Annual Report

2021–2022

the royal victorian eye and ear hospital

Contents

General Information

The Royal Victorian Eye and Ear Hospital has provided state-wide eye, ear, nose and throat health care since it was founded in 1863. The hospital is accountable to the people of Victoria, through the Victorian Minister for Health.

Manner of establishment and relevant Minister

The Royal Victorian Eye and Ear Hospital was founded in 1863 by pioneer surgeon Dr Andrew Sexton Gray. The hospital is a public health service and is established under the Health Services Act 1988 (Vic). The responsible Ministers for Health during the reporting period were:

From 1 July 2021 to 27 June 2022
The Hon Martin Foley MP
Minister for Health
Minister for Ambulance Services
Minister for Equality

From 27 June 2022 to 30 June 2022
The Hon Mary-Anne Thomas MP
Minister for Health
Minister for Ambulance Services

Powers and duties

The power and duties of The Royal Victorian Eye and Ear Hospital are prescribed by the Health Services Act 1988 (Vic).

Nature and range of services

The Royal Victorian Eye and Ear Hospital (Eye and Ear) provides a state-wide specialist tertiary and emergency eye, ear, nose and throat (ENT) health care service. It is internationally recognised as a leader in clinical service delivery, teaching and research in ophthalmology and otolaryngology.

The hospital operates from two central locations in East Melbourne to ensure ease of access to eye and ENT specialists. Services are provided in outpatient and community settings.

As the largest public provider of ophthalmology and ENT services in Victoria, the hospital delivers more than half of Victoria's public eye surgery and all of Victoria's public cochlear implants. The Eye and Ear has more than 80 outpatient clinics for the diagnosis, monitoring and treatment of vision and hearing loss and provides a 24-hour emergency eye and ENT health service. Most services provided at the Eye and Ear are on an outpatient or same-day basis. In 2021-2022 we provided more than 171,000 episodes of care to our patients including:

- 120,327 outpatient appointments
- 12,756 inpatient admissions
- 38,588 emergency attendances.

The hospital is a teaching and research centre and has key partnerships with the Centre for Eye Research Australia, The University of Melbourne, the Bionics Institute, Bionic Vision Technologies and HEARnet.

Vision, mission and values

The Royal Victorian Eye and Ear Hospital is Australia's leading provider of eye, ear, nose and throat health care.

In 2021-2022, the Eye and Ear cared for patients from throughout Victoria and interstate, maintaining essential specialist services throughout the considerable challenges associated with the COVID-19 pandemic and its broader implications on the Victorian healthcare system.

Vision

A world leader providing exceptional care.

Mission

We aspire to be the world's leading eye and ear health service through:

- Outstanding patient experience
- Exemplary leadership
- Inspiring our people
- Building a platform for the future.

Values

Integrity, care, teamwork, excellence

Integrity
We act ethically, accept personal accountability, communicate openly and honestly and treat everyone with trust and respect.

Care
We treat patients with respect, are compassionate, thoughtful and responsive to their needs and sensitive to diversity.

Teamwork
We communicate openly, respect diversity of views and skills and work effectively with partners and in multi-disciplinary teams to deliver the best outcomes for patients.

Excellence
We give our personal best at all times, deliver exemplary customer service, monitor performance and seek leading edge ways to improve performance.

Chair and CEO report

Throughout the 2021-2022 period, The Royal Victorian Eye and Ear Hospital has continued to respond and adapt to the COVID-19 pandemic, producing high-quality care and a safe environment for patients, visitors and staff. We acknowledge that the pandemic has presented further challenges for staff and patients this year, and we thank the entire Eye and Ear community for its ongoing efforts and resilience during this time. The hospital is committed to patient centred care and is working to enhance access in a COVID-normal environment.

In 2021-2022, we provided care for 120,327 outpatients, 12,756 inpatients and 38,588 emergency patients. During another challenging year for Victoria's healthcare sector, July 2021 saw the hospital successfully achieve reaccreditation via the National Safety and Quality Health Service Standards Accreditation Survey without any recommendations. The result was an endorsement of the hospital's deep-seated commitment to quality and safety. The period also saw the hospital redevelopment project continue to progress. Highlights for 2021-2022 included the opening of the new Perioperative Suite and completion of the building's façade. Another significant milestone was the rollout of the hospital's Digital Health Strategy following endorsement by the Hospital's Board.

Digital health initiatives

The Eye and Ear finalised its Digital Health Strategy in Q4 FY 2021 to address the growing need for a centralised approach to managing the hospital's existing and future digital health needs.

This year, a Director of Digital Health was appointed and began execution of the strategy commenced. Most notably, the Eye and Ear became the first hospital in Australia to implement the Pharmacist Shared Medicines List (PSML) medicine safety initiative. The PSML shares this critical documentation of a patient's medications with myHealthRecord. PSML is part of the hospital's commitment to an outstanding patient experience and there is real interest in adopting this medicine safety initiative across the state's health system.

During 2022-2023, several projects have commenced to further our clinical service delivery including electronic referrals (eReferrals). This will enable electronic processing of referrals and support secure communication with referrers via digital channels. Work has also started on the development of a patient portal and patient engagement framework which will improve the hospital's ability to communicate with patients and enable patients to access key clinical information about their treatment and appointments. These clinical improvements will sit alongside further work being undertaken on the consolidation of systems used by clinicians and staff, leading to a more integrated digital approach across the hospital.

In November 2021, the Eye and Ear website was relaunched with an improved design and functionality to support future digital integrations. With a focus on accessibility, the website achieved a double A (AA) Web Content Accessibility Guidelines score, and since its launch, website traffic has almost doubled compared to the previous year.

Working in partnership

This year the Eye and Ear became a part of the North East Metropolitan Health Service Partnership (NEMHSP). Within this group of health services opportunities were identified to develop shared service models that aim to improve access, quality and efficiency of home-delivered and virtual care. This includes Better At Home, a Victorian Department of Health initiative that was funded to meet the growing demand for healthcare through increased delivery of hospital services in patients' homes.

The Eye and Ear is supporting several of its specialist clinics identified as being able to adopt a virtual approach for elements of our patients' care. In a further initiative, the Eye and Ear started a nurse-led Ocular Rheumatology Clinic, undertaking nurse-led assessment and education for immuno-suppressed patients in their homes to reduce time spent in hospital.

Work also commenced on the establishment of a Joint Strategic plan between the Eye and Ear and the Centre for Research Australia (CERA). This united approach will provide greater access to research that will translate to changes in clinical care that will deliver improved patient outcomes

Cataract Clinical Care Standard

The Cataract Clinical Care Standard was developed by the Australian Commission on Safety and Quality in Health Care, in consultation with consumers and healthcare professionals. This new national standard will help to define clear pathways of care so that decisions about cataract surgery are consistent and equitable.

The standard provided insights into post-operative pathways created at the Eye and Ear which led to service efficiencies and reduction of cataract surgery waitlists.

COVID-19 Positive Care Pathway Program

While elective surgery was temporarily suspended throughout 2021-2022, it created capacity at the Eye and Ear to support Victoria's response to COVID-19. In October 2021, as part of the NEMHSP, the Eye and Ear mobilised to support the COVID Positive Care Pathway Program. Staff were asked to volunteer to be part of the effort. They were trained by the NEMHSP and worked with COVID-19 patients who were being managed at home via telehealth. The program centred on providing timely high-quality care. This involved the team contacting patients to determine their risk category and monitoring them closely to detect if their condition was worsening. The Eye and Ear's involvement ended in February 2022 as staff returned to their usual roles to respond to the return of elective surgery.

Outstanding patient experience

In July 2021, the Eye and Ear was recommended as the designated Victorian hospital provider of the Novartis gene therapy treatment, Luxturna. The drug is the first gene therapy to treat inherited retinal disease (IRD).

Luxturna is a one-time gene therapy used for the treatment of a small group of patients with a specific IRD. In collaboration with our partner, the Centre for Eye Research Australia, the rollout of this revolutionary treatment is paving the way for gene therapy and sight-saving research to support better patient outcomes.

A continuing joint research venture between the Eye and Ear, CERA and global healthcare company Novartis will provide genetic testing of patients at risk of blindness from Inherited Retinal Disease (IRD). Currently IRDs are the most common cause of blindness in working-aged Australians.

The new venture will give patients with inherited eye diseases visiting the hospital's Ocular Genetics Clinic supported access to genetic testing and the opportunity to take part in a natural history study (the VENTURE study) and other research at CERA. This fast-tracks patients at risk of blindness towards involvement in clinical trials as new gene therapies for IRDs become available over the next few years. It also enables us to attract more trials to Victoria and supports the development of gene therapies and associated technologies in Victoria.

Equity and inclusion

The hospital continued to work with the community to meet the diverse needs of patients and consumers.

April 2022 marked 10 years of partnership between the Victorian Aboriginal Health Service (VAHS) and the Eye and Ear and the launch of the Healthy Ears Clinic for Aboriginal and Torres Strait Islander children. 2022-2023 will also see the hospital's Aboriginal Health Unit set to expand on our Innovate Reconciliation Action Plan.

Over the past 10 years, the clinic has provided more than 1,500 instances of care, and the Eye and Ear has facilitated over 220 ENT surgeries for young patients. VAHS and the Eye and Ear have collaborated closely to provide a model of care that suits patients' needs.

Additionally, our Mirring Ba Wirring team has this year been working on the creation of an Aboriginal and Torres Strait Islander welcome space for staff and patients to enjoy. The space is set to launch in October 2022. Mirring Ba Wirring means eyes and ears in Woi Wurrung language of the Wurundjeri, in Taungurong and also in Boon Wurrung language. In taking this name, we sought permission from Wurundjeri Elder, Aunty Gail Smith and also the Wurundjeri Land Council.

The Eye and Ear is committed to providing an inclusive and respectful environment, free from discrimination. As part of this commitment the hospital's first Gender Equality Action Plan was endorsed by the Board in 2022. The hospital has also appointed an Equity and Inclusion Coordinator to develop and implement equity and diversity strategies throughout the hospital.

Staff training and development

During 2021-2022 we continued to provide training to support staff understanding and awareness of diversity.

The hospital's commitment continued to strengthening our response to family violence in accordance with updates to the Family Violence Act 2008 as part of Multi-Agencies Risk Management and Information Sharing. To support staff understanding, two eLearning modules were launched:

- Foundational Practice (non-clinical staff)
- Foundational and Sensitive Practice (clinical staff).

We continued to provide training to support staff safety and wellbeing. Our commitment to providing a safe workplace was demonstrated by the delivery of training in: occupational violence, manual handling train the trainer, peer support, mental health first aid and the wellbeing series. Most training was available for whole of health service participation.

Redevelopment

The hospital redevelopment project, designed to provide a better experience for patients, staff and visitors, progressed well despite difficulties associated with ongoing supply chain and workforce issues relating to COVID-19.

The hospital's Perioperative Suite opened in September 2021. The launch of this space involved moving the Day Surgery service and Sterile Processing Services from their temporary location at Eye and Ear on the Park back to the main hospital campus. Moving the theatres was a major milestone in our hospital redevelopment and required significant involvement from all departments. Staff and patients have benefitted from the streamlined service that the new Perioperative Suite provides. The development of the Suite was informed by consumer, patient and staff feedback. Now in full operation, the

space continues to be evaluated for improvement opportunities, with the patient at the centre of all decision-making.

Another milestone included the completion of the façade.

The 2022-2023 period will be an exciting one for the Eye and Ear with the completion of the redevelopment project. This includes: relocation of our 60 specialist clinics back to the main campus; the opening of a new state-of-the- art 20 bed inpatient ward (that can increase to 24) and the utilisation of a world class education centre. It also sees the expansion of the Emergency Department which will bring the Eye and Ear in line with the state's emergency model of also being used as a short stay unit. The completed project sees patients benefitting from an easier to navigate hospital, with all services operating from single levels.

Staff recognition

The Eye and Ear Excellence Awards acknowledge individuals and specialist groups who have contributed to achieving organisational excellence. The awards recognise creative and original thinking that result in positive outcomes for our patients, an improved working environment or improved hospital systems.

Recipients of the 2021 Excellence Awards were:

- **Board Chair's Medal** – Renee Chmielewski, Director, Partnerships, Clinical Education and Planning (former Acting Quality Manager)
- **Administrative/Clerical/Support Services Excellence** – Kathryn Day, Manager Patient Services and Access
- **Allied Health Excellence** - Pelin Ozturk, Orthoptist
- Nursing Excellence – Anna Parkhomenko, Operating Theatre Suite Nurse
- **Dr J Aubrey Bowen Medal** – Dr Claire Iseli, ENT Surgeon
- **Team Excellence Award** – Perioperative Suite Team

Acknowledgements

This has been another year of challenge and opportunity for the hospital. The Board Chair and CEO thanks all of our staff, volunteers, consumer representatives and Board Directors for their courage, compassion and commitment during this difficult period. Further thanks are extended to the Eye and Ear's partners and stakeholders, including the Department of Health, who have continued to support the hospital in delivering care to the people of Victoria.

Thank you

The Eye and Ear is most appreciative of the generosity of its supporters. Financial support from our loyal donors and philanthropic Trusts and Foundations helps the hospital continue to provide world-leading care.

We are also sincerely grateful to our volunteers and community advisory members who offer their time to help others.

Responsible Bodies Declaration

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for The Royal Victorian Eye and Ear Hospital for the year ending 30 June 2022.

Dr Sherene Devanesen
Chair, Board of Directors
23 August 2022

Brendon Gardner
Chief Executive Officer
The Royal Victorian Eye and Ear Hospital
23 August 2022

Board of Directors and Board Committees

The Board of Directors is appointed by the Governor in Council on the recommendation of the Victorian Minister for Health and is governed by the principles contained within the Health Services Act 1988 (Vic).

The Board provides governance of The Royal Victorian Eye and Ear Hospital and is responsible for its financial performance, strategic directions, the quality of its health care services and strengthening community involvement through greater partnerships.

The Eye and Ear by-laws enable the Board to delegate certain responsibilities. The by-laws are supported by the delegation of executive and operational responsibility, enabling designated executives and staff to perform their duties through the exercise of specified authority. The Board meets monthly during the year excluding January.

Dr Sherene Devanesen MBBS; Dip(Obs)RACOG; FRACMA; FACHSM; FIML; FHKCCM; GAICD
Appointed 14 April 2015
Chair Board of Directors
Member Finance Committee, Remuneration Committee

Dr Devanesen was Chief Executive Officer of Yooralla until February 2021. Before joining Yooralla in January 2014, Dr Devanesen was Chief Executive Officer of Peninsula Health. With more than 30 years' experience in the management of health services and medical administration, her experience has provided her with a strong reputation in consumer consultation and engagement and in achieving quality outcomes for human and community services. Dr Devanesen is a Fellow of The Royal Australasian College of Medical Administrators, the Australasian College of Health Service Management, the Australian Institute of Managers and Leaders and the Hong Kong College of Community Medicine. She is also a graduate of the Australian Institute of Company Directors. Dr Devanesen is a member of the Northern Health Board and the Northern Territory Health Governance and Assurance Committee.

Mr David Anderson BCOM, MCOM (Finance), GAICD
Appointed 26 April 2016
Chair Finance Committee
Member Audit Committee, Remuneration Committee

Mr Anderson brings a wealth of experience in finance and audit. He has held senior finance positions in the Departments of Water Resources, Health and Human Services within the Victorian Government over 20 years and was Executive Director of Finance at Peninsula Health for 16 years to 2018. Mr Anderson has recently undertaken work for the Department of Health and HealthShare Victoria and is a Director of the newly constituted Grampians Health comprising Ballarat, Stawell, Horsham and Edenhope. He has a demonstrated commitment to the wider community and roles include being a Fellow of the Healthcare Financial Management Association (HFMA) and previously Treasurer of the State-wide Autistic Society (Vic).

Mr Simon Brewin MBL, GDHSM, BBus, GAICD
Appointed 1 July 2017
Deputy Board Chair; Chair Audit Committee
Member Digital Health and Information Communication Technology Governance Committee, Quality and Safety Committee, Remuneration Committee.

Mr Brewin is an experienced non-executive director holding several health-related board appointments including Uniting AgeWell Ltd and Guardian Network. He is experienced in corporate and clinical governance, risk and compliance and strategy. Previously Mr Brewin held senior appointments in the Victorian healthcare sector including executive director roles at Alfred Health, Monash Health and Peninsula Health. Mr Brewin is a graduate of the Australian Institute of Company Directors, past state branch president of the Australasian College of Health Service Management, and The Royal Victorian Eye and Ear Hospital nominee as Director to the Board of CERA.

Ms Jane Hider LLM, LLB, BA
Appointed 1 July 2021
Member Digital Health and Information Communication Technology Governance Committee, Finance Committee

Ms Hider joined the Eye and Ear Board in July 2021 and is a partner at leading legal firm Corrs Chambers Westgarth. Since 2018 Ms Hider has been a member of the Corrs' Board and its Audit and Risk Management Committee. Ms Hider has more than 20 years' experience in construction and infrastructure, as well as government advisory practice. She specialises in government major projects and procurement, commercial development, transport and energy. She has experience in all forms of procurement, collaborative models and consultancy arrangements. Ms Hider works with clients to structure their approaches to market, and gives tendering and probity advice. She is regularly asked to peer review delivery models and project documentation, and to investigate probity compliance. Ms Hider has also worked with government agencies to develop and implement supply and procurement policies. She is also actively involved in the firm's pro bono program and assists a range of pro bono clients including Very Special Kids.

Ms Linda Hornsey Grad. Dip AB, MAICD

Appointed 2 August 2016

Chair Community Advisory Committee

Member Finance Committee, Primary Care and Population Health Advisory Committee

Ms Hornsey is a past General Manager for Organisational Transformation at Vision Australia, a provider of services for people who are blind or have low vision. Previously, she was Secretary of the Department of Premier and Cabinet in Tasmania for nine years, worked as a journalist and political adviser and had many years' experience in public administration. She had a leadership role in changing Tasmania's old economy. This involved the first whole-of-state consultation in Australia which reached most of the population in many old and new forums. Ms Hornsey and a colleague from the Australian Bureau of Statistics were invited to the annual OECD Conference in Palermo in 2004 to present the resulting strategic plan to be measured and implemented over decades. She has held many statutory board directorships including Western Health. Previously, Ms Hornsey was a member of the Parenting Research Centre Board and its Governance Committee.

Professor Alan Lilly MHA, Grad Dip HSM, RGN, RPN, FIML, FCHSM CHE, MAICD

Appointed 1 July 2019

Chair Quality and Safety Committee

Member Remuneration Committee

Adjunct Professor Alan Lilly is a Registered Psychiatric Nurse and Registered General Nurse with a Graduate Diploma in Health Services Management and a Master of Business in Health Administration. He has worked across the health, disability and aged care sectors and was a Chief Executive for ten years in public and private organisations. He is also an Adjunct Professor with Australian Catholic University.

In addition to his appointment at The Royal Victorian Eye and Ear Hospital, Adjunct Professor Lilly is also a Director of The Royal Women's Hospital. He is a Fellow of the Australian Institute of Managers and Leaders and the Australasian College of Health Services Management and a Member of the Australian Institute of Company Directors. Until December 2021, Adjunct Professor Lilly was Principal of his own consulting firm, Acumenity, providing consulting services in health and aged care. He became Chief Executive of Jewish Care Victoria in January 2022.

Mr Bruce Mildenhall BA, GD Rec, GAICD

Appointed 1 July 2018

Member Finance Committee, Community Advisory Committee, Quality and Safety Committee

Mr Mildenhall has an extensive background in governance at a public sector and community level. He served as the State MP for Footscray for 14 years including seven years as Parliamentary Secretary to Premier, and nine years as a councillor with the City of Footscray. In the health sector he served on the board of a primary health service for more than 20 years, chaired the board of the largest residential aged care service in the western suburbs for nine years, led a review of mental health workforce training, and been a board member of the Victorian Health Promotion Foundation and a metropolitan hospital. Mr Mildenhall also regularly attends the Eye and Ear Primary Care and Population Health Advisory Committee meetings. He is a graduate of the Australian Institute of Company Directors and was a senior manager in the Victorian Public Service before entering parliament.

