The Royal Melbourne Hospital

Annual Report

2024-2025

Advancing health for everyone, every day

About this report

This annual report outlines the operational and financial performance for the Royal Melbourne Hospital (RMH) from 1 July 2024 to 30 June 2025.

The relevant Ministers for the reporting period were:

Minister for Health and Minister for Ambulance Services

The Hon. Mary-Anne Thomas

1 July 2024 to 30 June 2025

Minister for Health Infrastructure

The Hon. Mary-Anne Thomas

1 July 2024 to 19 December 2024

The Hon. Melissa Horne

19 December 2024 to 30 June 2025

Minister for Mental Health and Minister for Ageing

The Hon. Ingrid Stitt

1 July 2024 to 30 June 2025

Minister for Disability

The Hon. Lizzie Blandthorn

1 July 2024 to 30 June 2025

Melbourne Health (operating as the Royal Melbourne Hospital) is a health service established under the Health Services Act 1988 (Victoria). This report is also available online at thermh.org.au

About the cover

The 2024–25 Annual Report cover features Dr William Wilson, cardiologist and Director of Structural Intervention at the RMH, who led Australia's first implantation of the minimally invasive Venus P-Valve - a landmark procedure that's transforming care for patients with congenital heart disease.

The RMH acknowledges the Kulin nations as the Traditional Custodians of the land on which our services are located. We are committed to improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

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Report from the Chair and Chief Executive

We are delighted to present the Royal Melbourne Hospital's 2024-25 Annual Report on behalf of the Board of Directors and Executive Team.

This past year has been one of significant purpose, progress and partnership. Across every area of our hospital – from the Emergency Department to our research initiatives – our people have supported patient care, spearheaded innovation, led exciting research and delivered exceptional services that improved the lives of patients across Victoria.

Excellence in clinical care

Our clinical teams continue to deliver some of the most complex care in the state. As one of two adult major trauma services in Victoria, and a centre for world-leading stroke, cardiac and infectious diseases care, we look after some of the highest acuity and challenging conditions. The last 12 months saw some impressive milestones.

We celebrated the launch of the second life-saving Mobile Stroke Unit (MSU), together with our partners including Ambulance Victoria. The broader service provides critical care to patients across Melbourne suspected of having a stroke, right at their doorstep. The new MSU doubled both the resourcing and radius of help to include Melbourne's southeast and included a higher-tech CT scanner, larger space and virtual neurologist based at the RMH.

Advancing health for everyone, every day

We opened the Colonial Foundation Diagnostic Centre, a research centre dedicated to finding more answers to inflammatory disease and collaborated with our partners on the Melbourne Clinical Trials Centre, giving more Victorians early access to the next generation of treatment. The Parkville Local Health Services Network (LHSN) was formed, and the precinct readied itself to welcome more organisations to our network from 1 July 2025, further strengthening the care we can collectively provide to the community.

Our promise to 'Build for the future' moved another step forward, with plans to decant and demolish the old Materials Handling Building well underway. Stage one – the design phase – is almost complete, mapping out the relocation of key teams such as Mental Health, Facilities Management, Capital Development, and Engineering, as well as essential services like Waste and Supply. The design also covers the complex work needed to untangle the RMH from the building's critical infrastructure – from power and water to oxygen and fire systems. A procurement process is underway to appoint who will carry out the initial

construction activities, followed by the decant and demolition work. It is expected construction will commence early 2026. Demolition of the Materials Handling Building is scheduled for mid-2027 – however these timelines are still being finalised via the builder procurement process.

We held the inaugural RMH Research Conference, which brought together brilliant minds from across our hospital and wider network to discuss big ideas, make connections and hear from one another.

Further, we continued our commitment to advance healthcare for everyone, every day by strengthening care, investing in research and prioritising innovation through projects such as upgrading systems and automation.

Our people remain at the heart of this organisation who ensured it was another record year for our services:

93,000+

Emergency Department (ED) presentations

9,946

planned surgeries

2500+

trauma patients treated.

Collaborating for the future

Collaboration remains at the core of the RMH and this financial year we further invested in research partnerships and landmark trials across some of the most pressing areas of medical science.

In partnership with the Walter and Eliza Hall Institute (WEHI) and the Colonial Foundation, we proudly launched the Colonial Foundation Diagnostic Centre. This initiative is unlocking new ways to diagnose and treat inflammatory diseases by building our understanding of these illnesses at a cellular level. These breakthroughs have the potential to completely shift how we approach chronic and complex conditions, such as rheumatoid arthritis, inflammatory bowel disease, multiple sclerosis and lupus.

We also marked the first full year of the Snow Centre for Immune Health, established through a $100 million commitment from Snow Medical. This long-term collaboration is giving our clinicians, together with WEHI's scientists, the time, space and resources to ask bold questions and explore immune-related disease in new ways, setting the stage for breakthroughs that will improve lives around the world. We appointed the first PhD students, and a renowned UK scientist Dr Paul Lyons joined as the centre's Consulting Chief Scientist. This incredible work was further showcased at the centre's inaugural Annual Conference in March 2025, which platformed the progress, early challenges and road map for the future.

In September 2024 the RMH joined the 10-year anniversary celebrations of one of our most successful collaborations: the Peter Doherty Institute for Infection and Immunity, a joint venture between the RMH and University of Melbourne. This milestone was a fantastic opportunity to reflect on the life-changing work the RMH has been a part of, including throughout the COVID-19 pandemic.

And we continue to work with our partners on world-leading research and initiatives. Last year, we were proud to join our peers at Barwon Health in launching a trial with the aim to better treat the Buruli ulcer – a debilitating mosquito-borne disease which has spread across Victoria in recent years. The trial, which uses a new antibiotic, is the first of its kind and could cut both the treatment timeframe and number of antibiotics required in half.

Operational excellence in action

In 2024-25, we made meaningful improvements in how we deliver care – streamlining services and embedding technology and automation to help improve patient flow. Our Digital Coordination Centre (DCC) continues to make access to care and patent flow easier and more efficient.

Our digital innovations are also supporting more of our patients receive the care they need, when and where they need it. Our RMH@Home team, together with data specialists, developed a digital tool called the hospital-in-the home (HITH) eligibility identifier (HEI) to support clinical decision making and streamline the identification process. This tool is embedded within the RMH's electronic medical record (EMR) and helps identify potential patients for HITH services, to maximise acute home-based care and the number of patients referred to HITH. Outcomes included an increase in the number of patients treated within HITH, improvements in timeliness of referrals plus a reduced length of stay and positive consumer feedback.

