, Minister for Housing, Disability and Ageing	01/07/2018 - 29/11/2018
The Honourable Luke Donnellan, Minister for Child Protection, Minister for Disability, Ageing and Carers	29/11/2018 - 30/06/2019
Governing Boards	
Quentin Norton	01/07/2018 - 30/06/2019
Freule Jones	01/07/2018 - 30/06/2019
Bruce Myers	01/07/2018 - 30/06/2019
Kady Moore	01/07/2018 - 30/06/2019
Trung (Jack) Dang	01/07/2018 - 30/06/2019
Glenn Stewart	01/07/2018 - 30/06/2019
Yvonne Brown	01/07/2018 - 30/06/2019
Abby White	01/07/2018 - 30/06/2019
Accountable Officers	
Mrs Mara Richards	01/07/2018 - 30/06/2019

Remuneration of Responsible Persons

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

Income Band	**2019**	**2018**
$0 - $9,999	8	10
$190,000 - $199,999	0	1
$210,000 - $219,999	1	0
Total Numbers	9	11

	$000	**$000**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	$230	$198

Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Services' Financial Report as disclosed in Note 8.4.

Note 8.3: EXECUTIVE OFFICER DISCLOSURES

The number of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the table below. Total annualised employee equivalent provides a measure of full time equivalent executive officers over the reporting period. Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered, and is disclosed in the following categories:

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

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

Other Long-term Benefits
Long service leave, other long-service benefit or deferred compensation.

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

Remuneration of executive officers	**Total Remuneration**	
	2019	**2018**
	$000	**$000**
Short-term employee benefits	373	248
Post-employment benefits	33	22
Other long-term benefits	9	6
Total Remuneration	**415**	**276**
Total Number of executives	3	2
Total annualised employee equivalent (AEE)	3.0	2.0

Notes:
(i) The executives are not considered to meet the definition of Key Management Personnel (KMP) of the entity under AASB 124 Related Party Disclosures and are therefore not reported within the related parties note disclosure (Note 8.4).
(ii) Annualised employee equivalent is based on the time fraction worked over the reporting period. This is calculated as the total number of days the employee is engaged to work during the week by the total number of full-time working days per week (this is generally five full working days per week).

Note 8.4: RELATED PARTIES

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

- all key management personnel and their close family members;
- all cabinet ministers and their close family members; and
- Jointly Controlled Operation - A member of the Loddon Mallee Rural Health Alliance; and
- all health service's and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of the Health Service and its controlled entities, directly or indirectly.

The Board of Directors and the Chief Executive Officer of Robinvale District Health Services are deemed to be KMPs.

Entity	KMPs	Position Title
Robinvale District Health Services	Quentin Norton	Chair of the Board
Robinvale District Health Services	Freule Jones	Board Member
Robinvale District Health Services	Bruce Myers	Board Member
Robinvale District Health Services	Kady Moore	Board Member
Robinvale District Health Services	Trung (Jack) Dang	Board Member
Robinvale District Health Services	Glenn Stewart	Board Member
Robinvale District Health Services	Yvonne Brown	Board Member
Robinvale District Health Services	Abby White	Board Member
Robinvale District Health Services	Mrs Mara Richards	Chief Executive Officer

The compensation detailed below excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the *Parliamentary Salaries and Superannuation Act 1968,* and is reported within the Department of Parliamentary Services' Financial Report.

COMPENSATION	2019 $000	2018 $000
Short term employee benefits	208	178
Post-employment benefits	17	16
Other long-term benefits	4	4
Termination benefits	0	0
Share based payments	0	0
Total	**230**	**198**

KMPs are also reported in Note 8.2 Responsible Persons.

Significant transactions with government-related entities

Robinvale District Health Services received funding from the Department of Health and Human Services of $7,143,653 (2018: $7,272,000)

Expenses incurred by the Health Service in delivering services and outputs are in accordance with Health Purchasing Victoria requirements. Goods and services including procurement, diagnostics, patient meals and multi-site operational support are provided by other Victorian Health Service Providers on commercial terms.