Ms Llewellyn Prain BA (hons), LLB (hons), FAICD

Appointed 1 July 2015

Chair Primary Care and Population Health Advisory Committee

Member Quality and Safety Committee, Community Advisory Committee

Ms Prain has a background in law and public policy. She has extensive corporate governance experience and has served as a company director for more than ten years. She is a director at the Public Transport Ombudsman and genU and Deputy Chair of Greater Western Water. Ms Prain was the first woman to chair the board of the Western Region Health Centre. She is a Williamson Alumnus and received a Victorian Disability Award in the emerging leader category in 2021. Ms Prain has a vision impairment and is a strong advocate for the rights and strengths of people with disability. She is also the Eye and Ear's Nominee as the Alternate Director to the Board of The Centre for Eye Research Australia (CERA).

Mr Bruce Ryan BSc (maj. Comp Science and Statistics)

Appointed 1 July 2017

Chair Digital Health and Information Communication Technology Governance Committee

Member Audit Committee

Mr Ryan has extensive information and communications technology (ICT) management expertise within the Victorian public health sector and other Victorian government settings. He worked with the Department of Health and Human Services to assist with delivery of large-scale ICT projects and worked closely with Eastern Health during the redevelopment of Box Hill Hospital and commissioning of advanced electronic records management there. Mr Ryan is also a former Chief Information Officer at Yooralla.

Board Committees

Audit Committee

The Audit Committee membership comprises the following non-executive directors: Mr Simon Brewin (Chair), Mr David Anderson and Mr Bruce Ryan.

The committee meets at least four times per year and assists the Board in monitoring compliance with laws, regulations, standards and internal controls. Key responsibilities for the Audit Committee include monitoring the hospital's strategic and operational risks, developing the hospital's strategic internal audit plan, oversight of the Internal Audit Program, review of the Draft Annual Accounts and review of the relevant risk policies and procedures. All Audit Committee members are independent of management.

Finance Committee

The Finance Committee membership comprises the following non-executive directors: Mr David Anderson (Chair), Dr Sherene Devanesen, Ms Linda Hornsey and Ms Jane Hider. Advisor: Mr Grant Cashin.

The committee meets at least seven times per year and assists the Board to fulfil its duties relating to the effective financial management of the Eye and Ear. Key responsibilities for the Finance Committee include oversight of the hospital's annual operating and capital budget, review of the financial management reports, advising the Board on financial implications associated with major projects and reviewing the relevant financial policies and procedures. All Finance Committee members are independent of management.

Digital Health and Information Communication Technology Governance Committee

The Digital Health and Information Communication Technology Governance Committee membership comprises the following non-executive directors: Mr Bruce Ryan (Chair), Mr Simon Brewin and Ms Jane Hider.

The committee was formed on 14 May 2020 and meets at least quarterly. Its primary purpose is to ensure that all digital health, information communication technology (ICT), clinical informatics (eHealth) and electronic medical record (EMR) strategies, risks, work plans and high-level operations are monitored centrally to ensure coordination of teams and functions, compliance with hospital policies and procedures, and alignment with the hospital's strategic and business plans. All Digital Health and Information Communication Technology Governance Committee members are independent of management.

Quality and Safety Committee

The Quality and Safety Committee membership comprises the following non-executive directors: Professor Alan Lilly (Chair), Mr Simon Brewin, Mr Bruce Mildenhall and Ms Llewellyn Prain. Consumer members: Ms Ileana Guizzo and Ms Stephanie Thow-Tapp.

The committee meets quarterly and provides leadership and strategic direction on quality of services at the Eye and Ear. The committee's focus is delivery of the highest level of quality and safety to patients, family and staff and ensuring that all relevant standards are met. Innovation to improve quality and safety systems is a priority. The committee works in conjunction with the Community Advisory Committee to develop the annual Quality Account which highlights patient and family centred care service improvements. All Quality and Safety Committee members are independent of management.

Remuneration Committee

The Remuneration Committee membership comprises the following non-executive directors: Dr Sherene Devanesen (Chair), Mr David Anderson, Mr Simon Brewin and Professor Alan Lilly.

The committee meets at least annually and makes assessments and recommendations to the Board about the performance against the agreed performance plan, remuneration and terms and conditions of employment for the Chief Executive Officer. It also provides oversight of the remuneration of the Executive Directors of the hospital. All Remuneration Committee members are independent of management.

Community Advisory Committee

The Community Advisory Committee membership includes the following non-executive directors: Ms Linda Hornsey (Chair), Mr Bruce Mildenhall and Ms Llewellyn Prain. Consumer members: Mr Ramakrishnan (Rama) Appuswamy, Ms Jayne Howley (from May 2022), Ms Sandra Knight, Mr Mick Shaddock, Ms Carolyn Tran, Mr Desbele (Des) G. Temelso, Mr Gordon Proudfoot and Ms Stephanie Thow-Tapp.

Membership comprises at least six and up to eight members nominated by the Committee Chair and approved by the Board to represent views of the communities served by the Eye and Ear. The Community Advisory Committee advises the Board on consumer and community participation in the development and delivery of services. The committee meets six times annually. All Community Advisory Committee members are independent of management.

Primary Care and Population Health Advisory Committee

The Primary Care and Population Health Advisory Committee membership includes the following non-executive directors: Ms Llewellyn Prain (Chair), Ms Linda Hornsey and Mr Bruce Mildenhall.

The committee provides advice to the Board on working with primary health services and responding to population health issues. The committee is focused on the Eye and Ear's Aboriginal health strategy and improving health outcomes for Aboriginal and Torres Strait Islander people. The committee meets at least twice a year. All members are independent of management.

The hospital is grateful for the commitment and contribution of outgoing Director, Adjunct Professor Allan Lilly and welcomed Dr Susan Sdrinis to the Board on 1 July, 2022.

Executive Management

Chief Executive Officer (CEO)

Brendon Gardner B.AppSc (HIM), MHA UNSW

The Chief Executive Officer is accountable to the Board for executive leadership and management of operational, policy and strategic goals agreed with the Board and in accordance with the funding, planning and regulatory framework of the Victorian Department of Health.

Executive Director Medical Services and Chief Medical Officer

Dr Sean Jespersen MB ChB, M Med Psych, FRANZCP, FRACMA, FCHSM (end 30 May 2022)

Dr Birinder Giddey MBBS(Hon), MHLM, FRACMA

The Executive Director, Medical Services and Chief Medical Officer (CMO) has executive responsibility for medical workforce, medical training and education, and research at the hospital. The CMO is also responsible for leading clinical governance, risk, quality and safety, and clinical improvement initiatives. In addition, the role provides executive leadership and oversight for health information services, clinical informatics, digital health and the development of the hospital's electronic medical record.

Clinical Director Ophthalmology Services

Dr Mark McCombe MBBS, FRANZCO

The Clinical Director Ophthalmology Services is responsible for ophthalmic medical leadership. The role advises on strategy and models of care in ophthalmology that are sustainable and lead to excellence.

Executive Director Operations and Chief Nursing Officer

Ms Tracy Siggins MPH, DipLeadership and Mgt, DipAppSc(OralHlthTherapy), (Acting 11 January 2021 - 9 August 2021)

Ms Jane Poxon

The Executive Director Operations is responsible for overseeing all clinical operations for the organisation including surgical and inpatient services, the Emergency Department, Specialist Clinics, the Cochlear Implant program, pharmacy services and all related patient support services. The role is also responsible for overseeing the emergency management requirements for both sites.

Clinical Director Ear, Nose and Throat (ENT) Services

Dr David Marty MBBS, FRACS

The Clinical Director ENT Services provides clinical and medical leadership, and advice on models of care to support clinical excellence in ear, nose and throat and surgical support services.

Executive Director Redevelopment, Planning and Infrastructure

Mr Ian Leong B.Bldg (QS) (Hons), Grad Dip Comp Sc, MBA GAICD (end 4 February 2022). Position not replaced. Tasks redistributed among executive team.

The Executive Director Redevelopment, Planning and Infrastructure has overarching responsibility for capital redevelopment of the Eye and Ear, and Business and Strategic Planning incorporating future health service delivery strategy, patient experience, facility maintenance and security services. The role has overview of the Eye and Ear on the Park site/services and oversight of the redevelopment program including the model of care and physical works associated with the redevelopment and service planning.

Executive Director Finance and Corporate Services

Mr Danny Mennuni B.Bus, CPA

The Executive Director Finance and Corporate Services is the Chief Financial Officer and the hospital's Chief Procurement Officer. He is responsible for providing leadership in financial management, reporting and controls. The position is also responsible for leading and managing efficient and effective information technology, decision support, contracts and procurement services.

Executive Director People and Communication

Loretta Sheales BSc, MEd(RC), GradDipHRMngt, FAHRI, GAICD

The Executive Director People and Communication is responsible for leadership and support of People and Culture, Marketing and Communications, Organisational Development, Payroll Services, Employee Support Services, Safety and Wellbeing and Library Services.

Organisational Chart

Donors and Supporters

The Eye and Ear appreciates the continued support of our donors, ambassadors and volunteers.

The financial donations and funding we receive enable us to improve our services to patients through buying state-of-the-art equipment, new treatment options and continued research into new diagnostic techniques and treatments.

We also gratefully acknowledge our supporters who have expressed their intent to leave a bequest to the Eye and Ear. This helps us continue to improve care and treatment for those living with vision and hearing loss in the future.

Patron
Mr Anthony Howard QC (11 August 2015 - present)

Zoran Georgievski Memorial Research Scholarship 2019-2022
In 2012, a scholarship in memory of the late Associate Professor Zoran Georgievski (Manager, Diagnostic Eye Services) was established in conjunction with La Trobe University.

Ms Emilie Rohan is the current recipient starting in 2019. Her project is entitled: 'Identifying predictors of progression from early to advanced diabetic retinopathy.'

Early Career Research Support Grants (ECRSG)
Total awarded for 2021-2022 - $105,000 ($35,000 per recipient).

ECRSG grants were awarded in June 2021 to Dr Claire Iseli, Dr Doron Hickey and Dr Jennifer Fan Gaskin, starting in January 2022.

Our Major Donors, Bequestors, Corporate and Community Supporters

Trusts and Foundations

Joe White Bequest
The Eirene Lucas Foundation
The J and Hope Knell Trust Fund
The Muriel and Les Batten Foundation
The Orloff Family Charitable Trust

Bequests

Estate of Sue Lissenden
The Penelope Foster Foundation
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Estate of Ian Donald Stringer
Estate of Nola Alwynee Jennings
Estate of Patricia Ann Britten
Estate of Ron Charles Forsythe
Ms Jean Leehane

Estates

Estate of Alfred H W Dehnert
Estate of John Alexander Anderson
Estate of Peter Lawlor Jarman
The Elizabeth and Alexander Reddan Memorial Foundation
The Harry Yoffa Charitable Bequest
The Joseph and Kate Levi Charitable Trust
The William and Mary Ievers and Sons Maintenance Fund

Estates managed by Equity Trustees

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Estate of Heather Sybil Smith
Estate of John F Wright
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The Joseph Kronheimer Charitable Fund
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Arthur Gordon Oldham Charitable Trust
Estate of Martha Miranda Livingstone
The Valda Salton Charitable Trust
The Louis and Lesley Nelken Trust

Major donors

Mr Anthony Robins
Mr Arun Kollamana
Mr Boo Tsan Khoo
Ms Christina So
Mr Colm O'Donovan
Mr and Mrs David and Cynthia Webb
Mr Elias Jreissati
Mr Greg Shalit and Dr Miriam Faine
Mr Graham McKnight
Mr John Cook
Dr Jonathan Orelowitz
Mr James Ring
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Miss Katie Schumann
Ms Kaye Cleary
Ms Kim Ngo
Mr Kenneth Stephens
Mrs Kyung Angela Kim
Mr Michael Halprin
Mr Peter Handford
The Pegg Family
Mr Raymond Hemphill
Dr Robert Webb
Mrs Ruth Crutch
Mr Trevor Edwards
FOE Productions Pty Ltd

Volunteers

2022 marks 100 years of volunteers at the Eye and Ear. The first official volunteers were the wives of the hospital's Committee of Management members who started helping in the hospital in 1922. The first hospital auxiliaries were established, founded by women from Olinda, Sassafras and the Dandenong Ranges. This was instrumental for the hospital as a rapidly expanding population in the 1920s saw large growth in patients.

The hospital 100 years later is home to a dedicated and growing group of volunteers who assist in a range of roles, offer a welcoming smile and assist patients as needed. Due to the pandemic, our volunteer program has paused and we are working towards a safe return on site. We have continued to stay in touch by way of disseminating information via emails and Zoom meetings.

A highlight was celebrating National Volunteer Week in May 2022 to thank our volunteers for their understanding and patience in working with us during the pandemic. We are grateful that most of our volunteers are well and keen to come back when it is safe to do so.

During the past 12 months our volunteers have helped with administrative tasks and reviewing patient material. This has been vital to ongoing operational processes of the hospital.

We sincerely thank all our volunteers for their patience and continued commitment and loyalty to the Eye and Ear Hospital.

Consumer representatives

Among our volunteers is a dedicated group of consumer representatives who partner with us to help improve our services for our patients, their families and carers. Consumer representatives can be involved in several ways. They participate in committees and working groups, attend focus group activities, review patient information developed by the hospital and share their stories in our publications. These representatives ensure the voice or needs of our patients, carers and families are heard within the organisation. Consumer representatives on our committees and working groups have continued to participate through online platforms. We thank them for adapting along with us to the new means of communication. We look forward to resuming our face-to-face meetings when it is safe to do so.

Key financial and service performance reporting

Workforce data

	June current month FTE		Average monthly FTE	
Hospitals labour category	**2021**	**2022**	**2021**	**2022**
Nursing	172	169	170	169
Administration and clerical	163	168	167	169
Medical support	56	55	55	56
Hotel and allied services	17	18	17	18
Medical Officers	5	6	5	5
Hospital Medical Officers	60	55	56	58
Sessional clinicians	41	42	42	41
Ancillary staff (allied health)	40	40	39	38
	554	**553**	**551**	**554**

The FTE figures in the table above exclude overtime. These do not include contracted staff (for example agency staff or fee-for-service Visiting Medical Officers) who are not regarded as employees for this purpose.

Application of employment and conduct principles

The Eye and Ear Hospital is committed to upholding the principles of merit and equity in all aspects of the employment relationship. We have policies and practices in place to ensure all employment related decisions, including recruitment, promotion, training and retention, are based on merit. Any complaints, allegations or incidents involving discrimination, vilification, bullying or harassment are taken seriously and addressed. All staff are provided with education and training on their rights and responsibilities and are provided with the necessary resources to ensure equal opportunity principles are upheld.

People and culture

In 2021-2022, our workforce strategy focus was on effective communication of change and on employee wellbeing. We supported managers to position them to lead throughout the prolonged challenges of disruption. Our online educational resources and training modules continued and focused on managing wellbeing and communicating during change.

Employee culture and engagement

In 2021, our People Matter Survey results reflected a positive trend in: staff engagement; staff psychological health safety climate; job enrichment; diversity and inclusion; and results supporting the view that senior leaders actively support diversity and inclusion in the workplace. Our results for incidences of bullying, discrimination, sexual harassment and occupational violence were particularly reflective of lower incidences compared with other hospitals. Other positive trends in our results related to the following themes: equal employment opportunity; job enrichment; workload; patient safety climate; and safety climate.

Health and wellbeing initiatives

The Eye and Ear recognises that work purpose, job control and design and team culture can improve staff health and wellbeing and provide better work outcomes.

As part of our wellness@work program we focused on: psychological health, nutrition, physical activity; financial health; providing assistance to stop smoking and safer use of alcohol and other drugs. During the year, a key focus was to support the psychological impact on staff during the continued uncertainty as we returned to a 'new normal'. This was to counter the impact of post lockdowns and associated fatigue, ongoing change and disruption related to the hospital redevelopment project.

The Eye and Ear was successful in obtaining Department of Health funding as part of the *bewell. besafe Healthcare Worker Wellbeing* program. We focused on three major activities:

1. Increasing and expanding our internal peer support service;
2. Increasing manager support and training to manage burnout and stress;
3. Developing and delivering health and wellbeing webinar sessions for all staff.

We understand that hybrid/remote work is likely to increase engagement, be empowering and lead to improved productivity and employee satisfaction. We continued to support hybrid working arrangements when it was deemed beneficial to the employee and team, and where a high standard of service to our patients and consumers was maintained. Consideration was given to: the type of work being carried out; wellbeing, health and safety; impact on performance and operations; and, financial impact on the hospital. Approximately nine percent of staff had an agreement to work up to 40 per cent of their contracted hours away from their work office location.

Recruiting and onboarding staff

In 2021-2022, the Eye and Ear workforce comprised approximately 965 staff. We recruited and onboarded approximately 195 new staff, all of whom participated in an orientation program. Our employee separation rate (the percentage of employees who left) was 13.9 per cent. A supportive and informative onboarding process is imperative for new employees to position themselves for success and ensure they understand their environment and relevant systems and processes to effectively contribute to the organisation. This process is face to face and also complemented with online courses to provide a more flexible general orientation.

Pre-employment credentialing

The organisation has thorough credentialing and pre-employment verification checks to ensure staff are qualified to deliver safe patient care. Most clinical staff are required to hold and maintain current registration with the relevant National Board in conjunction with the Australian Health Practitioner Regulation Agency (AHPRA) or equivalent. All staff are required to be vaccinated unless medically exempt, maintain a satisfactory Criminal Record Check and relevant staff are required to hold a valid Working with Children Check.

Employee reward and recognition

The Eye and Ear recognises that its current and future success relies on the capacity and engagement of our staff. We support staff with a fair and equitable reward and recognition system. We aim to create a climate for excellence at every level for individual and team performance.

The annual Excellence Awards recognise individuals in each professional discipline and teams that have contributed to achieving organisational excellence. There are six categories and each acknowledges going above and beyond to provide positive outcomes for our patients.

The winners of our 2021 Excellence Awards are listed in our Board Chair and CEO Report on page 10. The following staff were the recipients of the Values Award in 2022:

- **Sarah Gladman**, Associate Nurse Unit Manager, Specialist Clinics
- **Dr Lawrence Kwok,** Hospital Medical Officer

Building a capable workforce

Our leadership development pathway outlines development opportunities for four different levels in the organisation. The need to optimise clinical leadership and operational leadership across the organisation is critically important to the delivery of excellence and improved patient outcomes.

The programs on our Leadership Pathway are aligned to our Leadership and Change Capabilities, group needs and organisational needs. Our programs are designed to include formal learning time through interactive workshops and recognise the important role that the manager has in reinforcing leadership development on the job.

During 2021-2022, leadership development has involved tailored programs for: Associate Nurse Unit Managers (ANUM), team leaders, medical clinical leadership, executive, emerging leaders and experienced managers. Our 2021 programs were delivered virtually and provided valuable learning opportunities for our leaders. This was the fifth year we have held a *Leading with Impact* program delivered via web-based training and virtual practice labs. Post program evaluations showed us that participants felt confident to apply their skills on the job. The development of an ANUM Success Profile is driving their specific development needs and provides a pathway for internal development and future promotion. Medical clinical leaders participated in evidence-based workshops about giving and receiving feedback delivered by the University of Melbourne.

We continue to improve the quality of our performance and development discussions by implementing two online courses to support managers and employees. These critical discussions ensure performance feedback is provided, and that work and personal development goals are established for the future.

Each year this process includes review of: individual clinical scope of practice; mandatory training, professional development; expectations about quality and safety responsibilities and; upward feedback (where employees provide feedback to managers or supervisors) and feedback on quality and safety processes.

Employee Assistance Program

Confidential counselling and support services provided externally were utilised at a rate of 4.5 per cent of all staff, slightly higher than the previous year. The Employee Assistance Program is a confidential outsourced counselling service available to staff, their family and household members. The service provides wellness at work, education and awareness programs, financial coaching, family violence support and nutritional and legal consultation aimed to assist personal or work-related issues that have an impact on wellbeing and quality of life. The service also offers manager support and post incident debriefing in the workplace.

Occupational Health and Safety (OHS)

The Eye and Ear is committed to providing a safe and healthy workplace. To achieve this, management of our occupational health and safety is based on a continuous improvement model of planning, implementing, monitoring and reviewing health, safety and wellbeing related to prevention, early intervention promotion and response activities. The Eye and Ear considers physical and psychosocial hazards and understands the impact psychosocial hazards can have on wellbeing and workplace health and safety.

The table below shows highlights of OHS performance. There were an additional 2 incidents for the year per full time equivalent employees but our WorkCover claims and time lost to injuries reduced. This indicates there was higher reporting of incidents with lower severity.