We have also launched a new digital Emergency Department (ED) wait-time dashboard on the RMH website, which shows the anticipated time non-emergency and less urgent patients may expect to wait between being assessed by the triage nurse and being treated by a doctor. Our ED is one of the busiest in the country, and we are seeing an average of 260 to 300-plus patients every day - this dashboard will be available 24/7 and will give those patients who need our care an indication of the level of demand we are experiencing in our ED.

We focussed on improving ambulance handover and wait times, in support of the release of new Department of Health Standards for Safe and Timely Ambulance and Emergency Care for Victorians. We improved the number of patients transferred from ambulance to the ED within 40 minutes by over 10% this year and in the last three months of the financial year exceeded the state target of 80%. This isn't just a performance measure – it is about dignity, access, and clinical safety for every person who arrives at our doors – and it is a credit to the tireless work of our incredible people.

We also established our first Community Engagement Strategy, which aims to build a strong, inclusive community and make healthcare equitable and accessible for everyone. We also proudly launched the RMH's second Reconciliation Action Plan (RAP): Innovate. This plan marks another significant step in our ongoing commitment to Reconciliation with First Nations peoples.

As one of the largest health services in Victoria, we have a responsibility and an opportunity to play a leading role in closing the healthcare gap between First Nations and non-Indigenous Australians.

A culture to be proud of

Perhaps most inspiring this year has been the cultural growth across our teams. In a period where health services continue to experience high demand, our people have shown extraordinary resilience, kindness and teamwork.

We saw this reflected in our People Matter Survey results, which showed strong employee engagement and significant improvements across key areas including psychological safety and team connection. The successful rollout of the RMH-designed and delivered Active Bystander training added to this culture by empowering staff to intervene when witnessing inappropriate behaviour, particularly microaggressions affecting transgender and gender diverse staff, people with disability and First Nations employees. More than 1,200 staff have acquired a set of meaningful new skills using this framework to create a safer, more inclusive workplace.

> This is a testament to the leadership across the organisation, and to every team member who has contributed to making the RMH a safer, more inclusive and supportive place to work.

Looking ahead

We would like to take a moment to acknowledge the RMH Board and Executive for their leadership over the past 12 months and extend a special thank you to outgoing Board members Eugene Arocca, Greg Tweedly and Professor Jane Gunn AO for their incredible service and dedication over many years. We also thank the Department of Health for their ongoing support and willingness to work together.

We remain focused on delivering outstanding care to the Victorian community through advancing research, life-saving care and fostering a culture where every person – patient, visitor or staff member – feels welcome and supported to receive care.

To our incredible staff, thank you for your commitment and care. To our partners and community, thank you for standing with us. And to every patient who places their trust in our people – thank you.

Together, we are proud to continue to advance health for everyone, every day.

Linda Bardo Nicholls AO
Board Chair

Professor Shelley Dolan
Chief Executive

Responsible body's declaration

In accordance with the *Financial Management Act 1994*, I am pleased to present the report of operations for Melbourne Health for the year ending 30 June 2025.

Linda Bardo Nicholls AO
Board Chair
Melbourne
29 August 2025

About the Royal Melbourne Hospital

The Royal Melbourne Hospital (RMH) began in 1848 as Victoria's first public hospital. While we only had 10 beds to our name, we had the community of Melbourne behind us, and we were ready to provide the best possible care for those in need.

Since those early years, we have moved forward with purpose. Always at the forefront, leading the way on improving the quality of life for all.

Today the RMH is one of the largest health providers in the state, providing a comprehensive range of services.

Our care extends across the whole of Victoria from the Parkville hospital campus through Royal Park and mental health services across the inner north-west suburbs of Melbourne. We are a designated state-wide provider for services including trauma and stroke, and we lead centres of excellence in several key specialties including neurosciences, nephrology, oncology, cardiology, endocrine and virtual health. As a leading teaching hospital, the RMH cultivates the next generation of healthcare professionals from education institutions across Victoria and around the world.

We are constantly striving to improve care and quality of life through research, translating discoveries into real-world health solutions for our patients. We are surrounded by a precinct of brilliant thinkers and are constantly collaborating to set new benchmarks in health excellence – benchmarks that impact across the globe. This includes the world-renowned Peter Doherty Institute for Infection and Immunity, our joint venture with the University of Melbourne. We also have strong relationships with the WEHI, The Florey and our health service partners across the precinct.

Our more than 11,000 people embody who we are and what we stand for. Our reputation for caring for all Victorians is essential. We are here when it matters most, and we will continue to be the first to speak out for the wellbeing of our diverse community.

Our purpose

Advancing healthcare for everyone, every day

Our community promise

Always there when it matters most

Our values

People First.

Lead with Kindness.

Excellence Together.

The RMH site locations

1. The RMH Parkville, Parkville
2. The RMH Royal Park, Parkville
3. Waratah Community Health Service, Moonee Ponds
4. The RMH Elizabeth St, Melbourne
5. Boyne Russell House, Brunswick
6. Cyril Jewell House, Keilor East
7. The RMH Coburg Dialysis Centre, Coburg
8. The RMH Essendon Fields Dialysis Centre, Essendon Fields
9. Norfolk Terrace Community Care Unit, Flemington
10. Arion Prevention and Recovery Care, Travancore
11. Homeless Outreach Mental Health Support (at Cohealth Central City), Melbourne

Board of Directors

The Board is comprised of independent non-executive directors and a chair. The Directors are elected for a term of up to three years and may be re-elected to serve for up to nine years. The Board is accountable to the Minister for Health.

The Directors for FY 2024-25 were:

Mrs Linda Bardo Nicholls AO – Chair
Appointed May 2018

Mr Eugene Arocca
Appointed July 2016

Ms Kylie Bishop
Appointed July 2021

Ms Philippa Connolly
Appointed July 2018

Mr Peter Funder
Appointed July 2019

Professor Jane Gunn AO
Appointed February 2021

Mr Sam Lobley
Appointed July 2021

Professor Mary O'Reilly
Appointed October 2023

Ms Emma Skinner
Appointed July 2021

Mr Gregory Tweedly
Appointed July 2016

Board Committees

The Board has established committees, advisory committees and advocacy committees, which are also attended by members of the RMH Executive.

The Board Chair is an ex-officio of each committee.