Professional medical indemnity insurance and other insurance products are obtained from a Victorian Managed Insurance Authority.

The Standing Directions of the Minister for Finance require Robinvale District Health Services to hold cash (in excess of working capital) in accordance with the State's centralised banking arrangements. All borrowings are required to be sourced from Treasury Corporation Victoria unless an exemption has been approved by the Minister for Health and Human Services and the Treasurer.

Note 8.4: RELATED PARTIES (Continued)

Transactions with key management personnel and other related parties

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the Public Administration Act 2004 and Codes of Conduct and Standards issued by the Victorian Public Sector Commission.

Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with the health service there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

Note 8.5: REMUNERATION OF AUDITORS

	2019	2018
Victorian Auditor-General's Office	**$000**	**$000**
Audit of the financial statements	24	23
	24	23

Note 8.6: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

There are no known events occurring after the balance sheet date that would materially effect the financial result.

Note 8.7: JOINTLY CONTROLLED OPERATIONS AND ASSETS

Name of Entity	Principal Activity	Ownership Interest 2019 %	Ownership Interest 2018 %
Loddon Mallee Rural Health Alliance	Information Systems	4.43	4.35

Robinvale District Health Service's interest in assets employed in the above jointly controlled operations and assets is detailed below.
The amounts are included in the financial statements under their respective categories:

Summarised Balance Sheet:	**2019**	**2018**
Current Assets	**$000**	**$000**
Cash and Cash Equivalents	196	214
Receivables	22	31
Prepayments	55	24
Total Current Assets	**273**	**269**
Non Current Assets		
Property Plant and Equipment	25	25
Total Non Current Assets	**25**	**25**
Total Assets	**298**	**294**
Current Liabilities		
Payables	68	69
Total Current Liabilities	**68**	**69**
Total Liabilities	**68**	**69**
Share of Joint Venture Net Assets	**230**	**225**

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

Summarised Operating Statement:		
Revenues		
Operating Income	343	348
Capital Income	9	0
Total Revenue	**352**	**348**
Expenses		
Information Technology and Administrative Expenses	340	341
Capital Expense	5	14
Total Expenses	**345**	**355**
Profit	**7**	**(7)**

Contingent Liabilities and Capital Commitments
There are no known contingent liabilities or capital commitments for Loddon Mallee Rural Health Alliance as at the date of this report.

Investments in joint operations
In respect of any interest in joint operations, Robinvale District Health Service recognises in the financial statements:

- its assets, including its share of any assets held jointly;
- any liabilities including its share of liabilities that it had incurred;
- its revenue from the sale of its share of the output from the joint operation;
- its share of the revenue from the sale of the output by the operation; and
- its expenses, including its share of any expenses incurred jointly.

NOTE 8.8: ECONOMIC DEPENDENCY
The Health Service is dependent on the Department of Health and Human Services for the majority of it revenue used to operate the entity.
At the date of this report, the Board of Directors has no reason to believe the Department will not continue to support the Health Service.

NOTE 8.9: AASBs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2019 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30 June 2019, 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. Robinvale District Health Services has not and does not intend to adopt these standards early.

Topic	Key Requirements	Effective date	Impact on financial statements
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. Note that amending standard AASB 2015-8 Amendments to Australian Accounting Standards - Effective Date of AASB 15 has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	01-Jan-19	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. Revenue from grants that are provided under an enforceable agreement that have sufficiently specific obligations, will now be deferred and recognised as the performance obligations attached to the grant are satisfied. There is an expectation this will impact capital grant funding and some primary health funding contracts, however it is not possible to quantify the impact until such time as funding is received and projects/contracted activities commence.
AASB 2016-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit-entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	01-Jan-19	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that are amended for not-for-profit application include: AASB 9 • Statutory receivables are recognised and measured similarly to financial assets. AASB 15 • The 'customer' does not need to be the recipient of goods and/or services; • The "contract" could include an arrangement entered into under the direction of another party; • Contracts are enforceable if they are enforceable by legal or 'equivalent means'; • Contracts do not have to have commercial substance, only economic substance; and • Performance obligations need to be 'sufficiently specific' to be able to apply AASB 15 to these transactions. The impact on reporting capital funding has potential to result in material change, however this is not able to be quantified prior to receipt of capital grants and commencement of projects.