Eye and Ear Staff	2019-2020	2020-2021	2021-2022
Incidents/hazards per 100 full-time equivalent staff members	25	35	37
Lost time standard claims per 100 full-time equivalent staff members	1.13	0.18	0.36
The average cost per WorkCover claim for the year	$119,047	$67,488	$15,182

WorkCover and injury management

During 2021-2022, the Eye and Ear's injury management program continued to have positive results with a focus on preventative, proactive early intervention and injury management programs. The emphasis of early intervention is to address issues before escalation and help manage injuries and illnesses. Our non-work-related injury management program ensures coordination of staff to return or remain at work which creates great benefit for individual staff and their work teams.

The table above shows highlights our OHS performance. There were 37 incidents for the year per full time equivalent employees which was an increase of 2. Our WorkCover claims and time lost to injuries decreased by one. This indicates a continued trend of higher reporting of incidents with lower severity.

Our key occupational health and safety incidents related to slips, trips and falls; occupational violence and aggression; psychological safety (including fatigue); manual handling and occupational exposures.

Our open WorkCover claims are related to manual handling, slips, trips and falls. The highest claims costs, with low incidence, is attributed to mental health injury.

There was a reduction in number of claims lodged and a reduction in claims costs from July 2019 to June 2022.

Our Employer Performance Rating was 54 per cent better than industry average in the 2021-2022 period.

We continue to implement preventative actions to reduce likelihood and severity of injuries. WorkCover claims for 2021-2022 reduced from the previous year from five to four.

Injury prevention strategies

To minimise risk and promote staff safety, the following programs, activities and key messages were provided:

- Zero tolerance for inappropriate behaviour at work including bullying, harassment and occupational violence and aggression.
- Raising awareness of appropriate behaviours and encouraging staff to report concerns through online education and staff forums.
- Ensuring People and Culture staff can respond to complaints and are adequately skilled in conducting workplace investigations.
- Reporting incidents, hazards and near misses to enable the Eye and Ear to address individual issues and collect data for trend analysis and development of risk controls.
- The importance of appropriate consultation between Health and Safety representatives, staff, managers and People and Culture before implementing new work practices or equipment.
- Risk assessments to identify hazards that have the potential to cause harm before a change in work practices, procedures or work environment.

In 2021-2022, the Health, Safety and Environment Committee met quarterly to discuss, monitor and agree on remedial action for safety issues. Committee members include management, Health and Safety representatives and a consumer representative.

The Laser and Radiation Safety and Emergency Management Committee held quarterly has management, medical and clinical staff representatives who oversee radiation and laser safety at the Eye and Ear.

Virtual forums with the health and safety representatives were regularly held during 2021-2022. The forums provide an opportunity for the representatives to discuss health and safety concerns and raise issues related to their designated work group.

The following OHS related training was provided:

- Appropriate workplace behaviours that incorporate the prevention of bullying, discrimination and harassment for all managers;
- Responding to occupational violence and aggression for clinical and front-line staff;
- OHS training for Health and Safety Representatives;
- Train the trainer manual handling training and laser safety training.

Occupational Violence

Occupational violence is any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of, their employment. The Health, Safety and Environment Committee has oversight of occupational violence and aggression issues across the organisation. The committee has developed an Occupational Violence and Aggression (OVA) Action Plan to address specific occupational violence needs and promote staff safety.

In 2021-2022 all staff had the opportunity to complete an online occupational violence and aggression training package to increase staff awareness and understanding of OVA. An external training provider facilitated Occupational Violence and Aggression training for clinical and front-line staff and Code Grey and Code Black emergency response team members.

The Eye and Ear implemented several initiatives including increasing staff awareness of inappropriate behaviours that constitute occupational violence and aggression.

The table below outlines the comparison in occupational violence incidents compared with the previous year.

Occupational violence statistics	2020-2021	2021-2022
WorkCover accepted claims with an occupational violence per 100 FTE	0	0
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0	0
Number of occupational violence incidents reported	82	84
Number of occupational violence incidents reported per 100 FTE	14.9	15.2
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	2.4	2.4

There was an increase of two occupational violence and aggression reported incidents to 84 in 2021-2022, compared with 82 incidents the previous year. Many related to changes in hospital processes stemming from COVID-19 and the requirement for patients, visitors and carers to wear masks and comply with COVIDSafe requirements.

Definitions of occupational violence:

- **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 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 2021-2022.
- **Lost time** – is defined as greater than one day.
- **Injury, illness or condition** –includes all reported harm due to the incident, regardless of whether the employee required time off work or submitted a claim.

Financial information

	2022 $000	2021 $000	2020 $000	2019 $000	2018 $000
Operating result*	**422**	**96**	**824**	**148**	**272**
Total revenue	156,638	157,785	148,986	147,407	158,047
Total expense	(136,557)	(129,357)	(126,934)	(128,890)	(122,238)
Net result from transactions	**20,081**	**28,428**	**22,052**	**18,517**	**35,809**
Total other economic flows	(4,861)	4,784	(1,836)	(4,088)	639
Net result	**15,220**	**33,212**	**20,216**	**14,429**	**36,448**
Total assets	410,143	388,452	345,001	326,678	332,022
Total liabilities	(51,693)	(45,222)	(34,983)	(36,876)	(34,050)
Net assets/total equity	**358,450**	**343,230**	**310,018**	**289,802**	**297,972**

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

Reconciliation of net result from transactions and operating result

	2021-2022 $000
Operating result	**422**
Capital and specific items:	
Capital purpose income	30,802
Specific income	-
COVID-19 State Supply Arrangements:	
- Assets received free of charge or for nil consideration under the State Supply Arrangements	604
- State supply items consumed up to 30 June 2021	(604)
Assets received for free	-
Assets provided for free	-
Expenditure for capital purposes	5
Depreciation and amortisation	(11,349)
Impairment of non-financial assets	-
Finance costs	201
Net result from transactions	**20,081**

Significant changes in financial position during 2021-2022

There were no significant changes in the financial position during 2021-2022.

Operational and budgetary objectives and performance against objectives

The Eye and Ear met the budgetary requirements for 2021-22, however operational performance was impacted by the COVID-19 pandemic restrictions and elective surgery suspensions.

Significant events occurring after balance date

There were no significant events occurring after balance date.

Consultancies information FRD 11(e)

Details of consultancies (under $10,000)

In 2021-2022, there were no consultancies where the total fees payable to the consultants were less than $10,000.

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

In 2021-2022, there were six consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2021-2022 in relation to these consultancies is $161,701 (excluding GST). Details of individual consultancies can be viewed at www.eyeandear.org.au.

Consultant	Purpose	Start date	End date	Total approved project fee (excluding GST)	Expenditure 2021-2022 (excluding GST)	Future expenditure (excluding GST)
Workwell Consulting	Advisory and facilitation services relating to strategy and governance development.	March - 2021	August - 2021	$50,000	$12,500	$0
Workwell Consulting	For the boards of Eye and Ear and CERA to reach a unified position on 'shared value', enabling the formation and harmonious maintenance of ongoing operating agreements.	October - 2021	December - 2021	$20,000	$20,000	$0
Infodex Consulting	Performance reporting assessment and development.	October - 2021	December - 2022	$90,000	$44,520	$45,480
D W Bowe and Associates	A healthy positive and effective culture project.	May - 2022	May - 2022	$15,400	$15,400	$0
Xponential Group	Fundraising campaign readiness assessment and feasibility study.	December - 2021	August - 2022	$35,750	$35,750	$0
Chrysalis Clinical	Research governance review.	June - 2022	June - 2022	$33,531	$33,531	$0

Information and communication technology (ICT) expenditure

Business as usual (BAU) ICT Expenditure	Non-business as usual (non-BAU) ICT expenditure		
Total (excluding GST)	**Total=operational expenditure and capital expenditure (a+b) (excluding GST)**	**Operational expenditure (excluding GST) (a)**	**Capital expenditure (excluding GST) (b)**
$5.3 million	$1.7 million	$0.5 million	$1.2 million

Disclosures required under Legislation

Freedom of Information Act 1982

The Victorian Freedom of Information (FOI) Act 1982 provides members of the public with the right to apply, in writing, to the Eye and Ear for access to information held by the hospital. The hospital provides an annual report of all FOI requests to the Victorian Department of Justice.

The cost to make a FOI request in the 2021-2022 financial year was:

Application fee	$30.58
Search and retrieval fee	$5.00
Photocopying/printing (black & white)	$0.20 per page
Photographs	$5 per photo
Supervised viewing	$27.00 per ¼ hour ($85.20 max.)

Freedom of Information applications 2021–2022		Requestors	No. of requests
Total requests	175	General Public	42
Fully granted	143	Lawyers and insurance companies	133
Completed	143	Total	175

The requirements for making a request are:

- it should be in writing
- it should identify as clearly as possible which document is being requested
- it should be accompanied by the appropriate application fee.

The FOI officer for the Eye and Ear is Dr Birinder Giddey.

Building Act 1993

During the financial year, building permits were obtained for building projects and certificates of occupancy or certificates of final inspection were obtained for all completed projects. Registered building practitioners were engaged for all building projects including new or major refurbishments.

Ongoing maintenance programs ensure buildings are maintained in a safe and functional condition.

There is a requirement under the Building Act 1993 (Building Regulations 2006, rr. 1209, 1215) for the hospital to establish comprehensive management of the Essential Safety Measures (ESM). In 2021-2022, The Royal Victorian Eye and Ear Hospital at 32 Gisborne St, East Melbourne achieved 100 per cent compliance with mandatory ESM inspections, testing, maintenance and documentation for building safety. The hospital established comprehensive management of the Essential Safety Measures (ESM). All ESM are annually audited and identified on the Certificate of Occupancy issued by the building surveyor with each ESM maintained as per certified maintenance agreements at specified time intervals. The ESM compliance certificates are on display in the hospital's main entrance.

Privacy

Privacy is an important part of the culture at the Eye and Ear. Since the Health Records Act 2001 became legally binding in 2002, the hospital has aimed to ensure all staff are aware of the Act and its implications in the workplace. The hospital also aims to ensure compliance with the Privacy and Data Protection Act 2014.

The Eye and Ear's Privacy Officer is the Executive Director Medical Services/Chief Medical Officer.

Public Interest Disclosures Act 2012 (Vic)

The Eye and Ear has policies that include mandatory notification requirements of suspected corruption under the Directions made pursuant to section 57A of the Independent Broad-based Anti-Corruption Commission Act 2011 and the requirements under the Public Interest Disclosures Act 2012 (Vic).

This includes the obligation to report to IBAC any suspected corrupt conduct occurring at the Eye and Ear or in other organisations connected with the Eye and Ear. Under the Public Interest Disclosures Act 2012 (Vic) (the Act), complaints about certain serious misconduct or corruption involving a public health service in Victoria should be made directly to IBAC to remain protected under the Act. The Eye and Ear encourages individuals to make any disclosures which are protected disclosures within the meaning of the Act to IBAC.

The hospital also has a range of procedures to protect people making disclosures and to ensure, where possible, no detrimental action is taken against anyone who makes or is involved in the investigation of a protected disclosure, including an overarching procedure available through the hospital's website. The hospital is not an entity that can receive protected disclosures under the Act.

DataVic Access Policy

Making datasets freely available to the public is the State's default position and where possible agencies must make datasets available with minimum restrictions including the proactive removal of cost barriers. The Eye and Ear complies with this policy in all relevant business activities.

National Competition Policy

In accordance with the Competition Principles Agreement (CPA), Victoria is obliged to apply competitive neutrality policy and principles to all significant business activities undertaken by government agencies and local authorities. The Victorian Government's competitive neutrality policy commits public health services to apply this policy to all dealings. This includes the adoption of pricing principles to take account of the full cost attribution for net competitive advantages conferred by government ownership.

The policy directs that where the government's business activities involve it in competition with private sector business activities, the net advantages that accrue to a government business are offset.

Neutrality Policy Victoria 2000 sets out the Victorian approach to competitive neutrality. The Eye and Ear complies with this policy in all relevant business activities.

Carers Recognition Act 2012

The Carers Recognition Act 2012 recognises, promotes and values the role of carers. The Eye and Ear understands the different needs of carers and the value they provide to the community.

In our commitment to a model of patient and family centred care, we recognise and involve carers at a governance level in development, delivery and evaluation of our services, and at an individual patient care level to support discussions and decision-making between patients and staff, with the patient's consent.

The Safe Patient Care Act

The Eye and Ear takes all practicable measures to ensure compliance with the Safe Patient Care Act 2015. The hospital has no matters to report in relation to its obligations under section 40 of the Act.

Environmental performance

The Eye and Ear has a commitment to environmental sustainability. As we continue our redevelopment, we are considering our energy and water consumption, as well as improving the management of waste and hazardous materials. We aim to achieve this by using resources efficiently, maximising recycling opportunities and minimising the amount of waste going to landfill. The Eye and Ear is committed to many waste management and sustainability practices including PPE (personal protective equipment) preservation, a recycling program and donating equipment to community organisations and charities. In preparation for the relocation of remaining clinics and staff from the Eye and Ear on the Park to the main campus, staff have been undertaking a "5S" approach – sort, set in order, shine, standardise and sustain. The focus in the sorting process has been recycling and donating suitable items that are no longer required.

Total greenhouse gas emissions (tonnes CO2e)	2019-2020	2020-2021	2021-2022
Scope 1	1,842	2,279	2,213
Scope 2	10,375	11,717	10,629
Total	**12,217**	**13,996**	**12,942**
Total stationary energy purchased by energy type (GJ)			
Electricity	36,618	43,041	42,048
Natural gas	35,741	44,230	44,888
Total	**72,359**	**87,271**	**86,936**
Total water consumption by type (kL)			
Class A recycled water	N/A	N/A	N/A
Potable water	34,387	37,559	36,729
Reclaimed water	N/A	N/A	N/A
Total	**34,387**	**37,559**	**36,729**
Waste			
Total waste generated (kg clinical waste + kg general waste + kg recycling waste)	388,589	404,884	348,022
Total waste to landfill generated (kg clinical waste + kg general waste)	351,240	345,471	289,306
Total waste to landfill per patient treated (kg clinical waste + kg general waste)/PPT)	4.70	5.11	4
Recycling rate % (kg recycling / (kg general waste + kg recycling)	10.6	16.09	18

Disability Action Plan

The Eye and Ear is committed to providing an inclusive and accessible environment for staff, patients and visitors to the hospital, regardless of ability or capacity. The Partnering with Consumers and Community Plan 2020-2023 incorporates the Disability Action Plan (DAP) and includes a governance model to ensure organisation-wide engagement in the plan's key deliverables and objectives.

The DAP reflects the vision and strategic priorities of the Eye and Ear and is aligned with the Victorian Department of Health and Human Services Disability Action Plan 2018-2020.

Car parking fees

The Eye and Ear complies with the Department of Health's hospital circular on car parking fees. Details of car parking fees and concession benefits can be viewed at: https://eyeandear.org.au/about/policies-procedures/car-parking/

Local Jobs First Act 2003

The Eye and Ear complies with the policy on Local Jobs First Act 2003. The Act requires, wherever possible, local industry participation, taking into consideration the principle of value for money and transparent tendering processes. No contracts started in 2021-2022 for which compliance with this Act was necessary.

Gender Equality Act 2020

The organisation started activities in recognition of the Gender Equality Act 2020, which focuses on developing strategies and measures to promote gender equality within the workplace. With other health services, representatives from the Eye and Ear completed training delivered by the Commission for Gender Equality in the Public Sector and participated in a sector-wide working group. We convened a Gender Equality Working Group comprising a consumer representative and representatives from other departments in the hospital.

Based on their work, our Gender Equality Audit was submitted to the Commission and approved.

In this plan, we have set two quantitative goals. First, movement toward a 40:40:20 gender balance (40% women, 40% men, 20% mix of women, men and self-defined/prefer not to say) in all leadership positions and, second, pay gap reduced by 2% by 2025. We have also set three goals for improvement as measured in our People Matters Survey: an increase of 5% in the number of people willing to report non-dominant identities, a 5% decrease in intersectionality being a barrier to success and a reduction by 10% in the disparity between seeking support / reporting of sexual harassment internally.

Leadership and accountability (requirements 1-19)
The hospital met its target maturity level for all requirements in this category although there are areas where reviews are needed for improvement. Overall, there were no material non-compliances reported in this category. The hospital also exceeded the target in one performance area – the Strategic Capital Plan - where it incorporates asset management into the overall corporate and strategic planning framework.

Planning (requirements 20-23)
The hospital met its target maturity level in this category.

Acquisition (requirements 24 and 25)
The hospital met its target maturity level in this category.

Operation (requirements 26-40)
The hospital met its target maturity level under all requirements in this category. Similar to the leadership and accountability category, there are some areas that need review for improvement, particularly around non-financial information (eg service history) and implementing effective processes to generate required information. But no material non-compliance was reported in this category.

The hospital is ahead of target in establishing and maintaining asset information databases and asset registers.

Disposal (requirement 41)
The hospital met its target maturity level in this category.

Additional Information Available on Request (FRD 22 Appendix)
In compliance with the requirements of FRH 22 Standard Disclosures in the Report of Operations, details regarding items listed below have been retained by The Royal Victorian Eye and Ear Hospital and are available to the relevant Ministers, Members of Parliament and the public on request (subject to Freedom of Information requirements, if applicable):

- a statement that declarations of pecuniary interests have been duly completed by all relevant officers;
- details of shares held by a senior officer as nominee or held beneficially in a statutory authority or subsidiary;
- details of publications produced by the entity about itself and how these can be obtained;
- details of changes in prices, fees, charges, rates and levies charged by the entity;
- details of any major external reviews carried out on the entity;
- details of major research and development activities undertaken by the entity;
- details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;
- details of major promotional, public relations and marketing activities undertaken by the entity to develop community awareness of the entity and its services;
- details of assessments and measures undertaken to improve the occupational health and safety of employees;
- a general statement on industrial relations within the entity and details of time lost through industrial accidents and disputes;
- a list of major committees sponsored by the entity, the purposes of each committee and the extent to which the purposes have been achieved; and
- details of all consultancies and contractors including:
    - (I) consultants/contractors engaged;
    - (ii) services provided; and
    - (iii) expenditure committed for each engagement.

Attestations

Financial management compliance attestation

I, Simon Brewin, on behalf of the Board, certify that The Royal Victorian Eye and Ear Hospital has no Material Compliance Deficiency with respect to the applicable Standing Directions under the ***Financial Management Act 1994*** and Instructions.

Mr Simon Brewin
Board Member and Chair, Audit Committee
23 August 2022

Data Integrity

I, Brendon Gardner certify that The Royal Victorian Eye and Ear Hospital has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. The Royal Victorian Eye and Ear Hospital has critically reviewed these controls and processes during the year.

Brendon Gardner
Chief Executive Officer
The Royal Victorian Eye and Ear Hospital
23 August 2022

Conflict of Interest

I, Brendon Gardner, certify that The Royal Victorian Eye and Ear Hospital 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 The Royal Victorian Eye and Ear Hospital 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.

Brendon Gardner
Chief Executive Officer
The Royal Victorian Eye and Ear Hospital
23 August 2022

Integrity, fraud and corruption

I, Brendon Gardner certify that The Royal Victorian Eye and Ear Hospital has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at The Royal Victorian Eye and Ear Hospital during the year.

Brendon Gardner
Chief Executive Officer
The Royal Victorian Eye and Ear Hospital
23 August 2022

Reporting against the Statement of Priorities Part A: Strategic priorities

For financial year 2021-2022 and the second consecutive year there have been no individual deliverables that constitute Statement of Priorities due to the COVID-19 pandemic. The Eye and Ear has reported on the overarching strategic priorities provided by the Minister for Health. Priority statements and responses are outlined below.

Maintain robust COVID-19 readiness and response and working with the Department of Health ensure we rapidly respond to outbreaks, if and when they occur, which includes providing testing for your community and staff, where necessary and if required. This includes preparing to participate in, and assist with, the implementation of our COVID-19 vaccine immunisation program rollout, ensuring your local community's confidence in the program.

The Eye and Ear continued to adapt operations in response to the COVID-19 pandemic throughout 2021-2022. The Operations Working Group is ongoing and meets regularly. The group includes representatives from teams across the hospital including senior medical staff, nursing, surgical, procurement, communications and clinical improvement unit staff. This allows for more efficient decision-making and management of the day-to-day operation of the hospital in an ever-changing pandemic landscape. The concierge entrance screening process remains in place for all patients, carers and visitors entering the hospital.