Audit Committee

Board members:

Mr Sam Lobley (Chair)

Mr Peter Funder

Ms Emma Skinner

Frequency of meetings:
Quarterly

Community Advisory Committee

Board members:

Professor Mary O'Reilly (Chair)

Mr Gregory Tweedly

Frequency of meetings:
Bi-monthly

Finance Committee

Board members:

Ms Emma Skinner (Chair)

Ms Kylie Bishop

Mr Peter Funder

Ms Philippa Connolly

Mr Gregory Tweedly

Frequency of meetings:
Bi-monthly

People, Culture and Remuneration Committee

Board members:

Ms Kylie Bishop (Chair)

Mr Eugene Arocca

Ms Phillippa Connolly

Frequency of meetings:
Quarterly

Quality Committee

Board members:

Mr Greg Tweedly (Chair)

Mr Eugene Arocca

Mr Sam Lobley

Professor Mary O'Reilly

Frequency of meetings:
Bi-monthly

Redevelopment Committee

Board members:

Mr Peter Funder (Chair)

Ms Phillippa Connolly

Frequency of meetings:
As required

The RMH Foundation Committee

Board members:

Mr Eugene Arocca (Chair)

Mr Peter Funder

Ms Kylie Bishop

Frequency of meetings:
Quarterly

Membership of other committees

The WEHI Audit, Risk and Compliance Committee, the Ethical Practice and Integrity Committee, and the Master planning subcommittee are attended by Ms Phillipa Connolly.

The West Metro Health Service Partnership Joint Board Chair and CEO Committee is attended by Mrs Linda Bardo Nicholls AO.

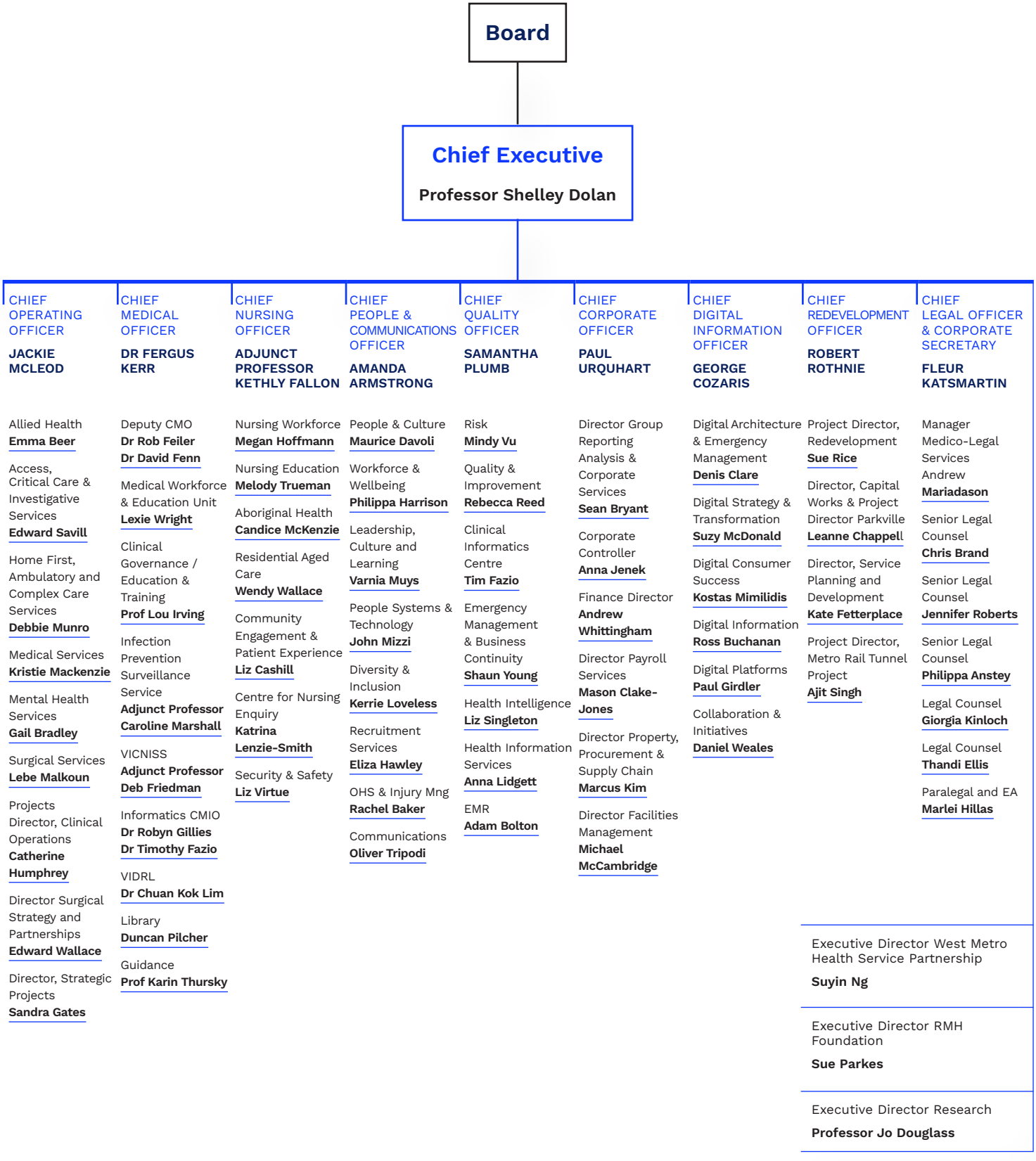
The Parkville LHSN Joint Board Chair and CEO Committee is attended by Mrs Linda Bardo Nicholls AO.

The Parkville Primary Care and Population Health Committee is attended by Mr Gregory Tweedly.

The WEHI Board is attended by Ms Phillipa Connolly and Professor Shelley Dolan.

The RMH organisation structure

As of 30 June 2025



Our care at a glance

130,399

Inpatient admissions (non-mental health)

2,094

Mental health inpatient admissions

93,643

Emergency Department presentations

461

Arrivals by air

2503

Trauma patients treated

11,297

Emergency surgeries

16,967

Planned surgeries performed at the RMH (including surgeries and procedures in the endoscopy and cardiology departments)

353

Public-in-private planned surgeries

141

Kidney transplants

242,112

Specialist clinic (outpatient) appointments (including 86,949 telehealth appointments)

4,479

Hospital-in-the-home care episodes

253,306

Mental health service contacts in the community

Year in review

The RMH is working across six strategic pillars to advance health for everyone, every day. Here are some of the highlights from the past financial year.