NOTE 8.9: AASBs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Topic	Key Requirements	Effective date	Impact on financial statements
AASB 16 Leases	The key changes introduced by AASB 16 include the recognition of most operating leases (which are currently not recognised) on balance sheet.	01-Jan-19	The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability. In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge. There will be no change for lessors as the classification of operating and finance leases remains unchanged. There is no material impact from implementation of this standard due to the lack of existing operating leases.
AASB 2018-8 Amendments to Australian Accounting Standards – Right of Use Assets of Not-for-Profit entities	This standard amends various other accounting standards to provide an option for not-for-profit entities to not apply the fair value initial measurement requirements to a class or classes of right of use assets arising under leases with significantly below-market terms and conditions principally to enable the entity to further its objectives. This Standard also adds additional disclosure requirements to AASB 16 for not-for-profit entities that elect to apply this option.	01-Jan-19	Under AASB 1058, not-for-profit entities are required to measure right-of-use assets at fair value at initial recognition for leases that have significantly below-market terms and conditions. For right-of-use assets arising under leases with significantly below market terms and conditions principally to enable the entity to further its objectives (peppercorn leases), AASB 2018-8 provides a temporary option for Not-for-Profit entities to measure at initial recognition, a class or classes of right-of-use assets at cost rather than at fair value and requires disclosure of the adoption. The State has elected to apply the temporary option in AASB 2018-8 for not-for-profit entities to not apply the fair value provisions under AASB 1058 for these right-of-use assets. In making this election, the State considered that the methodology of valuing peppercorn leases was still being developed. No material impact during the period applicable under the election.
AASB 1058 Income of Not-for-Profit Entities	AASB 1058 will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 Contributions. The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context, AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objective	01-Jan-19	Grant revenue is currently recognised up front upon receipt of the funds under AASB 1004 Contributions. The timing of revenue recognition for grant agreements that fall under the scope of AASB 1058 may be deferred. For example, revenue from capital grants for the construction of assets will need to be deferred and recognised progressively as the asset is being constructed. The impact on current revenue recognition of the changes is the potential phasing and deferral of revenue recorded in the operating statement. Impact is not able to be quantified until such time as capital grants are received and projects commence.
AASB 2018-7 Amendments to Australian Accounting Standards – Definition of Material	This Standard principally amends AASB 101 Presentation of Financial Statements and AASB 108 Accounting Policies, Changes in Accounting Estimates and Errors. The amendments refine and clarify the definition of material in AASB 101 and its application by improving the wording and aligning the definition across AASB Standards and other publications. The amendments also include some supporting requirements in AASB 101 in the definition to give it more prominence and clarify the explanation accompanying the definition of material.	01-Jan-20	The standard is not expected to have a significant impact on the public sector. No material impact is expected.

NOTE 8.9: AASBs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Topic	Key Requirements	Effective date	Impact on financial statements
AASB 2018-5 Amendments to Australian Accounting Standards – Deferral of AASB 1059	This standard defers the mandatory effective date of AASB 1059 from 1 January 2019 to 1 January 2020. AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objective.	1 January 2020 (The State is intending to early adopt AASB 1059 for annual reporting periods beginning on or after 1 January 2019)	This standard defers the mandatory effective date of AASB 1059 for periods beginning on or after 1 January 2019 to 1 January 2020. As the State has elected to early adopt AASB 1059, the financial impact will be reported in the financial year ending 30 June 2019, rather than the following year.

The following accounting pronouncements are also issued but not effective for the 2018‑18 reporting period. At this stage, the preliminary assessment suggests they may have insignificant impacts on public sector reporting.

- AASB 2017-6 Amendments to Australian Accounting Standards – Prepayment Features with Negative Compensation
- AASB 2017-7 Amendments to Australian Accounting Standards – Long-term Interests in Associates and Joint Ventures
- AASB 2018-3 Amendments to Australian Accounting Standards – Reduced Disclosure Requirements

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