During 2021, the Eye and Ear Disability Liaison Officer supported patients with a disability to access COVID-19 vaccinations at the Eye and Ear and as part of the Northeast Metro Health Services Partnership (NEMHSP).

To further assist with social distancing and waiting room capacity, the hospital continued to use the temporary outdoor waiting space for Emergency Department attendances. The hospital maintained ongoing adherence to and updating of COVID-19 management protocols in response to evolving requirements. Infection Control and People and Culture teams facilitated the COVID-19 vaccine mandate and rollout for healthcare workers in accordance with Department of Health requirements.

Driving improvement in access to emergency services by reducing department four-hour wait times, improving ambulance to health service handover times, and implementing strategies to reduce bed-blockage to enable improved whole of hospital system flow.

During 2021-2022, as with Victoria's wider health system, the Eye and Ear experienced ongoing pressures due to the COVID-19 pandemic. To improve Emergency Department (ED) wait times and overall hospital flow, the Eye and Ear introduced the following initiatives:

- A review of patient flow in the ED was undertaken. The working group's priorities were in line with recommendations identified by the ED Director, Nurse Unit Manager and Executive Director of Operations.
- Expansion of our ED and ED Short Stay Unit which will provide further ability to improve patient flow in 2022-2023.
- A focus on ENT services and flow improvements even though the area continues to meet KPI targets.

Actively collaborate on the development and delivery of priorities within your Health Service Partnership, contribute to inclusive and consensus-based decision-making, support optimum utilisation of services, facilities and resources within the partnership, and be collectively accountable for delivering against partnership accountabilities as set out in the Health Service Partnership Policy and Guidelines.

The Eye and Ear is committed to collaborating with the wider community and health network to improve patient experience and outcomes. As part of this commitment, the Eye and Ear supported the North East Metro Health Service Partnership (NEMHSP) to accelerate deliverables. Key achievements include:

- Collaboration with the NEMHSP to drive clinically-led transformation of elective surgery and deliver end-to-end pathway change to improve patient experience, optimisation of access and efficiency of care while keeping patients safe. Improvement initiatives, clinical networks and collaborative approaches to care delivery will be used to:
  - support a stronger culture around same-day surgery and shorter length of stay;
  - improve primary care and patient understanding of the care pathway;
  - make best use of the overall capacity across the partnership; and
  - enhance use of conservative and holistic management approaches.

Delivery of virtual home-based specialist clinic consultation services under the Better At Home initiative to minimise requirements for patients to attend the hospital setting and participating in Better At Home working group and governance group meetings.

Review of the Eye and Ear's ability to adopt the 'Virtual ED' model being led by Northern Hospital as part of the NEMHSP. Participation by Eye and Ear Senior Eye and Ear Ophthalmology and ENT medical staff in the

development of state-wide referral criteria for several ENT and ophthalmology diagnoses.

Engage with your community to address the needs of patients especially our vulnerable Victorians whose care has been delayed due to the pandemic and provide the necessary catch-up with your Health Service Partnership to:

- **implement the Better at Home initiative to enhance in-home and virtual models of patient care when it is safe, appropriate and consistent with patient preference.**
- **improve elective surgery performance and ensure that patients who have waited longer than clinically recommended for treatment have their needs addressed as a priority.**

The Eye and Ear engages with the community to support patients and vulnerable Victorians experiencing care delays during the pandemic by focusing on the following:

The Eye and Ear Specialist Clinics team assessed sub-specialist areas and service types where a virtual approach may be possible as part of the Better At Home initiative. Work began on delivering hybrid models for eligible patients who undergo specialist diagnostics at the hospital then their medical consultation virtually. One clinic has shown a 46 per cent reduction in patients' wait time during their visit because of this approach. Due to the high dependence on assessment to inform patient diagnosis and treatment, there has been limited ability to deliver home-based services in comparison to other general hospitals in the NEMHSP.

Due to disruptions to elective surgery caused by the COVID-19 pandemic, there is a backlog of deferred surgical care with an increase in patients on the Elective Surgery Wait Lists (ESWL).

Temporary elective surgery suspensions throughout 2021-2022 created capacity at the Eye and Ear to support Victoria's response to COVID-19 by joining the COVID Positive Care Pathway Program. Staff were trained by the NEMHSP and worked with COVID-19 patients who were being managed at home via telehealth.

The recently announced COVID Catch-Up Plan provides health services with funding, presenting opportunities to identify, expand and implement surgical reforms that ensure additional surgical capacity, infrastructure and workforce can drive sustainable improvements.

The Eye and Ear is committed to delivering on targets outlined in the plan by implementing change initiatives focussed on key elements in the plan. These include:

- Increasing public activity and throughput by
  - Introduction of weekend theatre sessions
  - Extension of theatre session times
  - Introduction of twilight theatre sessions
- Maximising private capacity
  - Initiation of private hospital partnerships
- Introducing rapid patient prioritisation and assessment
  - Elective Surgery Transformation Lead role
  - Patient Support Units (including Surgical Liaison Nurses)
  - Fast Track Reassessment
- Local Transformation Projects

Embed the Aboriginal and Torres Strait Islander Cultural Safety Framework into your organisation and build a continuous quality improvement approach to improving cultural safety, underpinned by Aboriginal self-determination, to ensure delivery of culturally safe care to Aboriginal patients and families, and to provide culturally safe workplaces for Aboriginal employees.

As part of The Royal Victorian Eye and Ear Hospital's Reconciliation Action Plan, we fostered relationships with our Aboriginal and Torres Strait Islander community members, patients and staff in the following ways during 2021-2022:

- Hired an Equity and Inclusion Coordinator, taking the lead on Aboriginal and Torres Strait Islander employment.
- Our cultural awareness e-learning package achieved a 100 per cent staff completion rate. Other staff training included; cultural awareness training with student nurses, Aboriginal mental health first aid training and the 'Ask the Question' campaign rollout to all clinical staff.
- Acknowledging and celebrating cultural events, including Close the Gap Day and NAIDOC Week where the Mirring Ba Wirring Aboriginal Health Unit hosted documentary screenings for staff.
- Development of an Aboriginal welcome space for patients, carers and staff to enjoy which includes Aboriginal artwork panels and an Indigenous garden.
- The Eye and Ear and the Victorian Aboriginal Health Service (VAHS) Healthy Ears Clinic funding increased to allow for an additional day per month in clinic and to extend appointments to include adult patients. The recruitment of an additional ENT Specialist and continued partnership with the University of Melbourne Audiology Department offered further hearing assessment appointments and several hearing blitz clinics which ran at the Eye and Ear to support wait list demands.
- The Eye and Ear and VAHS Ophthalmology Clinic employed an additional Ophthalmology specialist and funding increased enabling a supplementary full day per fortnightly clinic.
- Dharri Baagon (meaning "supporting together") ongoing network meetings with partners to share resources and support Aboriginal and Torres

Islander staff. Dharri Baagon Network is a peer support group for AHLOs in specialist health care organisations in Melbourne.

- Mirring Ba Wirring Aboriginal Health Unit ongoing membership and attendance at state-wide meetings through the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

The Aboriginal Health Unit will expand the Innovate Reconciliation Action Plan (RAP) for 2022-2023 by participating in a staff survey led by Reconciliation Australia to inform and strengthen future RAP actions.

Part B: Key performance measures

High quality and safe care

Key performance measure	Target	2021-2022 result
Infection prevention and control		
Compliance with the Hand Hygiene Australia program	85%	88%
Percentage of healthcare workers immunised for influenza	92%	93%
Patient experience		
Victorian Healthcare Experience Survey – percentage of positive patient experience responses- Quarter 1	95%	95%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 2	95%	99%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 3	95%	96%
Healthcare associated infections (HAIs)		
Rate of patients with SAB (staphylococcus aureus bloodstream infections) per 10,000 occupied bed days	≤ 1	0

*Given COVID-19 resulted in delays to surgery, visitor restriction and increased demand for services, patient experience has been impacted

Strong governance, leadership and culture

Key performance measure	Target	2021-2022 result
Organisation culture		
People matter survey - percentage of staff with an overall positive response to safety culture survey questions	62%	62%

Timely access to care

Key performance measure	Target	2021-2022 result
Percentage of ambulance patients transferred from ambulance to emergency department within 40 minutes	90%	98%
Percentage of Triage Category 1 emergency patients seen immediately	100%	100%
Percentage of Triage Category 1 to 5 emergency patients seen within clinically recommended time	80%	88%
Percentage of emergency patients with a length of stay in the emergency department of less than four hours	81%	75%
Number of patients with length of stay in the Emergency Department greater than 24 hours	0	1
Elective surgery		
Number of patients on the elective surgery waiting list at 30 June 2022	4,153	4,095
Number of patients admitted from the elective surgery waiting list	8,600	8,692

Key performance measure	Target	2021-2022 result
Percentage of Urgency Category 1 elective surgery patients admitted within 30 days	100%	100%
Percentage of Urgency Category 1, 2 and 3 elective patients admitted within clinically recommended time-frames	94%	85%
Percentage of patients on the waiting list who waited longer than clinically recommended times for their triage category	5% or 15% proportional improvement from previous year	27%
Number of hospital-initiated postponements per 100 scheduled admissions	≤ 7	3.91
Specialist clinics		
Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days	100%	92%
Percentage of routine patients referred by a GP or external specialist who attended a first appointment within 365 days	90%	73%

Effective financial management

Key performance measure	Target	2021-2022 result
Operating result ($m)	0.00	0.42
Average number of days to pay trade creditors	60 days	33 days
Average number of days to receive patient fee debtors	60 days	36 days
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	2.15
Actual number of days available cash, measured on the last day of each month.	14 days	61.8 days
Variance between forecast and actual net result from transactions (NRFT) for the current financial year ending 30 June.	Variance ≤ $250,000	Not achieved

Part C: Activity and funding

Funding type	2021-2022 activity achievement
Consolidated activity funding	
Acute admitted, subacute admitted, emergency services, non-admitted NWAU (national weighted activity unit)	21,953
Acute admitted	
Acute admitted DVA	16
Acute admitted TAC	1
Acute non-admitted	
Specialist clinics	13,620

Disclosure index

The annual report of The Royal Victorian Eye and Ear Hospital is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department of Health's compliance with statutory disclosure requirements.

Legislation	Requirement	Page reference
Ministerial directions		
Report of Operations		
Charter and purpose		
FRD 22	Manner of establishment and the relevant Ministers	2
FRD 22	Purpose, functions, powers and duties	2
FRD 22	Nature and range of services provided	2
FRD 22	Activities, programs and achievements for the reporting period	3-5
FRD 22	Significant changes in key initiatives and expectations for the future	3-5
Management and structure		
FRD 22	Organisational structure	10
FRD 22	Workforce data/ employment and conduct principles	14
FRD 22	Occupational Health and Safety	15-17
Financial information		
FRD 22	Summary of the financial results for the year	18-19
FRD 22	Significant changes in financial position during the year	18
FRD 22	Operational and budgetary objectives and performance against objectives	18
FRD 22	Subsequent events	18
FRD 22	Details of consultancies under $10,000	18
FRD 22	Details of consultancies over $10,000	18-19
FRD 22	Disclosure of ICT expenditure	19
Legislation requirement		
FRD 22	Application and operation of Freedom of Information Act 1982	20
FRD 22	Compliance with building and maintenance provisions of Building Act 1993	20
FRD 22	Application and operation of Public Interest Disclosure Act 2012	20
FRD 22	Statement on National Competition Policy	20-21
FRD 22	Application and operation of Carers Recognition Act 2012	21
FRD 22	Summary of environmental performance	21
FRD 22	Additional information on request	22
Other relevant reporting directives		
FRD 25	Local Jobs First Act 2003 disclosures	21
SD 5.1.4	Financial Management Compliance attestation	23
SD 5.1.3	Declaration in report of operations	23
Attestations		
Attestation on data integrity		23
Attestation on managing conflicts of interest		23
Attestation on integrity, fraud and corruption		23
Other reporting requirements		
Reporting of outcomes from Statement of Priorities 2021-2022		24-27
Occupational Violence reporting		17
Gender Equality Act 2020		21-22
Reporting obligations under the Safe Patient Care Act 2015		21
Reporting of compliance regarding car parking fees		21

Financial Statements

Financial Statements

Financial Year ended 30 June 2022

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

The attached financial statements for *The Royal Victorian Eye and Ear Hospital* 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 2022 and the financial position of *The Royal Victorian Eye and Ear Hospital* at 30 June 2022.

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 23 August 2022.

Dr Sherene Devanesen
Chair, Board of Directors
23 August 2022

Brendon Gardner
Chief Executive Officer
23 August 2022

Danny Mennuni
Chief Finance and Accounting Officer
23 August 2022

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of The Royal Victorian Eye and Ear Hospital

Opinion	I have audited the financial report of The Royal Victorian Eye and Ear Hospital (the health service) which comprises the: • balance sheet as at 30 June 2022 • 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 2022 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

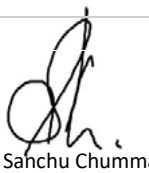
Auditor's responsibilities for the audit of the financial report

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.



Sanchu Chummar
as delegate for the Auditor-General of Victoria

MELBOURNE
15 September 2022

The Royal Victorian Eye and Ear Hospital
Comprehensive Operating Statement
For the Financial Year Ended 30 June 2022

	Note	2022 $'000	2021 $'000
Revenue and Income from Transactions:			
Operating Activities	2.1	153,730	155,319
Non-Operating Activities	2.1	2,908	2,466
Total Revenue and Income from Transactions		**156,638**	**157,785**
Expenses from Transactions:			
Employee Expenses	3.1	(84,146)	(80,224)
Supplies and Consumables	3.1	(25,217)	(24,802)
Finance Income/Costs	3.1	201	(56)
Administrative Expenses	3.1	(9,475)	(7,761)
Other Operating Expenses	3.1	(6,537)	(6,612)
Depreciation and Amortisation	4.5	(11,349)	(9,873)
Other Non-Operating Expenses	3.1	(34)	(29)
Total Expenses from Transactions		**(136,557)**	**(129,357)**
Net Result from Transactions - Net Operating Balance		**20,081**	**28,428**
Other Economic Flows Included In Net Result:			
Net Gain/(Loss) on Non-Financial Assets	3.2	(195)	412
Net Gain/(Loss) on Financial Instruments	3.2	(5,324)	3,646
Other Gain/(Loss) from Other Economic Flows	3.2	658	726
Total Other Economic Flows Included In Net Result		**(4,861)**	**4,784**
Net Result For The Year		**15,220**	**33,212**
Comprehensive Result For The Year		**15,220**	**33,212**

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

The Royal Victorian Eye and Ear Hospital
Balance Sheet
As at 30 June 2022

	Note	2022 $'000	2021 $'000
Current Assets			
Cash and Cash Equivalents	6.2	26,916	26,301
Receivables and Contract Assets	5.1	2,380	2,737
Investments and Other Financial Assets	4.1	441	141
Inventories	4.7	291	326
Prepaid Expenses		1,377	1,149
Total Current Assets		**31,405**	**30,654**
Non-Current Assets			
Receivables and Contract Assets	5.1	5,287	4,515
Investments and Other Financial Assets	4.1	40,211	45,488
Property, Plant and Equipment	4.2	312,642	286,199
Intangible Assets	4.4	7,781	8,586
Investment Properties	4.6	12,817	13,010
Total Non-Current Assets		**378,738**	**357,798**
Total Assets		**410,143**	**388,452**
Current Liabilities			
Payables and Contract Liabilities	5.2	22,606	14,933
Employee Benefits	3.3	21,249	20,244
Borrowings	6.1	1,736	1,736
Total Current Liabilities		**45,591**	**36,913**
Non-Current Liabilities			
Employee Benefits	3.3	2,840	3,109
Borrowings	6.1	3,262	5,200
Total Non-Current Liabilities		**6,102**	**8,309**
Total Liabilities		**51,693**	**45,222**
Net Assets		**358,450**	**343,230**
Equity			
Revaluation Surplus	4.3	67,428	67,428
General Purpose Reserve	SCE	246	258
Restricted Specific Purpose Reserve	SCE	30,822	41,922
Contributed Capital	SCE	51,568	51,568
Accumulated Surplus/(Deficit)	SCE	208,386	182,054
Total Equity		**358,450**	**343,230**

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

The Royal Victorian Eye and Ear Hospital
Statement of Changes in Equity
For the Financial Year Ended 30 June 2022

	Revaluation Surplus	General Purpose Reserve	Restricted Specific Purpose Reserve	Contributed Capital	Accumulated Surplus/ (Deficit)	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2020	**67,428**	**166**	**49,948**	**51,568**	**140,908**	**310,018**
Net Result for the Year	-	-	-	-	33,212	33,212
Transfer to/(from) Accumulated Surplus/(Deficit)	-	92	(8,026)	-	7,934	-
Balance at 30 June 2021	**67,428**	**258**	**41,922**	**51,568**	**182,054**	**343,230**
Net Result for the Year	-	-	-	-	15,220	15,220
Transfer to/(from) Accumulated Surplus/(Deficit)	-	(12)	(11,100)	-	11,112	-
Balance at 30 June 2022	**67,428**	**246**	**30,822**	**51,568**	**208,386**	**358,450**

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

The Royal Victorian Eye and Ear Hospital
Cash Flow Statement
For the Financial Year Ended 30 June 2022

	Note	2022 $'000	2021 $'000
Cash Flows From Operating Activities:			
Operating Grants from State Government		115,650	113,281
Operating Grants from Commonwealth Government		3,063	2,570
Capital Grants from State Government		8,299	3,829
Patient Fees Received		2,865	3,591
Private Practice Fees Received		1,613	1,606
Pharmaceutical Sales Received		500	514
Car Park Income Received		288	260
Donations and Bequests Received		326	1,148
GST Received from ATO		3,585	2,505
Interest and Investment Income Received		2,688	2,563
Other Receipts		4,837	6,041
Total Receipts		**143,714**	**137,908**
Employee Expenses		(81,595)	(76,577)
Non Salary Labour Costs		(1,347)	(895)
Payments for Supplies and Consumables		(23,534)	(24,523)
Payments for Medical Indemnity Insurance		(1,405)	(1,448)
Payments for Repairs and Maintenance		(2,283)	(2,085)
GST Paid to ATO		(260)	(208)
Other Payments		(14,781)	(13,838)
Total Payments		**(125,205)**	**(119,574)**
Net Cash Flows From/(Used In) Operating Activities	8.1	**18,509**	**18,334**
Cash Flows From Investing Activities:			
Purchase of Non-Financial Assets		(18,040)	(16,638)
Proceeds from Sale of Non-Financial Assets		14	12
Capital Donations and Bequests Received		1,868	935
Net Cash Flow From/(Used In) Investing Activities		**(16,158)**	**(15,691)**
Cash Flows From Financing Activities:			
Repayment of Borrowings		(1,736)	(1,736)
Net Cash Flow From/(Used In) Financing Activities		**(1,736)**	**(1,736)**
Net Increase/(Decrease) In Cash And Cash Equivalents Held		**615**	**907**
Cash and Cash Equivalents at Beginning of Year		26,301	25,394
Cash and Cash Equivalents at End of Year	6.2	**26,916**	**26,301**

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

Note 1: Basis of Preparation

These financial statements represent the audited general purpose financial statements for The Royal Victorian Eye and Ear Hospital ("the hospital") for the period ending 30 June 2022. The report provides users with information about the hospital's stewardship of resources entrusted to it.

This section explains the basis of preparing the financial statements.

Structure:

Note 1.1: Reporting Entity

The financial statements include all the controlled activities of The Royal Victorian Eye and Ear Hospital.

Its principal address is: 32 Gisborne Street, East Melbourne, Victoria 3002.

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

Note 1.2: Basis of Preparation of the Financial Statements

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

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

The Royal Victorian Eye and Ear Hospital is a not-for-profit entity and therefore applies the additional AUS paragraphs applicable to a "not-for-profit" health service under the Australian Accounting Standards. Australian Accounting Standards set out accounting policies that the AASB has concluded would result in financial statements containing relevant and reliable information about transactions, events and conditions. Apart from the changes in accounting policies, standards and interpretations as noted below, material accounting policies adopted in the preparation of these financial statements are the same as those adopted in the previous period.

The financial statements, except for the cash flow information, have been prepared on an accruals basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities.

The financial statements are prepared on a going concern basis (refer 8.9 Economic Dependency).

The financial statements are in Australian dollars.