A great place to work and a great place to receive care

- The 2024 People Matter Survey results showed that 80% of staff would recommend the RMH as a great place to work, reflecting our ongoing investment in leadership development, wellbeing initiatives, and support.
- In December 2024, the RMH joined the Hidden Disabilities Sunflower Program, a global initiative to support individuals with invisible disabilities in accessing care and services with dignity.
- The RMH has also launched its first Community Engagement Strategy, focusing on cultural safety, mutual trust, and accessible communication. The strategy strengthens partnerships with diverse communities, involving consumers in co-design to ensure healthcare is respectful, inclusive and responsive to their needs.
- The RMH continued our Reconciliation journey in 2024-25, delivering a range of initiatives to strengthen cultural safety and support for First Nations staff and patients. These have included the launch of the RMH's second Reconciliation Action Plan, our Innovate RAP; the expansion of the First Nations Health Unit team with new roles, including our inaugural First Nations Workforce Coordinator, two Clinical Nurse Support Officers, and a Bioethicist, Indigenous Health Practice, Education and Research, and; partnering with ABSTARR Consulting to develop an Anti-Racism and Cultural Safety Framework that builds on existing work to create a culturally safe, racism-free environment across all RMH sites.
- The RMH and our people continue to deliver breakthroughs in surgery. This year our people successfully performed the first Australian implantation of the Venus P-Valve, a minimally invasive, transcatheter pulmonary valve that avoids the need for open heart surgery and improves patient recovery.
- The RMH and the Peter MacCallum Cancer Centre's Professor Karin Thursky and Professor Monica Slavin were awarded National Health and Medical Research Council (NHMRC) Grants totalling $6m to advance care and treatment for patients.
- In August 2024, the RMH Department of Neurology and Stroke was certified as a Comprehensive Stroke Centre by the Australian Stroke Coalition (ASC). Neurology and Ward 8B were recognised for their high standard of stroke care, reflecting the ASC's strict certification criteria which includes treating stroke patients on a single dedicated ward, providing specialist staffing, regular training, data monitoring and improvement, and patient involvement in decision making.

> The RMH joined the Hidden Disabilities Sunflower Program, a global initiative to support individuals with invisible disabilities in accessing care and services with dignity.

Grow our Home First approach

- In 2024-25, RMH@Home delivered more than 4,400 hospital-in-the-home (HITH) episodes, helping more patients receive safe, high-quality care at home.
- A new digital tool – the Hospital-in-the-Home (HITH) Eligibility Identifier – developed by the RMH@Home and informatics teams, has supported growth and accessibility of the RMH@Home service. Embedded in the EMR, the tool scans real-time patient data to identify those most likely to benefit from home-based care, streamlining referrals and reducing variation in clinical decision-making. Since implementation, HITH occupancy has increased from 89% to 96%, average hospital stays have shortened by 1.5 days, and referrals are timelier. The tool has been embedded into routine workflows without additional staff, and 100% of surveyed patients said they felt safe and would recommend the service.
- The Victorian Palliative Care Advice Service (PCAS), by the RMH in partnership with the Peter MacCallum Cancer Centre, continues to provide timely specialist advice that helps avoid unnecessary hospital admissions and supports palliative care patients and their carers across Victoria. Over 2024-25 PCAS managed nearly 1400 contacts, supporting paramedics and residential aged care to reduce unnecessary hospital transfers and connect people to local services.

> In 2024-25, the RMH delivered more than **4,400** hospital-in-the-home episodes.

Realise the potential of the Melbourne Biomedical Precinct

- The RMH continues to embrace collaboration to improve the experiences and opportunities for staff and patients. In 2024-25 the RMH leaders worked with network partners on the formation of the Parkville Local Health Service Network. This new network presents an exciting and innovative opportunity to work more closely with our Parkville precinct colleagues and further advance the health of our community.
- In March, to celebrate International Women's Day, the RMH joined with its Parkville precinct colleagues for the inaugural Gender Equity in Healthcare Series. The RMH's key event, the Symposium for Gender and Health, brought together experts in health and research to bring an intersectional lens to incisive discussions around opportunities and barriers for women to achieve equitable outcomes. The RMH's inaugural 'Our Future, Together' scholarships were awarded at the symposium to Assistant Accountant Devi Nankoo, Staff Specialist Anaesthetist Dr Earlene Silvapulle, Ward Clerk Madison Walker, Critical Care Registered Nurse Lana Wyatt, and Clinical Assistant Mark Moran.
- Fifty staff took part in the Melbourne Way Leadership program, which is a highly regarded and collaborative training program delivered through the Melbourne Business School at the University of Melbourne.
- A collaborative study between the RMH and WEHI is using advanced mass spectrometry to develop a non-invasive urine test to detect early markers of kidney rejection, potentially reducing the need for invasive biopsies.

- Other collaborations and partnerships launched in 2024-25 include:
  - the inaugural RMH Research Conference, which brought together more than 160 attendees to celebrate the work of RMH researchers and partners from across the Melbourne Biomedical Precinct. Almost 60 staff presented abstract posters, and speakers from a wide range of disciplines shared innovations in clinical care and research. Collaborators included the University of Melbourne, the Doherty Institute, WEHI, and fellow precinct hospitals Peter MacCallum Cancer Centre, the Royal Women's Hospital, and the Royal Children's Hospital;
  - the launch of the second life-saving Mobile Stroke Unit (MSU), delivered in partnership with Ambulance Victoria. The expanded service provides critical care to patients across Melbourne suspected of having a stroke, at their doorstep with the new MSU doubling both the resourcing and radius of help to include Melbourne's southeast. The second vehicle has a higher-tech CT scanner, larger space and virtual neurologist based at the RMH.
  - the Melbourne Centre for Clinical Trails, a consortium of clinical trial and methodology groups that will deliver high-quality clinical trials holistically, while retaining individuality and existing business operations;
  - the Colonial Foundation Diagnostics Centre, a collaboration between the RMH, WEHI and the Colonial Foundation combining research, clinical care and cutting-edge technologies to give patients living with chronic inflammatory diseases a more accurate, and quicker, picture of their diagnosis and treatment options;
  - in September 2024 the RMH joined the 10th anniversary celebrations of the Peter Doherty Institute for Infection and Immunity, a joint venture between the RMH and University of Melbourne;
  - the Academy for Health Leadership, a partnership with the University of Melbourne's Faculty of Medicine, Dentistry and Health Sciences and Melbourne Business School, aims to strengthen leadership, innovation and talent across the health sector.