The amounts presented in the financial statements have been rounded to the nearest thousand dollars. Minor discrepancies in tables between totals and sum of components are due to rounding.

The annual financial statements were authorised for issue by the Board of The Royal Victorian Eye and Ear Hospital on 23 August 2022.

Note 1.3: Impact of COVID-19 Pandemic

In March 2020 a state of emergency was declared in Victoria due to the global coronavirus pandemic, known as COVID-19. On 2 August 2020 a state of disaster was added with both operating concurrently. The state of disaster in Victoria concluded on 28 October 2020 and the state of emergency concluded on 15 December 2021.

The COVID-19 pandemic has created economic uncertainty. Actual economic events and conditions in the future may be materially different from those estimated by the hospital at the reporting date. Management recognises that it is difficult to reliably estimate with certainty, the potential impact of the pandemic after the reporting date on the hospital, its operations, its future results and financial position.

In response to the ongoing COVID-19 pandemic, the hospital has:

- introduced restrictions on non-essential visitors
- utilised telehealth services
- reduced activity
- changed infection control practices
- implemented work from home arrangements where appropriate

As restrictions have eased towards the end of the financial year the hospital has been able to revise some measures where appropriate including returning elective surgery and other service activity to normal levels.

Where financial impacts of the pandemic are material to the hospital, they are disclosed in the explanatory notes. For the hospital, this includes:

- Note 2: Funding the Delivery of Services
- Note 5: Other Assets and Liabilities

Note 1.4: Abbreviations and Terminology Used in the Financial Statements

The following table sets out the common abbreviations used throughout the financial statements:

Reference	Title
AASB	Australian Accounting Standards Board
AASs	Australian Accounting Standards, which include Interpretations
DH	Department of Health
DTF	Department of Treasury and Finance
FMA	Financial Management Act 1994
FRD	Financial Reporting Direction
NWAU	National Weighted Activity Unit
SCE	Statement of Changes in Equity
SD	Standing Direction
VAGO	Victorian Auditor General's Office
WIES	Weighted Inlier Equivalent Separation

Note 1.5: Key Accounting Estimates and Judgements

Management make estimates and judgements when preparing the financial statements.

These estimates and judgements are based on historical knowledge and best available current information and assume any reasonable expectation of future events; actual results may differ.

Revisions to key estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision.

The accounting policies and significant management judgements and estimates used, and any changes thereto, are identified at the beginning of each section where applicable and are disclosed in further detail throughout the accounting policies.

Note 1.6: Accounting Standards Issued but Not Yet Effective

An assessment of accounting standards and interpretations issued by the AASB that are not yet mandatorily applicable to the hospital and their potential impact when adopted in future periods is outlined below:

Standard	Adoption Date	Impact
AASB 17: Insurance Contracts	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact.
AASB 2020-1: Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-Current	Reporting periods on or after 1 January 2022	Adoption of this standard is not expected to have a material impact.
AASB 2020-3: Amendments to Australian Accounting Standards – Annual Improvements 2018-2020 and Other Amendments	Reporting periods on or after 1 January 2022	Adoption of this standard is not expected to have a material impact.
AASB 2021-2: Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definitions of Accounting Estimates	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact.
AASB 2021-5: Amendments to Australian Accounting Standards – Deferred Tax related to Assets and Liabilities arising from a Single Transaction	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact.
AASB 2021-6: Amendments to Australian Accounting Standards – Disclosure of Accounting Policies: Tier 2 and Other Australian Accounting Standards	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact.
AASB 2021-7: Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections	Reporting periods on or after 1 January 2023	Adoption of this standard is not expected to have a material impact.

There are no other accounting standards and interpretations issued by the AASB that are not yet mandatorily applicable to the hospital in future periods.

Note 1.7: Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of GST, except where the GST incurred is not recoverable from the Australian Taxation Office (ATO). In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables in the Balance Sheet are stated inclusive of the amount of GST. 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 included in the Cash Flow Statement on a gross basis, except for the GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to the ATO, which are disclosed as operating cash flows.

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

Note 2: Funding the Delivery of Services

The hospital's overall objective is to provide quality health services that support and enhance the wellbeing of all Victorians.

The hospital is predominantly funded by grant funding for the provision of outputs. The hospital also receives income from the supply of goods and services.

Structure:

2.1 Revenue and Income from Transactions

Telling the COVID-19 Story

Revenue recognised to fund the delivery of our services decreased during the financial year which was partially attributable to the COVID-19 pandemic.

Activity based funding decreased as the level of activity agreed in the Statement of Priorities couldn't be delivered due to reductions in the number of patients being treated at various times throughout the financial year.

This was offset by funding provided by the Department of Health to compensate for reductions in revenue and to cover certain indirect COVID-19 related costs, including:

- decreased revenue from patient and private practice fees, car parking fees and rental income
- increased costs associated with implementing COVID safe practices

Funding provided included:

- COVID-19 and state repurposing grants

For the year ended 30 June 2022, the COVID-19 pandemic impacted the hospital's ability to satisfy its performance obligations contained within its contracts with customers. The hospital received notification that there would be no obligation to return funds to the Department of Health where performance obligations had not been met for base level activity grants, however there would be an obligation to return funds where performance obligations had not been met for growth activity grants.

This resulted in approximately $24.8M being recognised as revenue for the year ended 30 June 2022 (2021: $14.2M) which would have otherwise been recognised as a contract liability in the Balance Sheet until subsequent years when underlying performance obligations were fulfilled.

Key Judgements and Estimates

This section contains the following key judgements and estimates:

Key Judgements and Estimates	Description
Identifying performance obligations	The hospital applies significant judgment when reviewing the terms and conditions of funding agreements and contracts to determine whether they contain sufficiently specific and enforceable performance obligations. If this criteria is met, the contract/funding agreement is treated as a contract with a customer, requiring the hospital to recognise revenue as or when the hospital transfers promised goods or services to the beneficiaries. If this criteria is not met, funding is recognised immediately in the net result from operations.
Determining timing of revenue recognition	The hospital applies significant judgement to determine when a performance obligation has been satisfied and the transaction price that is to be allocated to each performance obligation. A performance obligation is either satisfied at a point in time or over time.
Determining timing of capital grant income recognition	The hospital applies significant judgement to determine when its obligation to construct an asset is satisfied. Costs incurred is used to measure the hospital's progress as this is deemed to be the most accurate reflection of the stage of completion.

Note 2.1: Revenue and Income from Transactions

	Note	2022 $'000	2021 $'000
Operating Activities			
Revenue from Contracts with Customers:			
Government Grants (State) - Operating		98,631	97,231
Government Grants (Commonwealth) - Operating		3,072	2,601
Patient Fees		3,044	3,669
Private Practice Fees		1,613	1,607
Commercial Activities [(i)]		1,054	973
Total Revenue from Contracts with Customers	2.1 (a)	**107,414**	**106,081**
Other Sources of Income:			
Government Grants (State) - Operating		12,186	6,969
Government Grants (State) - Capital		26,247	35,173
Assets Received Free of Charge or for Nominal Consideration	2.1 (b)	2,472	1,123
Other Revenue from Operating Activities (including Non-Capital Donations)		5,411	5,973
Total Other Sources of Income		**46,316**	**49,238**
Total Revenue and Income from Operating Activities		**153,730**	**155,319**
Non-Operating Activities			
Income from Other Sources:			
Rental Income		311	267
Capital Interest		130	124
Dividends		2,467	2,075
Total Income from Non-Operating Activities		**2,908**	**2,466**
Total Revenue and Income from Transactions		**156,638**	**157,785**

[(i)] Commercial Activities represent business activities which the hospital enters into to support its operations.

Note 2.1(a) Timing of Revenue Recognition from Contracts with Customers

	2022 $'000	2021 $'000
Goods and Services Transferred to Customers:		
At a Point In Time	107,198	105,921
Over Time	216	160
Total Revenue from Contracts With Customers	**107,414**	**106,081**

How We Recognise Revenue and Income From Transactions

Government Operating Grants

To recognise revenue, the hospital assesses whether there is a contract that is enforceable and has sufficiently specific performance obligations in accordance with AASB 15: Revenue from Contracts with Customers.

When both these conditions are satisfied, the hospital:

- identifies each performance obligation relating to the revenue
- recognises a contract liability for its obligations under the agreement
- recognises revenue as it satisfies its performance obligations, at the time or over time when services are rendered

If a contract liability is recognised, the hospital recognises revenue in profit or loss as and when it satisfies its obligations under the contract, unless a contract modification is entered into between all parties. A contract modification may be obtained in writing, by oral agreement or implied by customary business practices.

When the contract is not enforceable and/or does not have sufficiently specific performance obligations, the hospital:

- recognises the asset received in accordance with the recognition requirements of other applicable Accounting Standards (for example, AASB 9, AASB 16, AASB 116 and AASB 138)
- recognises related amounts (being contributions by owners, lease liabilities, financial instruments, provisions, revenue or contract liabilities from a contract with a customer)
- recognises income immediately in profit or loss as the difference between the initial carrying amount of the asset and the related amount in accordance with AASB 1058

In contracts with customers, the 'customer' is typically a funding body, who is the party that promises funding in exchange for the hospital's goods or services. Hospital funding bodies often direct that goods or services are to be provided to third party beneficiaries, including individuals or the community at large. In such instances, the customer remains the funding body that has funded the program or activity, however the delivery of goods or services to third party beneficiaries is a characteristic of the promised good or service being transferred to the funding body.

This policy applies to each of the hospital's revenue streams, with information detailed below relating to the hospital's significant revenue streams:

Government Grant	Performance Obligation
Activity Based Funding (ABF) paid as Weighted Inlier Equivalent Separation (WIES) casemix	The performance obligations for ABF are the number and mix of patients admitted to hospital (defined as 'casemix') in accordance with the levels of activity agreed to with the DH in the annual Statement of Priorities. Revenue is recognised at a point in time, which is when a patient is discharged. WIES activity is a cost weight that is adjusted for time spent in hospital, and represents a relative measure of resource use for each episode of care in a diagnosis related group (DRG). WIES was superseded by NWAU from 1 July 2021.
Activity Based Funding (ABF) paid as National Weighted Activity Unit (NWAU)	NWAU funding commenced 1 July 2021 and supersedes WIES for acute, sub-acute and state-wide services (which includes specified grants, state-wide services and teaching and training). Services not transitioning at this time include mental health and small rural services. NWAU is a measure of health service activity expressed as a common unit against which the national efficient price (NEP) is paid. The performance obligations for NWAU are the number and mix of admissions, emergency department presentations and outpatient episodes, and is weighted for clinical complexity. Revenue is recognised at point in time, which is when a patient is discharged.

Capital Grants

When the hospital receives a capital grant, it recognises a liability for the excess of the initial carrying amount of the financial asset received over any related amounts (being contributions by owners, lease liabilities, financial instruments, provisions, revenue or contract liabilities arising from a contract with a customer) recognised under other Australian Accounting Standards.

Income is recognised progressively as the asset is procured or constructed which aligns with the hospital's obligation to procure or construct the asset. The progressive percentage of costs incurred is used to recognise income, as this most accurately reflects the stage of completion.

Patient Fees

Patient fees are charges that can be levied on patients for some services they receive. Patient fees are recognised at a point in time when the performance obligation, the provision of services, is satisfied.

Private Practice Fees

Private practice fees include recoupments from various private practice organisations for the use of hospital facilities. Private practice fees are recognised over time as the performance obligation, the provision of facilities, is provided to customers.

Commercial Activities

Revenue from commercial activities includes commercial car parking facilities, property rental, sale of medication and providing education services. Commercial activity revenue is recognised at a point in time, upon provision of the goods or service to the customer.

How We Recognise Income from Non-Operating Activities

Rental Income – Investment Properties

Rental income from investment properties is recognised on a straight-line basis over the term of the lease, unless another systematic basis is more representative of the pattern of use of the underlying asset.

Where a lease incentive is provided to a lessee, this is considered an integral part of the net consideration agreed for the use of the lease asset and therefore the incentive is recognised as a reduction of rental income over the period to which it relates.

The following table sets out the maturity analysis of undiscounted future lease payments receivable under our operating leases:

As at 30 June	2022 $'000	2021 $'000
Within One Year	611	423
Within One to Two Years	322	273
Within Two to Three Years	150	42
Within Three to Four Years	67	13
Within Four to Five Years	70	13
After Five Years	36	50
Total Undiscounted Future Lease Payments Receivable	**1,256**	**814**

Dividend Income

Dividend income is recognised when the right to receive payment is established. Dividends represent the income arising from the hospital's investments in financial assets.

Interest Income

Interest income is recognised on a time proportionate basis that considers the effective yield of the financial asset, which allocates interest over the relevant period.

Note 2.1 (b): Fair Value of Assets and Services Received Free of Charge or For Nominal Consideration

	2022 $'000	2021 $'000
Donations and Bequests - Capital	1,868	935
Plant and Equipment	-	37
Personal Protective Equipment	604	150
Other Contributions	-	1
Total Fair Value of Assets and Services Received Free of Charge or For Nominal Consideration	**2,472**	**1,123**

How We Recognise the Fair Value of Assets and Services Received Free of Charge or For Nominal Consideration

Donations and Bequests

Donations and bequests are generally recognised as income upon receipt (which is when the hospital obtained control of the asset) as they do not contain sufficiently specific and enforceable performance obligations. Where sufficiently specific and enforceable performance obligations exist, revenue is recorded as and when the performance obligation is satisfied.

Personal Protective Equipment

In order to meet the State of Victoria's health system supply needs during the COVID-19 pandemic, arrangements were put in place to centralise the purchasing of essential personal protective equipment (PPE) and other essential plant and equipment.

The general principles of the State Supply Arrangement were that Health Share Victoria sourced, secured and agreed terms for the purchase of the PPE products, funded by the Department of Health, while Monash Health took delivery, and distributed an allocation of the products to the hospital as resources provided free of charge. Health Share Victoria and Monash Health were acting as an agent of the Department of Health under this arrangement.

Non-Cash Contributions from the Department of Health

The Department of Health makes some payments on behalf of the hospital as follows:

Supplier	Description
Victorian Managed Insurance Authority	The Department of Health purchases non-medical indemnity insurance for the hospital which is paid directly to the Victorian Managed Insurance Authority. To record this contribution, such payments are recognised as income with a matching expense in the net result from transactions.
Department of Health	Long Service Leave (LSL) revenue is recognised upon finalisation of movements in LSL liability in line with the long service leave funding arrangements with the Department of Health.
Various suppliers	The Department of Health makes payments on behalf of the hospital to various suppliers related to the hospital building redevelopment project.

Note 3: The Cost of Delivering Services

This section provides an account of the expenses incurred by the hospital in delivering services and outputs. In Note 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

3.4 Superannuation

Telling the COVID-19 Story

Expenses incurred to deliver services during the financial year were not materially impacted by the COVID-19 pandemic because the hospital's response was limited to implementing COVID safe practices.

Key Judgements and Estimates

This section contains the following key judgements and estimates:

Key Judgements and Estimates	Description
Classifying employee benefit liabilities	The hospital applies significant judgment when measuring and classifying its employee benefit liabilities. Employee benefit liabilities are classified as a current liability if the hospital does not have an unconditional right to defer payment beyond 12 months. Annual leave, accrued days off and long service leave entitlements (for staff who have exceeded the minimum vesting period) fall into this category. Employee benefit liabilities are classified as a non-current liability if the hospital has a conditional right to defer payment beyond 12 months. Long service leave entitlements (for staff who have not yet exceeded the minimum vesting period) fall into this category.
Measuring employee benefit liabilities	The hospital applies significant judgment when measuring its employee benefit liabilities. The hospital applies judgement to determine when it expects its employee entitlements to be paid. With reference to historical data, if the hospital does not expect entitlements to be paid within 12 months, the entitlement is measured at its present value, being the expected future payments to employees. Expected future payments incorporate anticipated future wage and salary levels, durations of service and employee departures, and are discounted at rates determined by reference to market yields on government bonds at the end of the reporting period. All other entitlements are measured at their nominal value.

Note 3.1: Expenses from Transactions

	Note	2022 $'000	2021 $'000
Salaries and Wages		65,513	62,496
On-Costs		16,591	15,487
Agency Expenses		458	515
Fee for Service Medical Officer Expenses		1,254	1,322
Workcover Premium		330	404
Total Employee Expenses		**84,146**	**80,224**
Drug Supplies		4,898	4,021
Medical and Surgical Supplies (including Prostheses)		14,948	16,052
Diagnostic and Radiology Supplies		1,279	981
Other Supplies and Consumables		4,092	3,748
Total Supplies and Consumables		**25,217**	**24,802**
Finance (Income)/Costs		(201)	56
Total Finance Costs		**(201)**	**56**
Administrative Expenses		9,475	7,761
Total Administrative Expenses		**9,475**	**7,761**
Fuel, Light, Power and Water		2,853	2,669
Repairs and Maintenance		428	402
Maintenance Contracts		1,855	1,683
Medical Indemnity Insurance		1,405	1,448
Expenditure for Capital Purposes		(4)	410
Total Other Operating Expenses		**6,537**	**6,612**
Total Operating Expense		**125,174**	**119,455**
Depreciation and Amortisation	4.5	11,349	9,873
Total Depreciation and Amortisation		**11,349**	**9,873**
Bad and Doubtful Debt Expense		34	29
Total Other Non-Operating Expenses		**34**	**29**
Total Non-Operating Expense		**11,383**	**9,902**
Total Expenses from Transactions		**136,557**	**129,357**

How We Recognise Expenses From Transactions

Expense Recognition

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; and
- Work cover premium.

Supplies and Consumables

Supplies and consumables costs 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.

Finance Costs

Finance costs include:

- amortisation of discounts relating to borrowings.

Other Operating Expenses

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

- Fuel, light and power;
- Repairs and maintenance;
- Administrative expenses; and
- Expenditure for capital purposes (includes expenditure related to the purchase of assets that are below the capitalisation threshold of $1,000).

The Department of Health also makes certain payments on behalf of the hospital. 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 amortisation and assets and services provided free of charge or for nominal consideration.

Note 3.2: Other Economic Flows

	2022 $'000	2021 $'000
Net Gain/(Loss) on Non-Financial Assets:		
Net Gain/(Loss) on Revaluation of Investment Property	(193)	400
Net Gain/(Loss) on Disposal of Property Plant and Equipment	(2)	12
Total Net Gain/(Loss) on Non-Financial Assets	**(195)**	**412**
Net Gain/(Loss) on Financial Instruments:		
Net Gain/(Loss) on Allowance for Impairment Losses of Contractual Receivables	10	55
Other Net Gains/(Losses) on Financial Instruments	(5,334)	3,591
Total Net Gain/(Loss) on Financial Instruments	**(5,324)**	**3,646**
Other Gains/(Losses) from Other Economic Flows:		
Net Gain/(Loss) from Revaluation of Long Service Leave Liability	658	726
Total Other Gains/(Losses) from Other Economic Flows	**658**	**726**
Total Gains/(Losses) from Other Economic Flows	**(4,861)**	**4,784**

How We Recognise Other Economic Flows

Other economic flows are changes in the volume or value of an asset or liability that do not result from transactions.

Net Gain/(Loss) on Non-Financial Assets

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

- Revaluation gains/(losses) of investment properties
- 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)

Net Gain/(Loss) on Financial Instruments

Net gain/(loss) on financial instruments at fair value includes:

- Realised and unrealised gains and losses from revaluations of financial instruments at fair value
- Impairment and reversal of impairment for financial instruments at amortised cost (refer Note 7.1)
- Disposals of financial assets and derecognition of financial liabilities

Other Net 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

Note 3.3: Employee Benefits and Related On-Costs

	2022 $'000	2021 $'000
Current Employee Benefits and Related On-Costs		
Accrued Days Off		
- Unconditional and expected to be settled wholly within 12 months [(i)]	198	183
Annual Leave		
- Unconditional and expected to be settled wholly within 12 months [(i)]	4,597	4,787
- Unconditional and expected to be settled wholly after 12 months [(ii)]	2,501	2,052
Long Service Leave		
- Unconditional and expected to be settled wholly within 12 months [(i)]	1,277	1,291
- Unconditional and expected to be settled wholly after 12 months [(ii)]	10,441	9,943
	19,014	**18,256**
Provisions related to Employee Benefit On-Costs		
- Unconditional and expected to be settled within 12 months [(i)]	669	669
- Unconditional and expected to be settled after 12 months [(ii)]	1,566	1,319
	2,235	**1,988**
Total Current Employee Benefits and Related On-Costs	**21,249**	**20,244**
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave	2,527	2,801
Provisions related to Employee Benefits On-Costs	313	308
Total Non-Current Employee Benefits and Related On-Costs	**2,840**	**3,109**
Total Employee Benefits and Related On-Costs	**24,089**	**23,353**

[(i)] The amounts disclosed are nominal amounts.

[(ii)] The amounts disclosed are discounted to present values.

Note 3.3 (a) Consolidated Employee Benefits and Related On-Costs

	2022 $'000	2021 $'000
Current Employee Benefits and Related On-Costs		
Unconditional Accrued Days Off	198	183
Unconditional Annual Leave Entitlements	7,911	7,591
Unconditional Long Service Leave Entitlements	13,140	12,470
Total Current Employee Benefits and Related On-Costs	**21,249**	**20,244**
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements	2,840	3,109
Total Non-Current Employee Benefits and Related On-Costs	**2,840**	**3,109**
Total Employee Benefits and Related On-Costs	**24,089**	**23,353**
Attributable to:		
Employee Benefits	21,541	21,057
Provision for Related On-Costs	2,548	2,296
Total Employee Benefits and Related On-Costs	**24,089**	**23,353**

Note 3.3 (b) Provision for Related On-Costs Movement Schedule

	2022 $'000	2021 $'000
Carrying Amount at Start of Year	**2,296**	**2,081**
Additional Provisions Recognised	1,107	930
Amounts Incurred During the Year	(927)	(791)
Net Gain/(Loss) Arising from Revaluation of Long Service Leave Liability	72	76
Carrying Amount at End of Year	**2,548**	**2,296**

How We Recognise Employee Benefits

Employee Benefits Recognition

Employee benefits are accrued for 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.

No provision has been made for sick leave as all sick leave is non-vesting and it is not considered probable that the average sick leave taken in the future will be greater than the benefits accrued in the future. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income as it is taken.

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 hospital does not have an unconditional right to defer settlements of these liabilities.

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

- Nominal value – if the hospital expects to wholly settle within 12 months; or
- Present value – if the hospital does not expect to wholly settle within 12 months.

Long Service Leave

The liability for long service leave (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 hospital 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 hospital expects to wholly settle within 12 months; or
- Present value – if the hospital does not expect to wholly settle within 12 months.

Conditional LSL is measured at present value and 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 eg. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flows.

Provision for On-Costs Related to Employee Benefits

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

Note 3.4: Superannuation

	Contributions Paid for the Year		Contributions Outstanding at Year End	
	2022 $'000	2021 $'000	2022 $'000	2021 $'000
Defined Benefit Plans[(i)]:				
Aware Super	119	138	3	-
Defined Contribution Plans:				
Aware Super	3,890	4,006	98	-
HESTA	2,379	2,116	47	-
Other	799	706	36	-
Total Superannuation	7,187	6,966	184	-

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

How We Recognise Superannuation

Employees of the hospital are entitled to receive superannuation benefits and the hospital contributes to both the defined benefit and defined contribution plans.

Defined Benefit Superannuation Plans

Defined benefit plans provide benefits based on years of service and final average salary. The amount charged to the Comprehensive Operating Statement in respect of defined benefit superannuation plans represents the contributions made by the hospital to the superannuation plans in respect of the services of current hospital 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 hospital does not recognise any unfunded defined benefit liability in respect of the plans because the hospital 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.

DTF discloses the State's defined benefits liabilities in its disclosure for administered items. However superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the Comprehensive Operating Statement of the hospital.

The name, details and amounts that have been expensed in relation to the major employee superannuation funds and contributions made by the hospital are disclosed above.

Defined Contribution Superannuation Plans

In relation to defined contribution (ie. 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.

The name, details and amounts that have been expensed in relation to the major employee superannuation funds and contributions made by the hospital are disclosed above.

Note 4: Key Assets to Support Service Delivery

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

Structure:

4.1 Investments and Other Financial Assets
4.2 Property, Plant and Equipment
4.3 Revaluation Surplus
4.4 Intangible Assets
4.5 Depreciation and Amortisation
4.6 Investment Properties
4.7 Inventories
4.8 Impairment of Assets

Telling the COVID-19 Story

Assets used to support the delivery of our services during the financial year were not materially impacted by the COVID-19 pandemic.

Key Judgements and Estimates

This section contains the following key judgements and estimates:

Key Judgements and Estimates	Description
Estimating useful life of property, plant and equipment	The hospital assigns an estimated useful life to each item of property, plant and equipment. This is used to calculate depreciation of the asset. The health service reviews the useful life and depreciation rates of all assets at the end of each financial year and where necessary, records a change in accounting estimate.
Estimating the useful life of intangible assets	The hospital assigns an estimated useful life to each intangible asset with a finite useful life, which is used to calculate amortisation of the asset.
Identifying indicators of impairment	At the end of each year, the hospital assesses impairment by evaluating the conditions and events specific to the hospital that may be indicative of impairment triggers. Where an indication exists, the hospital tests the asset for impairment. The hospital considers a range of information when performing its assessment, including considering: • if an asset's value has declined more than expected based on normal use • if a significant change in technological, market, economic or legal environment which adversely impacts the way the hospital uses an asset • if an asset is obsolete or damaged • if the asset has become idle or if there are plans to discontinue or dispose of the asset before the end of its useful life • if the performance of the asset is or will be worse than initially expected Where an impairment trigger exists, the hospital applies significant judgement and estimate to determine the recoverable amount of the asset.

Note 4.1: Investments and Other Financial Assets

	2022 $'000	2021 $'000
Current		
Australian Listed Equity Securities	441	141
Total Current	441	141
Non-Current		
Managed Investment Schemes	40,211	45,488
Total Non Current	40,211	45,488
Total Investments and Other Financial Assets *	**40,652**	**45,629**
*** Represented by:**		
Hospital Investments	40,652	45,629
Total Investments and Other Financial Assets	**40,652**	**45,629**

How We Recognise Investments and Other Financial Assets

The hospital's investments and other financial assets are made in accordance with Standing Direction 3.7.2 - Treasury Management, including the Central Banking System.

The hospital manages its investments and other financial assets in accordance with an investment policy approved by the Board.

Investments are recognised when the hospital enters into a contract to either purchase or sell the investment (i.e. when it becomes a party to the contractual provisions to the investment). Investments are initially measured at fair value, net of transaction costs.

The hospital classifies its other financial assets between current and non-current assets based on the Board's intention at balance date with respect to the timing of disposal of each asset.

All financial assets, except those measured at fair value through net result are subject to annual review for impairment.

Note 4.2: Property, Plant and Equipment

Note 4.2 (a) Gross Carrying Amount and Accumulated Depreciation

	2022 $'000	2021 $'000
Land		
Land at Fair Value		
- Crown	10,080	10,080
- Freehold	35,648	35,648
Total Land	**45,728**	**45,728**
Buildings		
Buildings at Fair Value	181,133	166,819
less Accumulated Depreciation	(22,001)	(14,060)
Total Buildings	**159,132**	**152,759**
Plant and Equipment		
Plant and Equipment at Fair Value	6,694	5,486
less Accumulated Depreciation	(4,357)	(3,696)
Total Plant and Equipment	**2,337**	**1,790**
Medical Equipment		
Medical Equipment at Fair Value	24,606	20,874
less Accumulated Depreciation	(14,665)	(13,021)
Total Medical Equipment	**9,941**	**7,853**
Assets Under Construction		
PP&E Assets Under Construction	95,504	78,069
Total Assets Under Construction	**95,504**	**78,069**
Total Property, Plant & Equipment	**312,642**	**286,199**

Note 4.2 (b) Reconciliation of the Carrying Amount by Class of Asset

	Land $'000	Buildings $'000	Plant & Equipment $'000	Medical Equipment $'000	Assets Under Construction $'000	Total $'000
Balance at 1 July 2020	**45,728**	**131,208**	**1,849**	**7,336**	**66,346**	**252,467**
Additions	-	39	485	1,841	40,464	42,829
Assets Written Back and Transferred to Expense	-	-	-	-	(39)	(39)
Net Transfers between Classes	-	28,538	42	138	(28,702)	16
Depreciation (Note 4.4)	-	(7,026)	(586)	(1,462)	-	(9,074)
Balance at 30 June 2021	**45,728**	**152,759**	**1,790**	**7,853**	**78,069**	**286,199**
Additions	-	2	791	2,662	33,375	36,830
Disposals	-	-	-	(15)	-	(15)
Assets Written Back and Transferred to Expense	-	-	-	-	(22)	(22)
Net Transfers between Classes	-	14,312	413	1,193	(15,918)	-
Depreciation (Note 4.4)	-	(7,941)	(657)	(1,752)	-	(10,350)
Balance at 30 June 2022	**45,728**	**159,132**	**2,337**	**9,941**	**95,504**	**312,642**

Land and Buildings Carried at Valuation

The Valuer-General Victoria undertook to re-value all of the hospital owned land and buildings to determine their 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 was 30 June 2019.

How We Recognise Property, Plant and Equipment

Property, plant and equipment are tangible items that are used by the hospital in the supply of goods or services, for rental to others, or for administration purposes, and are expected to be used during more than one financial year.

Initial Recognition

Items of property, plant and equipment are initially measured at cost. Where an asset is acquired for no or nominal cost, being far below the fair value of the asset, the deemed cost is its fair value at the date of acquisition. Assets transferred as part of an amalgamation/machinery of government change are transferred at their carrying amounts.

The cost of constructed non-financial physical assets includes the cost of all materials used in construction, direct labour on the project and an appropriate proportion of variable and fixed overheads.

Subsequent Measurement

Items of property, plant and equipment are subsequently measured at fair value less accumulated depreciation and impairment losses where applicable.

Fair value is determined with reference to the asset's highest and best use (considering legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset).

Further information regarding fair value measurement is disclosed in Note 7.4.

Revaluation

Fair value is based on periodic valuations by independent valuers, which normally occur once every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate a material change in fair value has occurred.

Where an independent valuation has not been undertaken at balance date, the hospital performs a managerial assessment to estimate possible changes in fair value of land and buildings since the date of the last independent valuation with reference to Valuer-General of Victoria (VGV) indices.

An adjustment is recognised if the assessment concludes that the fair value of land and buildings has changed by 10% or more since the last revaluation (whether that be the most recent independent valuation or managerial valuation). Any estimated change in fair value of less than 10% is deemed immaterial to the financial statements and no adjustment is recorded. Where the assessment indicates there has been an exceptionally material movement in the fair value of land and buildings since the last independent valuation, being equal to or in excess of 40%, the hospital would obtain an interim independent valuation prior to the next scheduled independent valuation.

An independent valuation of the hospital's property, plant and equipment was performed by the VGV on 30 June 2019. The valuation, which complies with Australian Valuation Standards, was determined by reference to the amount for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The managerial assessment performed at 30 June 2022 indicated an overall:

- decrease in fair value of land of 3.1% ($1.4 million)
- increase in fair value of buildings of 5.8% ($8.4 million)

As the cumulative movement was less than 10% for land and buildings since the last revaluation a managerial revaluation adjustment was not required as at 30 June 2022.

Revaluation increases (increments) arise when an asset's fair value exceeds its carrying amount. In comparison, revaluation decreases (decrements) arise when an asset's fair value is less than its carrying amount. Revaluation increments and revaluation decrements 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 increments are recognised in 'Other Comprehensive Income' and are credited directly to the asset revaluation reserve, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net result, in which case 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 reserve in respect of the same class of property, plant and equipment. Otherwise, the decrement is recognised as an expense in the net result.

The revaluation reserve included in equity in respect of an item of property, plant and equipment may be transferred directly to retained earnings when the asset is derecognised.

Note 4.3: Revaluation Surplus

	2022 $'000	2021 $'000
Balance at Beginning of Reporting Period	67,428	67,428
Balance at End of the Reporting Period *	**67,428**	**67,428**
* Represented by:		
- Land	42,079	42,079
- Buildings	25,349	25,349
Balance at End of the Reporting Period	**67,428**	**67,428**

Note 4.4: Intangible Assets

Note 4.4 (a) Gross Carrying Amount and Accumulated Amortisation

	2022 $'000	2021 $'000
Computer Software	16,852	16,492
Less Accumulated Amortisation	(9,243)	(8,244)
	7,609	**8,248**
Computer Software - Work in Progress	172	338
Total Intangible Assets	**7,781**	**8,586**

Note 4.4 (b) Reconciliation of the Carrying Amount by Class of Asset

	Computer Software $'000	Computer Software Work in Progress $'000	Total $'000
Balance at 1 July 2020	**2,643**	**2,506**	**5,149**
Additions	4,103	117	4,220
Assets transferred between Classes	2,301	(2,285)	16
Amortisation (Note 4.4)	(799)	-	(799)
Balance at 1 July 2021	**8,248**	**338**	**8,586**
Additions	100	94	194
Assets transferred between Classes	260	(260)	-
Amortisation (Note 4.4)	(999)	-	(999)
Balance at 30 June 2022	**7,609**	**172**	**7,781**

How We Recognise Intangible Assets

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

Initial Recognition

Purchased intangible assets are initially recognised at cost.

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

- the technical feasibility of completing the intangible asset so that it will be available for use or sale;
- an intention to complete the intangible asset and use or sell it;
- the ability to use or sell the intangible asset;
- the intangible asset will generate probable future economic benefits;
- the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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

Subsequent Measurement

Intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses.

Note 4.5: Depreciation and Amortisation

	2022 $'000	2021 $'000
Depreciation		
Buildings	7,941	7,026
Plant and Equipment	657	586
Medical Equipment	1,752	1,462
Total Depreciation	**10,350**	**9,074**
Amortisation		
Computer Software	999	799
Total Depreciation and Amortisation	**11,349**	**9,873**

How We Recognise Depreciation

All infrastructure assets, buildings, plant and equipment and other non-financial physical assets (excluding land and investment properties) that have finite useful lives are depreciated. 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.

How We Recognise Amortisation

Amortisation is the systematic allocation of the depreciable amount of an intangible asset over its useful life.

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

	2022	2021
Buildings		
- Structure Shell Building Fabric	2 to 80 years	2 to 80 years
- Site Engineering Services and Central Plant	2 to 15 years	2 to 15 years
Central Plant		
- Fit Out	2 to 20 years	2 to 20 years
- Trunk Reticulated Building Systems	2 to 30 years	2 to 30 years
Plant & Equipment	3 to 20 years	3 to 20 years
Medical Equipment	3 to 15 years	3 to 15 years
Intangible Assets	2 to 15 years	2 to 15 years

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

Note 4.6: Investment Properties

Note 4.6(a): Gross Carrying Amount

	2022 $'000	2021 $'000
Investment Properties at Fair Value	12,817	13,010
Total Investment Properties at Fair Value	**12,817**	**13,010**

Note 4.6(b) Reconciliations of Carrying Amount

	2022 $'000	2021 $'000
Balance at Beginning of Period	13,010	12,610
Net Gain/(Loss) from Fair Value Adjustments	(193)	400
Balance at End of Period	**12,817**	**13,010**

How We Recognise Investment Properties

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

Initial Recognition

Investment properties are initially recognised at cost. Costs incurred subsequent to initial acquisition are capitalised when it is probable that future economic benefits in excess of the originally assessed performance of the asset will flow to the hospital.

Subsequent Measurement

Subsequent to initial recognition at cost, investment properties are revalued to fair value, determined annually by independent valuers and/or reference to Valuer-General Victoria indices. Fair values are determined based on a market comparable approach that reflects recent transaction prices for similar properties. Investment properties are neither depreciated nor tested for impairment.

For investment properties measured at fair value, the current use of the asset is considered the highest and best use.

The fair value of the hospital's investment properties at 30 June 2019 were arrived at on the basis of an independent valuation carried out by the Valuer-General Victoria. The valuation was determined with reference to market evidence of properties including location, condition and lease terms. The fair value of the hospital's investment properties at 30 June 2022 are based on the 30 June 2019 valuation adjusted by the Valuer-General Victoria land and building indexation factors for the subsequent financial years.

Further information regarding fair value measurement is disclosed in Note 7.4.

Rental revenue from leasing of investment properties is recognised in the comprehensive operating statement in the periods in which it is receivable on a straight line basis over the lease term.

Note 4.7: Inventories

	2022 $'000	2021 $'000
Pharmaceuticals at Cost	291	326
Total Inventories	**291**	**326**

How We Recognise Inventories

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

Note 4.8: Impairment of Assets

How We Recognise Impairment

At the end of each reporting period, the hospital reviews the carrying amount of its tangible and intangible assets that have a finite useful life, to determine whether there is any indication that an asset may be impaired.

The assessment will include consideration of external sources of information and internal sources of information.

External sources of information include but are not limited to observable indications that an asset's value has declined during the period by significantly more than would be expected as a result of the passage of time or normal use. Internal sources of information include but are not limited to evidence of obsolescence or physical damage of an asset and significant changes with an adverse effect the hospital which changes the way in which an asset is used or expected to be used.

If such an indication exists, an impairment test is carried out. Assets with indefinite useful lives (and assets not yet available for use) are tested annually for impairment, in addition to where there is an indication that the asset may be impaired.

When performing an impairment test, the hospital compares the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in net result, unless the asset is carried at a revalued amount.

Where an impairment loss on a revalued asset is identified, this is recognised against the asset revaluation surplus in respect of the same class of asset to the extent that the impairment loss does not exceed the cumulative balance recorded in the asset revaluation surplus for that class of asset.

Where it is not possible to estimate the recoverable amount of an individual asset, the hospital estimates the recoverable amount of the cash-generating unit to which the asset belongs.

The hospital did not record any impairment losses for its tangible and intangible assets that have a finite useful life for the year ended 30 June 2022.

Note 5: Other Assets and Liabilities

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

Structure:

5.1 Receivables and Contract Assets

5.2 Payables and Contract Liabilities

Telling the COVID-19 Story

The measurement of other assets and liabilities were impacted during the financial year which was partially attributable to the COVID-19 pandemic.

The following items were impacted:

- The contractual payable liability for the Department of Health increased due to the level of activity agreed in the Statement of Priorities not be delivered due to reductions in the number of patients being treated at various times throughout the financial year.

Key Judgements and Estimates

This section contains the following key judgements and estimates:

Key Judgements and Estimates	Description
Estimating the provision for expected credit losses	The hospital uses a simplified approach to account for the expected credit loss provision. A provision matrix is used, which considers historical experience, external indicators and forward-looking information to determine expected credit loss rates.
Measuring deferred capital grant income	Where the hospital has received funding to procure or construct an identifiable non-financial asset, such funding is recognised as deferred capital grant income until the underlying asset is procured or constructed. The hospital applies significant judgement when measuring the deferred capital grant income balance, which references the estimated the stage of completion at the end of each financial year.
Measuring contract liabilities	The hospital applies significant judgement to measure its progress towards satisfying a performance obligation as detailed in Note 2. Where a performance obligation is yet to be satisfied, the hospital assigns funds to the outstanding obligation and records this as a contract liability until the promised good or service is transferred to the customer.

Note 5.1: Receivables and Contract Assets

	Note	2022 $'000	2021 $'000
Current			
Contractual			
Inter Hospital Debtors		61	968
Trade Debtors		797	891
Patient Fees		393	215
Allowance for Impairment Losses	5.1 (a)	(71)	(81)
Contract Assets	5.1 (b)	585	295
Total Current Contractual Receivables		**1,765**	**2,288**
Statutory			
GST Receivable		615	449
Total Current Statutory Receivables		**615**	**449**
Total Current Receivables and Contract Assets		**2,380**	**2,737**
Non-Current			
Contractual			
Long Service Leave - Department of Health		5,287	4,515
Total Non-Current Receivables and Contract Assets		**5,287**	**4,515**
Total Receivables and Contract Assets		**7,667**	**7,252**

	Note	2022 $'000	2021 $'000
Total Receivables and Contract Assets		7,667	7,252
GST Receivable		(615)	(449)
Total Financial Assets	7.1 (a)	**7,052**	**6,803**

Note 5.1 (a) Movement in Allowance for Impairment of Contractual Receivables

	2022 $'000	2021 $'000
Balance at Beginning of Year	81	136
Increase in Allowance	77	55
Amounts Written Off During the Year	(34)	(29)
Reversal of Allowance Written Off During Year as Uncollectable	(53)	(81)
Balance at End of Year	**71**	**81**

How We Recognise Receivables

Receivables consist of:

- **Contractual Receivables:** Mostly includes debtors in relation to goods and services. These receivables are classified as financial instruments and categorised as 'financial assets at amortised cost'. They are initially recognised at fair value plus any directly attributable transaction costs. The hospital holds the contractual receivables with the objective to collect the contractual cash flows and therefore they are subsequently measured at amortised cost using the effective interest method, less any impairment.