Become a digital health service

- The RMH's Advanced Kidney Care Clinic introduced PerEmpo™, a digital tool that captures patients' values and goals to guide shared decision-making. It has supported treatment choices, eased care transitions and improved end-of-life planning for patients with chronic kidney disease. Staff training in values-based care has improved communication and patient engagement. This approach is now expanding to dialysis units and other specialties like Neurology and Respiratory Medicine.
- The DCC – a co-located multidisciplinary team who analyse real-time data to improve access and flow across the RMH – has continued to mature since its establishment in August 2023. In July 2024, the DCC introduced a flexible bed model, allowing the team to adjust capacity depending on demand, which has delivered direct and indirect workforce cost savings and enables staff to access ad-hoc annual leave to support wellbeing. A Progression of Care Navigator team has also been centralised within the DCC which has helped support and improve access and flow.
- In June 2025, the RMH launched an ED wait-time dashboard on its website. The tool helps patients make informed decisions about what to expect when to seek care by displaying estimated wait times and information about how EDs work. The dashboard supports transparency, safety and patient-centred care.
- In October 2024, the RMH introduced a new workflow in the EMR to help staff proactively identify and respond to patients displaying behaviours of concern. This early-warning functionality supports a safer hospital environment for patients, visitors and staff alike by promoting timely, consistent responses across care teams.
- In late 2024, the RMH formalised a partnership with ANDHealth, Australia's leading organisation for digital health commercialisation. This collaboration provides independent, expert advice to help our teams assess, trial, and adopt new and emerging digital health technologies. Together, we aim to validate and scale innovations that enhance outcomes and experiences for both patients and staff.

Strive for sustainability

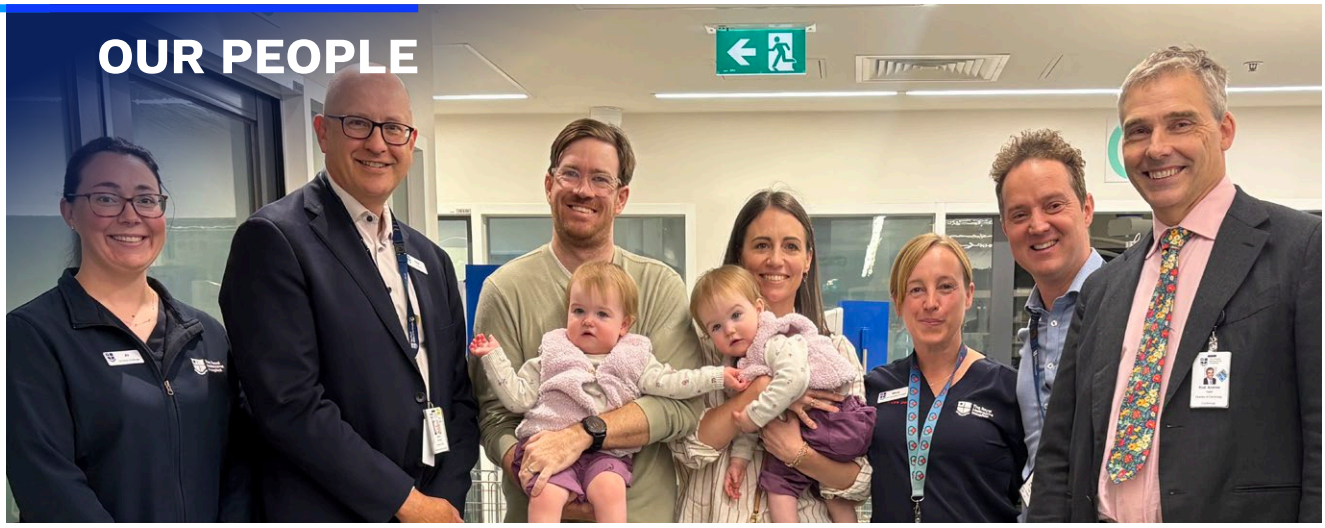
- Improvements to our General Medicine service have addressed rising inpatient demand, long length of stay (LOS), and fragmented patient flow. A three-pronged model of care redesign - including geographical co-location, seven-day model of care, and virtual follow-up service - resulted in a sustainable and replicable model of value-based care. Outcomes included a 2.02-day average LOS reduction (2024-25 year to date), significant decrease in outliers and a more connected, values-based care experience.
- The RMH Intensive Care Unit worked with Infection Prevention and Surveillance Service (IPSS) to change its practices on the use and disposal of aprons and gloves to reduce waste. The impact of the changes was estimated to reduce annual CO_2 emissions by approximately 50,800 kg and divert around 60,600 aprons and 345,000 gloves from landfill or clinical waste streams. The initiative delivered over $27,000 in savings during the first three months and later won the Best Emissions Reduction Award at the University of Melbourne's Health Service Environmental Sustainability Competition.
- Building on this work, the RMH IPSS launched a 'Gloves Off!' project targeting the reduction of unnecessary non-sterile glove use across four pilot wards with plans to expand hospital wide. Non-sterile gloves are often worn when not required, contributing to around 3 tonnes of glove waste and an estimated 10,500 kg CO_2 footprint annually at the RMH - the equivalent of several round trips between New York and London.
- The RMH's staff-led Sustainability Competition - a collaborative project co-led by the RMH, the University of Melbourne, Peter MacCallum Cancer Centre and the Royal Women's Hospital - was shortlisted for a 2024 Victorian Public Healthcare Award. The initiative empowered teams across the organisation to lead their own local sustainability projects, generating 47 ideas and practical actions focused on reducing emissions, waste and unnecessary resource use.

The competition also strengthened staff engagement and ownership of sustainability goals, with several ideas already being adopted at scale.

Build for the future

- After more than 20 years on site, the RMH courtyard portables were dismantled in September 2024. The work marks an early milestone in the hospital's 2024-25 redevelopment efforts, with the site being cleared for a new waste and logistics hub to support waste processing, recycling and food dehydration across the Parkville precinct.
- The Guaranteeing Future Energy Supply (GFES) project progressed significantly, ensuring electrical resilience following the retirement of the long-serving cogeneration plant. GFES delivers a new high-voltage backup feed from CitiPower and three emergency generators.
- The GFES works and dismantling of the courtyard portables also enable the next major milestone: the decant and demolition of the Materials Handling Building (MHB). Design planning of the MHB demolition is almost complete, covering service diversions and relocation of impacted teams. The RMH continues to work with the Victorian Health Building Authority as we move into the delivery phase of this significant project.

> The launch of the second life-saving Mobile Stroke Unit, delivered in partnership with Ambulance Victoria, doubles resourcing and coverage, providing doorstep critical care with a higher-tech CT scanner, larger space, and virtual neurologist support based at the RMH.



Mum of twins reunited with healthcare heroes who saved her life

A Melbourne Mum whose heart stopped pumping properly just hours after she gave birth to twin girls was reunited with the team of hospital heroes who saved her life.

Former patient Alex Judd visited the RMH to say thank you to the teams who saved her life.

Alex Judd thanks her lucky stars for the care she received in May 2024 - a day that was both the happiest and scariest of her and husband Tim's lives.

Just hours after their twin daughters were born safely via Caesarean section at Frances Perry House, Alex's heart started struggling to pump blood.

She had suffered a rare condition known as Takotsubo cardiomyopathy - or 'broken heart' syndrome.

Alex was rushed across an interconnecting bridge to the RMH's Intensive Care Unit, where she was intubated and given a life-saving treatment known as ECMO.

The special machine is an advanced form of life support that takes over the function of the heart and lungs.

It kept her alive for six days while highly trained teams from the RMH worked together to provide the complex, world-class care she needed to make a full recovery.

The family couldn't be more grateful for the care they received - visiting the RMH a year on to say "thank you".

"We came to the hospital to have twin girls... and ended up here in the ICU," Alex recalled.

"How do you ever thank someone that they saved your wife's life and all of your kids still have their mother?" Tim said.

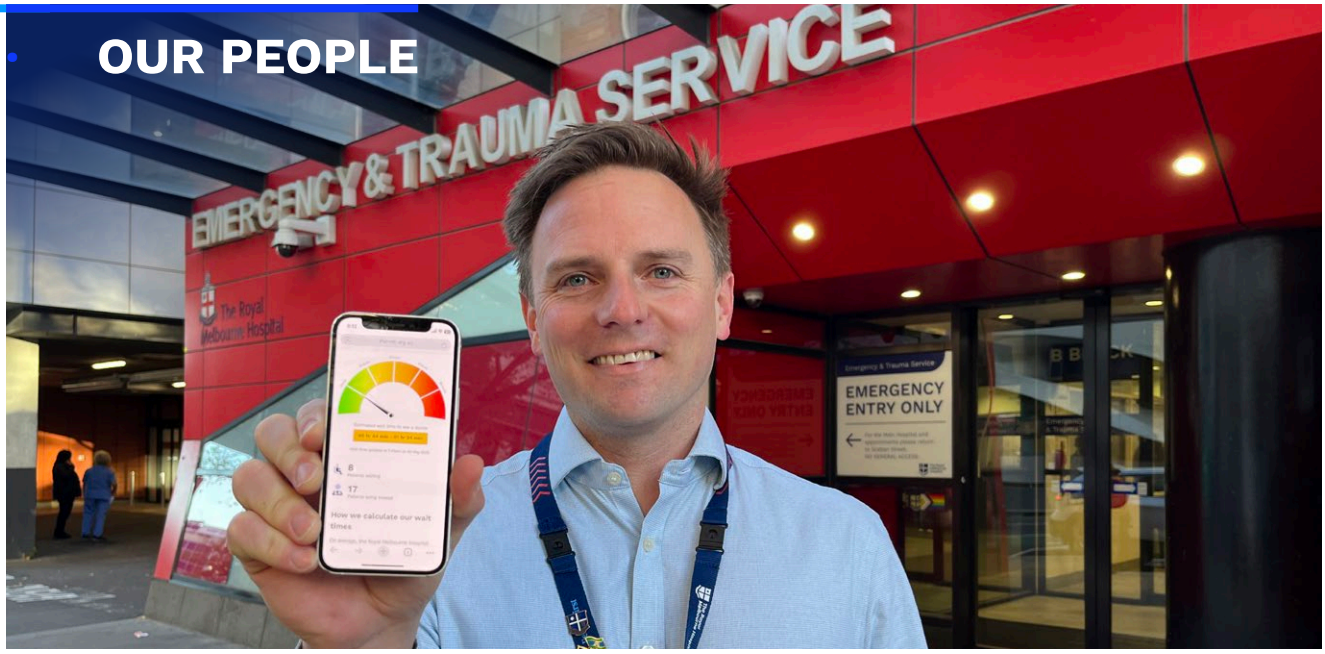
The visit was made even sweeter with the twins, Esther and Violet, celebrating their first birthdays earlier that month.

Members from the RMH's ICU and Cardiology Departments, who were instrumental in Alex's recovery, were present for the visit - with the twins and their parents bringing smiles to many faces.

Alex and her babies were the face of this year's RMH Foundation Tax Appeal campaign, which raised money for the Impella Heart Program - the "next generation" of life-saving heart devices to help ensure more people like Alex go home to their families.

"This is a new device which is much, much smaller," Professor Andrew Taylor, the RMH's Director of Cardiology, said.

"Every eight times you put one in, you're going to save a life."



ED wait-time dashboard goes live

The RMH has launched its ED wait-time dashboard.

The ED wait-time dashboard shows the anticipated time non-emergency and less urgent patients may expect to wait between being assessed by the triage nurse and being treated by a doctor. The information is updated regularly and may change based on presentations.

"Our ED is one of the busiest in the country, and on average we are seeing from 260 to 300-plus patients every day," said Dr Nicola Walsham, Interim Director of the RMH ED.

"This dashboard will be available 24/7 and will give those patients who need our care an indication of the level of demand we are experiencing in our ED so they have an idea of what to expect before they arrive and while they wait."

When patients arrive at the RMH ED, they are assessed by a triage nurse who categorises their condition on a scale from life-threatening to non-urgent. The sickest and most seriously injured patients are always treated first, regardless of how they arrive at the hospital and the order of their arrival.

Dr Walsham said no matter how busy the ED is, patients should never avoid or delay seeking care when they need it. **"We are always here when you need us. If you or another person needs urgent, life-saving medical care, call Triple Zero and ask for an ambulance or head to your local ED immediately,"** she said.

"For some people, the ED may not be the best or fastest option. If you need urgent care, but your illness or injury is not life-threatening, there are other health services that can support you to get the care you need, including the Victorian Virtual Emergency Department and local urgent care clinics. There are also online and telephone services such as Nurse-On-Call."