- **Statutory Receivables:** Includes Goods and Services Tax (GST) input tax credits that are 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 hospital 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 hospital 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 Note 7.2 (a) for the hospital's contractual impairment losses.

Note 5.1 (b) Contract Assets

	2022 $'000	2021 $'000
Balance at Beginning of Year	295	110
Add: Additional Costs Incurred Recoverable from Customer	585	295
Less: Transfer to Trade Receivable or Cash at Bank	(295)	(110)
Total Contract Assets *	**585**	**295**
*** Represented by:**		
- Current Contract Assets	585	295
Total Contract Assets	**585**	**295**

How We Recognise Contract Assets

Contract assets relate to the hospital's right to consideration in exchange for goods transferred to customers for works completed, but not yet billed at the reporting date. The contract assets are transferred to receivables when the rights become unconditional, at this time an invoice is issued. Contract assets are expected to be recovered early in the following financial year.

Note 5.2: Payables and Contract Liabilities

	Notes	2022 $'000	2021 $'000
Current			
Contractual			
Trade Creditors		744	165
Accrued Expenses		3,663	3,151
Accrued Salaries and Wages		2,145	1,746
Department of Health		15,344	9,744
Superannuation		184	-
Deferred Capital Grant Revenue	5.2 (a)	172	98
Contract Liabilities	5.2 (b)	354	29
Total Current Contractual Payables		**22,606**	**14,933**
Total Current Payables and Contract Liabilities		**22,606**	**14,933**
Total Payables and Contract Liabilities		**22,606**	**14,933**

	Note	2022 $'000	2021 $'000
Total Payables and Contract Liabilities		22,606	14,933
Deferred Capital Grant Revenue		(172)	(98)
Contract Liabilities		(354)	(29)
Total Financial Liabilities	7.1 (a)	**22,080**	**14,806**

How We Recognise Payables and Contract Liabilities

Payables consist of:

- **Contractual Payables:** Mostly includes payables in relation to goods and services. These payables are classified as financial instruments and measured at amortised cost. Accounts payable and salaries and wages payable represent liabilities for goods and services provided to the hospital prior to the end of the financial year that are unpaid.

- **Statutory Payables:** Includes Goods and Services Tax (GST) payable. Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

The normal credit terms for accounts payable are 30 days from the end of month of invoice.

Note 5.2 (a) Deferred Capital Grant Revenue

	2022 $'000	2021 $'000
Opening Balance of Deferred Capital Grant Revenue	98	98
Grant Consideration for Capital Works Received During the Year	26,321	35,173
Grant Revenue for Capital Works Recognised During the Year	(26,247)	(35,173)
Closing Balance of Deferred Capital Grant Revenue	**172**	**98**

How We Recognise Deferred Capital Grant Revenue

Grant consideration was received from the Department of Health for various projects including the redevelopment of the hospital building and for the procurement of equipment, technology and infrastructure replacement. Capital grant revenue is recognised progressively as the asset is constructed or procured, since this is the time when the hospital satisfies its obligations. The progressive percentage of costs incurred is used to recognise revenue because this most closely reflects the percentage of completion of the works or procurement. As a result, the hospital has deferred recognition of a portion of the grant consideration received as a liability for the outstanding obligations.

The hospital expects to recognise all of the remaining deferred capital grant revenue for capital works during the following financial year.

Note 5.2 (b) Contract Liabilities

	2022 $'000	2021 $'000
Opening Balance of Contract Liabilities	29	26
Payments Received for Performance Obligations Not Yet Fulfilled	354	29
Revenue Recognised for Completion of Performance Obligations	(29)	(26)
Total Contract Liabilities *	**354**	**29**
*** Represented by:**		
- Current Contract Liabilities	354	29
Total Contract Liabilities	**354**	**29**

How We Recognise Contract Liabilities

Contract liabilities include consideration received in advance from customers in respect of property rental, provision of education services and provision of patient services.

Contract liabilities are derecognised and recorded as revenue when promised goods and services are transferred to the customer (refer to Note 2.1).

Maturity Analysis of Payables

Refer Note 7.2 (b) for the ageing analysis of payables.

Note 6: Operational Financing

This section provides information on the sources of finance utilised by the hospital during its operations, along with other information related to financing activities of the hospital.

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

Structure:

6.1 Borrowings

6.2 Cash and Cash Equivalents

6.3 Commitments for Expenditure

Telling the COVID-19 Story

Our finance and borrowing arrangements were not materially impacted by the COVID-19 pandemic.

Key Judgements and Estimates

This section contains the following key judgements and estimates:

Key Judgements and Estimates	Description
Determining if a contract is or contains a lease	The hospital applies significant judgement to determine if a contract is or contains a lease by considering if the hospital: • has the right-to-use an identified asset • has the right to obtain substantially all economic benefits from the use of the leased asset • can decide how and for what purpose the asset is used throughout the lease
Determining if a lease meets the short-term or low value asset lease exemption	The hospital applies significant judgement when determining if a lease meets the short-term or low value lease exemption criteria. The hospital estimates the fair value of leased assets when new. Where the estimated fair value is less than $10,000, the hospital applies the low-value lease exemption. The hospital also estimates the lease term with reference to remaining lease term and period that the lease remains enforceable. Where the enforceable lease period is less than 12 months the hospital applies the short-term lease exemption.

Note 6.1: Borrowings

	2022 $'000	2021 $'000
Current		
Department of Health Loan [(i)]	1,736	1,736
Total Current Borrowings	**1,736**	**1,736**
Non-Current		
Department of Health Loan [(i)]	3,262	5,200
Total Non-Current Borrowings	**3,262**	**5,200**
Total Borrowings	**4,998**	**6,936**

[(i)] Unsecured loan which bears no interest.

How We Recognise Borrowings

Borrowings refer to interesting bearing liabilities mainly raised from advances from the Treasury Corporation of Victoria (TCV) and other funds raised through lease liabilities, service concession arrangements and other interest-bearing arrangements.

Initial Recognition

All borrowings are initially recognised at fair value of the consideration received, less directly attributable transaction costs. The measurement basis subsequent to initial recognition depends on whether the hospital has categorised its liability as either 'financial liabilities designated at fair value through profit or loss' or financial liabilities at 'amortised cost'.

Subsequent Measurement

Subsequent to initial recognition, interest bearing borrowings are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in the net result over the period of the borrowing using the effective interest method. Non-interest bearing borrowings are measured at 'fair value through net result'.

Maturity Analysis of Borrowings

Refer Note 7.2 (b) for the ageing analysis of Borrowings.

Note 6.2: Cash and Cash Equivalents

	2022 $'000	2021 $'000
Cash on Hand	2	3
Cash at Bank	114	77
Cash at Bank - Centralised Banking System (CBS)	26,800	26,221
Total Cash and Cash Equivalents	**26,916**	**26,301**

How We Recognise Cash and Cash Equivalents

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

Note 6.3: Commitments for Expenditure

	2022 $'000	2021 $'000
Capital Expenditure Commitments:		
Not Later Than One Year	2,274	13,679
Total Capital Expenditure Commitments	**2,274**	**13,679**
Operating Expenditure Commitments:		
Not Later Than One Year	14,906	8,824
Later Than One Year and Not Later Than Five Years	5,754	5,217
Later Than Five Years	-	60
Total Operating Expenditure Commitments	**20,660**	**14,101**
Total Commitments for Expenditure (inclusive of GST)	**22,934**	**27,780**
less GST Recoverable from the Australian Tax Office	(2,085)	(1,565)
Total Commitments for Expenditure (exclusive of GST)	**20,849**	**26,215**

How We Disclose Commitments

Our commitments relate to expenditure.

Expenditure Commitments

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

Capital expenditure commitments for 2021 include contributions to the hospital building redevelopment project that were payable to the Department of Health that were not subject to GST.

Note 7: Risks, Contingencies and Valuation Uncertainties

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

Structure:

7.1 Financial Instruments

7.2 Financial Risk Management Objectives and Policies

7.3 Contingent Assets and Contingent Liabilities

7.4 Fair Value Determination

Key Judgements and Estimates

This section contains the following key judgements and estimates:

Key Judgements and Estimates	Description
Measuring fair value of non-financial assets	Fair value is measured with reference to highest and best use, that is, the use of the asset by a market participant that is physically possible, legally permissible, financially feasible, and which results in the highest value, or to sell it to another market participant that would use the same asset in its highest and best use. In determining the highest and best use, the hospital has assumed the current use is its highest and best use. Accordingly, characteristics of the hospital's assets are considered, including condition, location and any restrictions on the use and disposal of such assets. The hospital uses a range of valuation techniques to estimate fair value, which include the following: • Market approach, which uses prices and other relevant information generated by market transactions involving identical or comparable assets and liabilities. The fair value of the hospital's specialised land, non-specialised land, non-specialised buildings and investment properties are measured using this approach. • Cost approach, which reflects the amount that would be required to replace the service capacity of the asset (referred to as current replacement cost). The fair value of the hospital's specialised buildings, plant and equipment, medical equipment and assets under construction are measured using this approach. The hospital selects a valuation technique which is considered most appropriate, and for which there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs. Subsequently, the hospital applies significant judgement to categorise and disclose such assets within a fair value hierarchy, which includes: • Level 1, using quoted prices (unadjusted) in active markets for identical assets that the hospital can access at measurement date. The hospital does not categorise any fair values within this level. • Level 2, inputs other than quoted prices included within Level 1 that are observable for the asset, either directly or indirectly. The hospital categorises non-specialised land and non-specialised buildings in this level. • Level 3, where inputs are unobservable. The hospital categorises specialised land, specialised buildings, plant and equipment, medical equipment and assets under construction in this level.

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 the hospital's activities, certain financial assets and financial liabilities arise under statute rather than a contract (eg. taxes). Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation.*

Note 7.1 (a) Categorisation of Financial Instruments

	Note	Financial Assets at Amortised Cost	Financial Assets at Fair Value through Net Result	Financial Liabilities at Amortised Cost	Total
		$'000	$'000	$'000	$'000
30 June 2022					
Contractual Financial Assets					
Cash and Cash Equivalents	6.2	26,916	-	-	26,916
Receivables and Contract Assets	5.1	7,052	-	-	7,052
Investments and Other Financial Assets	4.1	-	40,652	-	40,652
Total Financial Assets [(i)]		**33,968**	**40,652**	**-**	**74,620**
Financial Liabilities					
Payables	5.2	-	-	22,080	22,080
Borrowings	6.1	-	-	4,998	4,998
Total Financial Liabilities [(i)]		**-**	**-**	**27,078**	**27,078**
30 June 2021					
Contractual Financial Assets					
Cash and Cash Equivalents	6.2	26,301	-	-	26,301
Receivables and Contract Assets	5.1	6,803	-	-	6,803
Investments and Other Financial Assets	4.1		45,629	-	45,629
Total Financial Assets [(i)]		**33,104**	**45,629**	**-**	**78,733**
Financial Liabilities					
Payables	5.2	-	-	14,806	14,806
Borrowings	6.1	-	-	6,936	6,936
Total Financial Liabilities [(ii)]		**-**	**-**	**21,742**	**21,742**

[(i)] The carrying amount excludes deferred capital grant revenue and contract liabilities.

[(ii)] The carrying amount excludes statutory receivables (ie. GST receivable).

How We Categorise Financial Instruments

Categories of Financial Assets:

Financial assets are recognised when the hospital becomes party to the contractual provisions to the instrument. For financial assets, this is at the date the hospital commits itself to either the purchase or sale of the asset (i.e. trade date accounting is adopted).

Financial instruments (except for trade receivables) are initially measured at fair value plus transaction costs, except where the instrument is classified at fair value through net result, in which case transaction costs are expensed to profit or loss immediately.

Where available, quoted prices in an active market are used to determine the fair value. In other circumstances, valuation techniques are adopted.

Trade receivables are initially measured at the transaction price if the trade receivables do not contain a significant financing component or if the practical expedient was applied as specified in AASB 15 para 63.

Financial Assets at Amortised Cost

Financial assets are measured at amortised cost 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 hospital soley to collect the contractual cash flows, and
- The assets' contractual terms give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding on specific dates.

These assets are initially recognised at fair value plus any directly attributable transaction costs and are subsequently measured at amortised cost using the effective interest method less any impairment.

The hospital recognises the following assets in this category:

- Cash and cash equivalents; and
- Receivables (excluding statutory receivables).

Financial Assets at Fair Value through Net Result

The hospital initially designates a financial instrument as measured at fair value through net result if:

- It eliminates or significantly reduces a measurement or recognition inconsistency (often referred to as an "accounting mismatch") that would otherwise arise from measuring assets or recognising the gains and losses on them, on a different basis;
- It is in accordance with the documented risk management or investment strategy and information about the groupings was documented appropriately, so the performance of the financial asset can be managed and evaluated consistently on a fair value basis; or
- It is a hybrid contract that contains an embedded derivative that significantly modifies the cash flows otherwise required by the contract.

The initial designation of the financial instruments to measure at fair value through net result is a one-time option on initial classification and is irrevocable until the financial asset is derecognised.

The hospital recognises listed equity securities as mandatorily measured at fair value through net result and has designated all of its managed investment schemes as fair value through net result.

Categories of Financial Liabilities:

Financial liabilities are recognised when the hospital becomes a party to the contractual provisions to the instrument. Financial instruments are initially measured at fair value plus transaction costs, except where the instrument is classified at fair value through profit or loss, in which case transaction costs are expensed to profit or loss immediately.

Financial Liabilities at Amortised Cost

Financial liabilities are measured at amortised cost using the effective interest method, where they are not held at fair value through net result.

The effective interest method is a method of calculating the amortised cost of a debt instrument and of allocating interest expense in net result over the relevant period. The effective interest is the internal rate of return of the financial asset or liability. That is, it is the rate that exactly discounts the estimated future cash flows through the expected life of the instrument to the net carrying amount at initial recognition.

The hospital recognises the following liabilities in this category:

- Payables (excluding statutory payables and contract liabilities); and
- Borrowings.

Offsetting Financial Instruments

Financial instrument assets and liabilities are offset and the net amount presented in the consolidated balance sheet when, and only when, the hospital has a legal right to offset the amounts and intend either to settle on a net basis or to realise the asset and settle the liability simultaneously.

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

Derecognition of Financial Liabilities

A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified, such an exchange or modification is treated as a derecognition of the original liability and the recognition of a new liability. The difference in the respective carrying amounts is recognised as an 'other economic flow' in the comprehensive operating statement.

Reclassification of Financial Instruments

A financial asset is required to be reclassified between amortised cost, fair value through net result and fair value through other comprehensive income when, and only when, the hospital's business model for managing its financial assets has changed such that its previous model would no longer apply.

A financial liability reclassification is not permitted.

Note 7.2: Financial Risk Management Objectives and Policies

As a whole, the hospital's financial risk management program seeks to manage the risks and the associated volatility of its financial performance.

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

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

The hospital uses different methods to measure and manage the different risks to which it is exposed. Primary responsibility for the identification and management of financial risks rests with the Chief Finance and Accounting Officer.

Note 7.2 (a) Credit Risk

Credit risk refers to the possibility that a borrower will default on its financial obligations as and when they fall due. The hospital's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to the hospital. Credit risk is measured at fair value and is monitored on a regular basis.

Credit risk associated with the hospital's contractual financial assets is minimal because the main debtor is the Victorian Government. For debtors other than the Government, the hospital is exposed to credit risk associated with patient and other debtors.

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

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

Contract financial assets are written off against the carrying amount when there is no reasonable expectation of recovery. Bad debt written off by mutual consent is classified as a transaction expense. Bad debt written off following a unilateral decision is recognised as other economic flows in the net result.

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

There has been no material change to the hospital's credit risk profile in 2021-22.

Impairment of Financial Assets Under AASB 9

The hospital records the allowance for expected credit loss for the relevant financial instruments applying AASB 9's Expected Credit Loss approach. Subject to AASB 9, impairment assessment includes the hospital's contractual receivables.

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.

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.

Contractual Receivables at Amortised Cost

The hospital applies AASB 9's 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 hospital has grouped contractual receivables on shared credit risk characteristics and days past due and select the expected credit loss rate based on the hospital's past history, existing market conditions, as well as forward looking estimates at the end of the financial year.

On this basis, the hospital determines the closing loss allowance at the end of the financial year as follows:

	Note	Current	Less than 1 Month	1 to 3 Months	3 Months to 1 Year	1 to 5 Years	Total
30 June 2022							
Expected Loss Rate		1.0%	14.9%	23.5%	38.0%	100.0%	
Gross Carrying Amount of Contractual Receivables ($'000)	5.1	1,651	70	19	91	5	1,836
Loss Allowance		**(17)**	**(10)**	**(4)**	**(35)**	**(5)**	**(71)**
30 June 2021							
Expected Loss Rate		1.4%	14.0%	53.5%	65.5%	100.0%	
Gross Carrying Amount of Contractual Receivables ($'000)	5.1	2,244	61	10	53	1	2,369
Loss Allowance		**(32)**	**(9)**	**(5)**	**(35)**	**(1)**	**(81)**

Statutory Receivables

The hospital'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.

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. As a result, no loss allowance has been recognised.

Note 7.2 (b) Liquidity Risk

Liquidity risk arises from being unable to meet financial obligations as they fall due.

The hospital is exposed to liquidity risk mainly through the financial liabilities as disclosed in the face of the balance sheet.

The hospital manages its liquidity risk by:

- Close monitoring of its short-term and long-term borrowings by senior management, including monthly reviews on current and future borrowing levels and requirements:
- Maintaining an adequate level of uncommitted funds that can be drawn at short notice to meet its short-term obligations;
- Holding investments and other contractual financial assets that are readily tradeable in the financial markets; and
- Careful maturity planning of its financial obligations based on forecasts of future cash flows.

The hospital's exposure to liquidity risk is deemed insignificant based on prior periods' data and current assessment of risk. Cash for unexpected events is generally sourced from liquidation of investments and other financial assets.

The following table discloses the contractual maturity analysis for the hospital's financial liabilities.

	Note	Carrying Amount	Nominal Amount	Maturity Dates			
				Less than 1 Month	1 to 3 Months	3 months to 1 Year	1-5 Years
		$'000	$'000	$'000	$'000	$'000	$'000
30 June 2022							
Financial Liabilities [(i)]							
At Amortised Cost							
Payables	5.2	22,080	22,080	6,736	-	15,344	-
Borrowings	6.1	4,998	4,998	-	-	1,736	3,262
Total Financial Liabilities		**27,078**	**27,078**	**6,736**	**-**	**17,080**	**3,262**
30 June 2021							
Financial Liabilities [(i)]							
At Amortised Cost							
Payables	5.2	14,806	14,806	5,062	-	9,744	-
Borrowings	6.1	6,936	6,936	-	-	1,736	5,200
Total Financial Liabilities		**21,742**	**21,742**	**5,062**	**-**	**11,480**	**5,200**

[(i)] Ageing analysis of financial liabilities excludes deferred capital grant revenue and contract liabilities.

Note 7.2 (c) Market Risk

The hospital's exposures to market risk are primarily through interest rate risk, foreign currency risk and equity price risk. Objectives, policies and processes used to manage each of these risks are disclosed below.

Sensitivity Disclosure Analysis and Assumptions

The hospital's sensitivity to market risk is determined based on the observed range of actual historical data for the preceding five-year period. The hospital's fund managers cannot be expected to predict movements in market rates and prices. The following movements are 'reasonably possible' over the next 12 months:

- A change in interest rates of 3% up or down; and
- A change in the top ASX 200 index of 15% up or down.

Interest Rate Risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate because of changes in market interest rates. The hospital does not hold any interest-bearing financial instruments that are measured at fair value, and therefore has no exposure to fair value interest rate risk.

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

Foreign Currency Risk

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

The hospital has minimal exposure to foreign currency risk.

Equity Risk

The hospital is exposed to equity price risk through its investments in listed shares and managed investment schemes. Such investments are allocated and traded to match the hospital's investment objectives.

The hospital's sensitivity to equity price risk is set out below.