The project team also used feedback and discussions with our patients and consumers about what information they felt was most useful to be included for the dashboard.

The dashboard will also be available for patients in the waiting room.

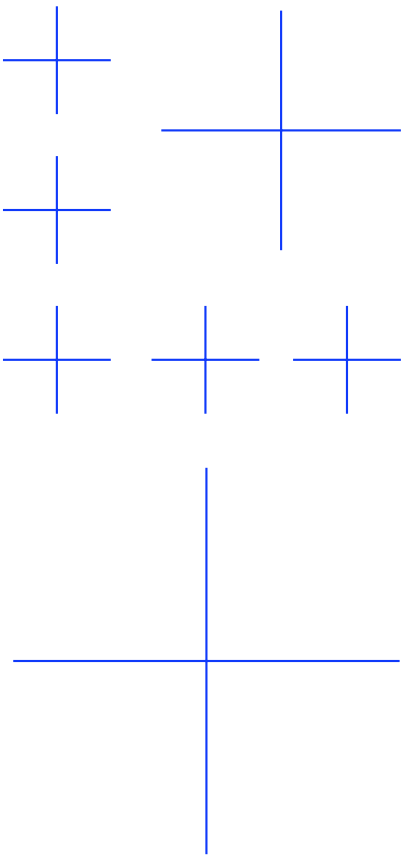
Awards, recognition and accolades

Staff and services that received recognition across the financial year:

- **The RMH received the People's Choice Award for Most Collaborative Health Service at the Timely Emergency Care Collaborative (TECC) awards**, a Department of Health initiative recognising collaborative achievements in emergency care across Victorian health services. This followed a March award recognising the RMH for **Significant and Sustained Improvement in emergency care delivery**. Projects involved included ED Fast Track, Digital Coordination Centre, Transit Lounge, STEP, and Patient Flow Coordination.
- Emergency Department Consultant **Dr Sarah Whitelaw** received the Australian Medical Association (AMA) 2024 Women in Medical Leadership Award for contributions to national health policy and support for doctors with disabilities.
- Intensive Care Specialist and Nephrologist **Dr Emily See** was awarded the University of Melbourne Dean's Award for Excellence in Graduate Research for her PhD thesis ranked among the top five in the School of Medicine, Dentistry and Health Sciences.
- Chief Allied Health Information Officer **Ms Kath Feely** was awarded the Don Walker Award by the Australian Institute of Digital Health (AIDH) for best Clinical Abstract at the Health Informatics Conference (HIC), recognising her work on co-designing EMR patient portals with vulnerable populations.
- Medical Oncologist and Joint Head of ACRF Cancer Biology and Stem Cells Division at WEHI **Professor Geoff Lindeman** was awarded the Buchanan Medal by the Royal Society (United Kingdom), jointly with WEHI **Professor Jane Visvader**. The award recognises distinguished contributions to medical sciences, particularly cancer biology research.
- Intensive Care Specialist **Dr Yasmine Ali Abdelhamid** received the University of Melbourne Puzey Postdoctoral Fellowship to support research on muscle loss in critical illness.
- General Medicine Consultant **Professor David Russell AM** received the Outstanding Clinician Award from the Gastroenterological Society of Australia (GESA), recognising clinical expertise and 40 years of service to the RMH.
- The RMH's Sleep and Respiratory Physician **Dr Asha Bonney**, and Palliative Care Physician **Dr Aaron Wong**, together with Neurologist and former RMH staff member **Dr Vignan Yogendrakumar**, received University of Melbourne Dean's Awards for Excellence in Graduate Research for outstanding achievements in research outputs and impact.

- **Professor Finlay Macrae AO**, **Professor Ingrid Winship AO**, **Professor Stephen Davis AO** and **Professor Monica Slavin** were inducted into the prestigious RMH Research Hall of Fame, each recognised for their contributions to medical research and commitment to improving patient outcomes.
- General Medicine Consultant Physician at the RMH and Professor Emeritus at the University of Melbourne **Professor Stephen Harrap** was awarded the Franz Volhard Lectureship and Award by the International Society of Hypertension for outstanding research in hypertension genetics.
- Emergency Physician **Associate Professor Melinda Truesdale** received the Australian College of Emergency Medicine (ACEM) Medal recognising exceptional service to emergency medicine and the ACEM College.
- Infectious Diseases Physician and Deputy Chief Medical Information Officer **Associate Professor Kudzai Kanhutu**, and Dean of Medicine, Dentistry and Health Sciences at the University of Melbourne and RMH Board Member **Professor Jane Gunn AO**, were inducted onto the Victorian Honour Roll of Women for leadership and contributions to health and community service.
- Consultant Haematologist and Scientist at the RMH, Peter MacCallum Cancer Centre, and WEHI **Professor Andrew Roberts AM** was appointed Editor-in-Chief of Blood, the American Society of Hematology (ASH) journal.
- Senior Research Officer **Dr Joanne Davis** received the Best Research Poster Award at the Australasian Cytometry Society Conference for research on chronic lymphocytic leukaemia.
- **The RMH was a finalist in five categories, and won two awards, at the 2024 Victorian Public Healthcare Awards.** Four of the five nominations recognise collaborations among the Parkville precinct hospitals, research institutions and other health leaders. The Parkville hospital disability identifier project, which aimed to improve person-centred care experiences for patients with disability across the RMH, Peter MacCallum Cancer Centre, the Royal Women's and the Royal Children's hospitals, in partnership with the Austin, won the 'Partnering with consumers to improve patient experience' category. Meanwhile, A Regional Approach to Enhanced Recovery After Surgery and Prehabilitation, a West Metro Health Service Partnership project between the RMH, Peter MacCallum Cancer Centre, the Royal Women's Hospital and Western Health to improve surgical care, won the Excellence in Value-Based Healthcare Award.
- Breast Surgeon and James Stewart Chair of Surgery at the RMH and the University of Melbourne **Professor Christobel Saunders AO** was awarded the Research Australia Health Services Research Award for contributions to breast cancer research and clinical leadership.
- Director of the RMH Heart Rhythm Services **Professor Jonathan Kalman AO,** and Head of Infectious Disease at Peter MacCallum Cancer Centre and RMH **Professor Monica Slavin AM**, received the University of Melbourne's Medical School Brownless Medal for outstanding contributions to medical education and research.
- **Professor Kalman** also received the Distinguished Teacher Award from the North American Heart Rhythm Society (NAHRS) for contributions to cardiac electrophysiology education.
- Intensivist **Dr Yasmine Ali Abdelhamid** won Best Medical Paper at the Australian and New Zealand Intensive Care Society (ANZICS) and Australian College of Critical Care Nurses (ACCCN) Annual Scientific Meeting for research on enteral glycine absorption in critically ill patients.