	Carrying Amount	-15% Net Result	+15% Net Result
30 June 2022			
Contractual Financial Assets			
Investments and Other Contractual Financial Assets	40,652	(6,098)	6,098
Total Impact		**(6,098)**	**6,098**
30 June 2021			
Contractual Financial Assets			
Investments and Other Contractual Financial Assets	45,629	(6,844)	6,844
Total Impact		**(6,844)**	**6,844**

Note 7.3: Contingent Assets and Contingent Liabilities

How We Measure and Disclose Contingent Assets and Contingent Liabilities

Contingent assets and contingent liabilities are not recognised in the balance sheet but are disclosed and, if quantifiable, are measured at nominal value.

Contingent assets and liabilities are presented inclusive of GST receivable or payable respectively.

Contingent Assets

Contingent assets are possible assets that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the hospital.

These are classified as either quantifiable, where the potential economic benefit is known, or non-quantifiable.

Contingent Liabilities

Contingent liabilities are:

- Possible obligations that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the hospital; or
- Present obligations that arise from past events but are not recognised because:
  - It is not probable that an outflow of resources embodying economic benefits will be required to settle the obligations; or
  - The amount of the obligations cannot be measured with sufficient reliability.

Contingent liabilities are also classified as either quantifiable or non-quantifiable.

The hospital has Nil contingent assets or contingent liabilities at 30 June 2022. (30 June 2021: Nil).

Note 7.4: Fair Value Determination

How We Measure Fair Value

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

The following assets and liabilities are carried at fair value:

- Financial assets and liabilities at fair value through net result
- Property, plant and equipment
- Investment properties

In addition, the fair value of other assets and liabilities that are carried at amortised cost, also need to be determined for disclosure.

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.

The hospital 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. There have been no transfers between levels during the period.

The hospital monitors changes in the fair value of each asset and liability through relevant data sources to determine whether revaluation is required. The Valuer-General Victoria (VGV) is the hospital's independent valuation agency for property, plant and equipment.

Identifying Unobservable Inputs (Level 3) Fair Value Measurement

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, ie. 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.

Note 7.4 (a) Fair Value Determination of Investments and Other Financial Assets

	Note	Carrying Amount as at 30 June 2022 $'000	Fair Value Measurement at End of Reporting Period using:		
			Level 1 [(i)] $'000	Level 2 [(i)] $'000	Level 3 [(i)] $'000
Australian Listed Equity Securities		441	441	-	-
Managed Investment Schemes		40,211	-	40,211	-
Total Financial Assets Held at Fair Value Through Net Result	4.1	**40,652**	**441**	**40,211**	**-**
Total Investments and Other Financial Assets at Fair Value		**40,652**	**441**	**40,211**	**-**

	Note	Carrying Amount as at 30 June 2021 $'000	Fair Value Measurement at End of Reporting Period using:		
			Level 1 [(i)] $'000	Level 2 [(i)] $'000	Level 3 [(i)] $'000
Australian Listed Equity Securities		141	141	-	-
Managed Investment Schemes		45,488	-	45,488	-
Total Financial Assets Held at Fair Value Through Net Result	4.1	**45,629**	**141**	**45,488**	**-**
Total Investments and Other Financial Assets at Fair Value		**45,629**	**141**	**45,488**	**-**

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

How We Measure Fair Value of Investments and Other Financial Assets

Australian Listed Equity Securities

Australian Listed Equity Securities are valued at fair value with reference to a quoted (unadjusted) market price from an active market.

The hospital classifies these instruments as Level 1.

Managed Investment Schemes

The hospital invests in managed funds, which are not quoted in an active market and which may be subject to restrictions on redemptions.

The hospital considers the valuation techniques and inputs used in valuing these funds as part of its due diligence prior to investment, to ensure they are reasonable and appropriate. The net asset value of these funds is used as an input into measuring their fair value, and is adjusted as necessary, to reflect restrictions and redemptions, future commitments and other specific factors of the fund.

The hospital classifies these funds as Level 2.

Note 7.4 (b) Fair Value Determination of Non-Financial Physical Assets

	Note	Carrying Amount as at 30 June 2022 $'000	Fair Value Measurement at End of Reporting Period using: Level 1 [(i)] $'000	Level 2 [(i)] $'000	Level 3 [(i)] $'000
Land					
Non-Specialised Land at Fair Value		4,880	-	4,880	-
Specialised Land at Fair Value		40,848	-	-	40,848
Total Land at Fair Value	4.2 (a)	**45,728**	**-**	**4,880**	**40,848**
Buildings					
Non-Specialised Buildings at Fair Value		3,191	-	3,191	-
Specialised Buildings at Fair Value		155,941	-	-	155,941
Total Buildings at Fair Value	4.2 (a)	**159,132**	**-**	**3,191**	**155,941**
Plant and Equipment					
Plant and Equipment at Fair Value	4.2 (a)	2,337	-	-	2,337
Medical Equipment					
Medical Equipment at Fair Value	4.2 (a)	9,941	-	-	9,941
Assets Under Construction					
Assets Under Construction at Fair Value	4.2 (a)	95,504	-	-	95,504
Total Non-Financial Physical Assets at Fair Value		**312,642**	**-**	**8,071**	**304,571**

	Note	Carrying Amount as at 30 June 2021 $'000	Fair Value Measurement at End of Reporting Period using: Level 1 [(i)] $'000	Level 2 [(i)] $'000	Level 3 [(i)] $'000
Land					
Non-Specialised Land at Fair Value		4,880	-	4,880	-
Specialised Land at Fair Value		40,848	-	-	40,848
Total Land at Fair Value	4.2 (a)	**45,728**	**-**	**4,880**	**40,848**
Buildings					
Non-Specialised Buildings at Fair Value		3,290	-	3,290	-
Specialised Buildings at Fair Value		149,469	-	-	149,469
Total Buildings at Fair Value	4.2 (a)	**152,759**	**-**	**3,290**	**149,469**
Plant and Equipment					
Plant and Equipment at Fair Value	4.2 (a)	1,790	-	-	1,790
Medical Equipment					
Medical Equipment at Fair Value	4.2 (a)	7,853	-	-	7,853
Assets Under Construction					
Assets Under Construction at Fair Value	4.2 (a)	78,069	-	-	78,069
Total Non-Financial Physical Assets at Fair Value		**286,199**	**-**	**8,170**	**278,029**

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

How We Measure Fair Value of Non-Financial Physical Assets

The fair value measurement of non-financial physical assets takes into account the market participant's ability to use the asset in its highest and best use, or to sell it to another market participant that would use the same asset in its highest and best use.

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 accordance with AASB 13 Fair Value Measurement paragraph 29, the hospital has assumed the current use of a non-financial physical asset is its highest and best use unless market or other factors suggest that a different use by market participants would maximise the value 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.

Non-Specialised Land, Non-Specialised Buildings and Investment Properties

Non-specialised land, non-specialised buildings and investment properties 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, non-specialised buildings and investment properties an independent valuation was performed by the Valuer-General Victoria to determine the fair value using the market approach. Valuation of the assets was determined by analysing comparable sales and allowing for share, size, topography, location and other relevant factors specific to the asset being valued. An appropriate rate per square metre has been applied to the subject asset. The effective date of the valuation is 30 June 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 hospital 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 also used for specialised land although it is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued. Specialised assets contain significant, unobservable adjustments; therefore these assets are classified as Level 3 under the market based direct comparison approach.

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

For the hospital, 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 hospital's specialised land and specialised buildings was performed by the Valuer-General Victoria. The effective date of the valuation is 30 June 2019.

Plant and Equipment

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

There were no changes in valuation techniques throughout the period to 30 June 2022.

Fair Value Determination of Level 3 Fair Value Measurement

Asset Class	Likely Valuation Approach	Significant Inputs (Level 3 only)
Non-Specialised Land	Market approach	N/A
Specialised Land (Crown / Freehold)	Market approach	Community Service Obligations adjustments (20%) [(i)]
Non-Specialised Buildings	Market approach	N/A
Specialised Buildings	Depreciated replacement cost approach	Cost per square metre Useful life
Plant and Equipment	Depreciated replacement cost approach	Cost per square metre Useful life

[(i)] A community service obligation (CSO) of 20% was applied to the hospital's specialised land.

Reconciliation of Level 3 Fair Value Measurement

	Land	Buildings	Plant and Equipment	Medical Equipment	Assets Under Construction	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2020	40,848	127,818	1,849	7,336	66,346	244,197
Additions/(Disposals)	-	39	485	1,841	40,464	42,829
Net Transfers Between Classes	-	28,538	42	138	(28,702)	16
Gains/(Losses) Recognised in Net Result						
- Depreciation	-	(6,926)	(586)	(1,462)	-	(8,974)
- Assets Written Back and Transferred to Expense	-	-	-	-	(39)	(39)
Balance at 30 June 2021	**40,848**	**149,469**	**1,790**	**7,853**	**78,069**	**278,029**
Additions/(Disposals)	-	2	791	2,647	33,375	36,815
Net Transfers Between Classes	-	14,312	413	1,193	(15,918)	-
Gains/(Losses) Recognised in Net Result						
- Depreciation	-	(7,842)	(657)	(1,752)	-	(10,251)
- Assets Written Back and Transferred to Expense	-	-	-	-	(22)	(22)
Balance at 30 June 2022	**40,848**	**155,941**	**2,337**	**9,941**	**95,504**	**304,571**

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 Flow from Operating Activities
8.2 Responsible Persons
8.3 Remuneration of Executives
8.4 Related Parties
8.5 Remuneration of Auditors
8.6 Ex-gratia Payments
8.7 Events Occurring After the Balance Sheet Date
8.8 Equity
8.9 Economic Dependency

Telling the COVID-19 Story

Our other disclosures were not materially impacted by the COVID-19 pandemic.

Note 8.1: Reconciliation of Net Result for the Year to Net Cash Flow from Operating Activities

	Note	2022 $'000	2021 $'000
Net Result for the Year	OS	15,220	33,212
Non-Cash Movements:			
Depreciation of Non-Current Assets	4.5	10,350	9,074
Amortisation of Non-Current Assets	4.5	999	799
(Gain)/Loss on Revaluation of Investment Property	4.6	193	(400)
Net (Gain)/Loss on Financial Instruments at Fair Value	3.2	5,333	(3,591)
Discount Interest on Loan	3.1	(201)	56
Loss Allowance for Receivables	5.1	(10)	(55)
Non-Cash DH Government Grants		(18,962)	(30,404)
Assets and Services Received Free of Charge		(356)	(140)
Movements Included in Investing and Financing Activities:			
Net (Gain)/Loss on Disposal of Non-Financial Assets	3.2	2	(12)
Capital Donations and Bequests Received	2.1 (b)	(1,868)	(935)
Movements in Assets and Liabilities:			
Change in Operating Assets and Liabilities:			
(Increase)/Decrease in Receivables and Contract Assets	5.1	(407)	(1,227)
(Increase)/Decrease in Prepaid Expenses	5.3	(228)	(6)
(Increase)/Decrease in Inventories	4.7	35	45
Increase/(Decrease) in Payables and Contract Liabilities	5.2	7,672	9,892
Increase/(Decrease) in Employee Benefits	3.3	737	2,026
Net Cash Inflow / (Outflow) from Operating Activities		**18,509**	**18,334**

Note 8.2: Responsible Persons

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
Relevant Minister:	
The Honourable Martin Foley, Minister for Health	1 Jul 2021 - 27 Jun 2022
The Honourable Mary-Anne Thomas, Minister for Health	27 Jun 2022 - 30 Jun 2022
Governing Board:	
Mr David Anderson	1 Jul 2021 - 30 Jun 2022
Mr Simon Brewin	1 Jul 2021 - 30 Jun 2022
Dr Sherene Devanesen	1 Jul 2021 - 30 Jun 2022
Ms Jane Hider	1 Jul 2021 - 30 Jun 2022
Ms Linda Hornsey	1 Jul 2021 - 30 Jun 2022
Professor Alan Lilly	1 Jul 2021 - 30 Jun 2022
Mr Bruce Mildenhall	1 Jul 2021 - 30 Jun 2022
Ms Llewellyn Prain	1 Jul 2021 - 30 Jun 2022
Mr Bruce Ryan	1 Jul 2021 - 30 Jun 2022
Accountable Officer:	
Mr Brendon Gardner	1 Jul 2021 - 30 Jun 2022

Remuneration of Responsible Persons

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

Income Band	2022 Number	2021 Number
$20,000 - $29,999	8	8
$60,000 - $69,999	1	1
$340,000 - $349,999	-	1
$350,000 - $359,999	1	-
Total Numbers	**10**	**10**

	2022 $'000	2021 $'000
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**635**	**629**

Amounts relating to Responsible Ministers are reported within the State's Annual Financial Report.

Note 8.3: Remuneration of Executives

The number of executive officers, other than Ministers and the Accountable Officer, 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 of Executives (including Key Management Personnel disclosed in Note 8.4)	2022 $'000	2021 $'000
Short Term Employee Benefits	1,138	1,222
Post-Employment Benefits	101	97
Other Long-Term Benefits	25	29
Total Remuneration [(i)]	**1,264**	**1,348**
Total Number of Executives	7	7
Total Annualised Employee Equivalent [(ii)]	4.34	4.80

[(i)] The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the hospital under AASB 124 Related Party Disclosures and are also reported within Note 8.4.
[(ii)] Annualised Employee Equivalent is based on working 38 ordinary hours per week 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 (such as superannuation guarantee contributions) 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.

Note 8.4: Related Parties

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

- All Key Management Personnel (KMP) and their close family members and personal business interests;
- Cabinet ministers (where applicable) and their close family members; and
- All health services and public sector entities that are controlled and consolidated into the whole of state consolidated financial statements.

Key Management Personnel (KMP)

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of the hospital, directly or indirectly.

The Board of Directors and the Executive Directors of the hospital are deemed to be KMPs.

Key Management Personnel of hospital:

- Dr Sherene Devanesen, Chair Board of Directors
- Mr David Anderson, Non-Executive Director
- Mr Simon Brewin, Non-Executive Director
- Ms Jane Hider, Non-Executive Director
- Ms Linda Hornsey, Non-Executive Director
- Professor Alan Lilly, Non-Executive Director
- Mr Bruce Mildenhall, Non-Executive Director
- Ms Llewellyn Prain, Non-Executive Director
- Mr Bruce Ryan, Non-Executive Director
- Mr Brendon Gardner, Chief Executive Officer and Accountable Officer
- Dr Sean Jespersen, Executive Director Medical Services and Chief Medical Officer (1 July 2021 to 29 May 2022)
- Dr Birinder Giddey, Executive Director Medical Services and Chief Medical Officer (30 May 2022 to 30 June 2022)
- Ms Tracy Siggins, Executive Director Chief Operating Officer and Chief Nursing Officer (Interim 1 July to 9 August 2021)
- Ms Jane Poxon, Executive Director Chief Operating Officer and Chief Nursing Officer (10 August 2021 to 30 June 2022)
- Mr Ian Leong, Executive Director Redevelopment, Planning and Infrastructure (1 July 2021 to 4 February 2022)
- Mr Danny Mennuni, Executive Director Finance and Corporate Services and Chief Finance and Accounting Officer
- Ms Loretta Sheales, Executive Director People and Communications

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 State's Annual Financial Report.

Compensation - Key Management Personnel	**2022 $'000**	**2021 $'000**
Short Term Employee Benefits	1,716	1,797
Post-Employment Benefits	150	143
Other Long-Term Benefits	33	37
Total Compensation [(i)]	**1,899**	**1,977**

[(i)] KMPs are also reported in Note 8.2 Responsible Persons or Note 8.3 Remuneration of Executives.

Significant Transactions with Government Related Entities

The hospital received funding from the Department of Health of $117.0 million (2021: $108.4 million) and indirect contributions of $20.0 million (2021: $31.0 million).

Expenses incurred by the hospital in delivering services and outputs are in accordance with HealthShare 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 the Victorian Managed Insurance Authority.

The Standing Directions under the *Financial Management Act 1994* require the hospital to hold cash (in excess of working capital) in accordance with the State of Victoria's centralised banking arrangements. All borrowings are required to be sourced from Treasury Corporation Victorian unless an exemption has been approved by the Minister for Health and the Treasurer.

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, eg. 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 HealthShare Victoria and Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with the hospital, there were no related party transactions that involved key management personnel, their close family members or their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2022 (2021: none).

There were no related party transactions required to be disclosed for the hospital Board of Directors, Chief Executive Officer and Executive Directors in 2022 (2021: none).

Note 8.5: Remuneration of Auditors

	2022 $'000	2021 $'000
Victorian Auditor-General's Office		
Audit of Financial Statements	48	48
Total Remuneration of Auditors	**48**	**48**

Note 8.6: Ex-Gratia Expenses

The hospital made Nil ex-gratia payments for the year ending 30 June 2022. (The year ending 30 June 2021: Nil.)

Note 8.7: Events Occurring After the Balance Sheet Date

There are no events occurring after the Balance Sheet date.

Note 8.8: Equity

Contributed Capital

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 hospital.

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.

Specific Restricted Purpose Reserves

The specific restricted purpose reserve is established where the hospital has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds received.

Note 8.9: Economic Dependency

The hospital is dependent on the Department of Health for the majority of its revenue used to operate the hospital. At the date of this report, the Board of Directors has no reason to believe the Department of Health will not continue to support the hospital.

Affiliations and Memberships

The Royal Victorian Eye and Ear Hospital is affiliated with:

Australian College of Optometry
Bionic Vision Technologies
Bionics Institute
Centre for Eye Research Australia
HEARnet
Lions Eye Donation Service Melbourne
The University of Melbourne
Victorian Aboriginal Health Service (VAHS)

The Royal Victorian Eye and Ear Hospital is a member of:

World Association of Eye Hospitals
Members: Aier Eye Hospital Group (China); Emory Eye Center (Atlanta, USA); Eye and ENT Hospital Fudan University (Shanghai, China); Fondation Asile des Aveugles (Lausanne, Switzerland); Hoftalon Eye Hospital (Londrina, Brasil); Ispahani Islamia Eye Institute and Hospital (Bangladesh, India); Jakarta Eye Center (Jakarta, Indonesia); Kellogg Eye Center (Ann Arbor, USA); Kim's Eye Hospital (Seoul, South Korea); King Khaled Eye Specialist Hospital (Riyadh, Saudi Arabia); Magrabi Eye Hospital (Saudi Arabia); Massachusetts Eye and Ear Infirmary (Massachusetts, USA); Moorfields Eye Hospital (London, UK); New York Eye and Ear Infirmary (New York, USA); Orenburg branch of S. Fyodorov Eye Microsurgery Federal State Institution (Orenburg, Russia) 2020; Phillips Eye Institute (Minneapolis, USA); Rutnin Eye Hospital (Bangkok, Thailand); Singapore National Eye Centre (Singapore); St. Erik Eye Hospital (Stockholm, Sweden); St. John of Jerusalem Eye Hospital (Jerusalem, Israel); Sydney Eye Hospital (Sydney, Australia); The Beijing TONGREN Hospital (Beijing, China); The Metta Eye Hospital (Mettapracharak (Wat Rai Khing) Hospital) (Bangkok – Thailand); The Niteroi Eye Hospital (Rio de Janeiro, Brasil); The Rotterdam Eye Hospital (Rotterdam, The Netherlands); The Royal Victoria Eye and Ear Hospital (Dublin, Ireland); The Xi'an Eye Hospital (Xi'an, China); Tianjin Medical University Eye Hospital (Tianjin, China);Tun Hussein Onn National Eye Hospital (Kuala Lumpur, Malaysia); Turin Ophthalmic Hospital (Turin, Italy); UCSF Eye Health (San Francisco, USA); Wills Eye Hospital (Philadelphia, USA); Wilmer Eye Institute at Johns Hopkins (Baltimore, USA).

American Association of Eye and Ear Centers of Excellence

Members: Bascom Palmer Eye Institute (Florida, USA); Emory Eye Center (Georgia, USA); The University of California, San Francisco Medical Center (San Francisco, USA); Massachusetts Eye and Ear Infirmary (Massachusetts, USA); Moorfields Eye Hospital (London, UK); Wills Eye Hospital (Philadelphia, USA); Phillips Eye Institute (Minnesota, USA); Rutnin Eye Hospital (Bangkok, Thailand); Singapore National Eye Centre (Singapore); St. Erik's Eye Hospital (Stockholm, Sweden); Wilmer Eye Institute at Johns Hopkins (Baltimore, USA).

Victorian Healthcare Association

Melbourne Academic Centre for Health

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