- Deputy Director of Trauma Associate **Professor Katherine Martin AM** was appointed Member of the Order of Australia (AM) for service to trauma care and surgery in the 26 January Honours.
- **Four members of the RMH community were recognised in the 2025 King's Birthday Honours** for their outstanding service to medicine and the community.
- Cardiothoracic Surgeon **Professor Alistair Royse** received a Member of the Order of Australia (AM) for his significant service to medicine as a cardiothoracic surgeon, researcher, educator and trainer.
- Director of the Head and Neck Tumour Stream **Professor David Wiesenfeld** was also awarded an AM for his significant service to medicine as an oral and maxillofacial surgeon.
- Deputy Director of Cardiology Associate **Professor Jeffrey Lefkovits** was recognised with a Medal of the Order of Australia (OAM) for his service to medicine as a cardiologist.
- Former Executive Director of the RMH Foundation **Mr David Zerman** also received a Member of the Order of Australia (AM) for his service to community health and fundraising.
- Early career researchers, Respiratory Physician **Dr Asha Bonney**, and Endocrinologist and General Medicine Physician **Dr Rahul Barmanray**, were recognised at the 2024-25 Premier's Awards for Health and Medical Research for contributions to lung cancer screening and endocrinology research.



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The RMH recognises and is deeply appreciative of the generous support received from individuals, including every Board Director, families, businesses, trusts, foundations, community groups and organisations. It gives us great pleasure to acknowledge these contributions below:

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Occupational health, safety and wellbeing

The RMH remains committed to a ‘safety first’ approach to promote and maintain a safe and healthy workplace.

In 2024-25, the Occupational Health and Safety (OHS) team focused on strengthening the RMH’s safety culture via several key initiatives, with a particular focus on the need to coordinate and address manual handling as a key challenge. We commenced with a thorough review and redevelopment of the Manual Handling Training program, resulting in the appointment of a dedicated Manual Handling Coordinator. While this work is still being finalised, it lays a strong foundation for building safer, more consistent practices across both clinical and support areas. The RMH continues to improve access to appropriate manual handling equipment to meet the diverse needs of our patients, while also ensuring we build capability across the workforce.

Our OHS for Managers training was developed and delivered this year, with a new e-learning module currently in progress to improve accessibility and engagement. Access to safety education is vital for leaders and this training covers important information including legislative compliance, consultation processes, hazard identification, risk assessment, and incident reporting and management.

Active consultation remained a focus, with Health and Safety Representatives and OHS Committee members continuing to work together to identify risks, develop solutions, and build a culture of speaking up. Committees remain active and well attended, with members working proactively to manage hazards and incidents with support from the OHS team.

The Injury Management team has strengthened partnerships with leaders by delivering targeted training and resources on injury prevention and incident reporting. This proactive approach – combined with thorough hazard investigations and workplace design improvements – has created safer operating environments across the RMH.

Looking forward, the RMH will continue building on this foundation by embedding these practices into everyday work and regularly updating resources to empower staff and leaders to actively contribute to a safer, more supportive workplace.

Workforce wellbeing

The Workforce Wellbeing team has continued to provide a range of proactive and reactive wellbeing supports to staff over the past year in response to the needs of the organisation. This has included supporting staff to navigate change processes, working with teams to respond to areas of growth identified in the People Matter Survey, and ongoing capacity building in supporting our people following a critical incident.

We have continued to develop our range of training offerings, working with local leaders to explore ways of connecting with staff at all levels of the organisation and increase the visibility of wellbeing supports both within the hospital and externally via our Employee Assistance Program. In preparation for the upcoming psychosocial safety legislation expected to be released in October 2025, we have commenced the planning process to support a gap analysis and staff consultation to guide the development of an organisation wide strategy to support our compliance.

Sexual safety

The new resource entitled *‘Responding to sexual safety incidents - Patient-to-staff guideline’* was launched in early 2025. This resource has been informed by the work of the RMH’s Sexual Safety Nurse Consultant who listened to, supported, and

learnt from the staff within the health service. It brings together research findings, best-practice and lived experience knowledge to provide a pathway of prevention and response that is both trauma-informed and immediately applicable to the hospital environment.

Education on the guideline is being rolled out to clinical staff across the organisations through the OVA team in conjunction with the Sexual Safety Nurse Consultant – and already this year more than 50 education sessions have been delivered. Feedback from staff has been very positive:

> "It's great to have a guide out there to follow... some really practical tips re: how to manage uncomfortable situations"
>
> "I feel safe and supported"

This guideline is now embedded as a reference tool within the OVA team's workflow. Following a referral, team members help clinical staff work through the guideline and implement care strategies to prevent further harm.

The sexual safety work being undertaken at RMH is gathering interest from the health sector more broadly. In October 2024, WorkSafe invited the RMH Sexual Safety Nurse Consultant as a guest presenter for the webinar 'Work-related gendered violence in healthcare'. In May 2025, the RMH sexual safety work was showcased at VHOGEN's Sexual Harassment in Healthcare forum – with many participating organisations requesting access to the guideline and associated resources developed at RMH. The Victorian Commissioner for Gender Equality also attended the forum and voiced support and appreciation for the work being undertaken at RMH to address the issue of sexual safety for health care staff. The Commissioner is also planning to refer to this work in an upcoming article to be published in the Australian Journal of Human Rights.

The RMH Sexual Safety Nurse Consultant was a finalist in the RMH Celebrating Excellence Awards and the sexual safety work at RMH has been nominated for both a WorkSafe and Victorian Public Healthcare Award.

Occupational violence and aggression

This year at the RMH, there has been a strong focus on the early recognition and intervention of patient behaviours to reduce the impact of occupational violence and aggression (OVA) in our workplace.

A consistent approach to assessing, identifying, and planning for patients at risk of exhibiting OVA was embedded into clinical workflows – beginning in the Emergency Department and continuing throughout the inpatient setting through the implementation of the revised Behaviour Observation Chart. By formally recognising behaviour as a clinical observation, staff were better equipped to monitor, escalate, and respond to early changes in patient behaviour using pathways similar to those used for clinical deterioration. This proactive approach aimed to reduce the overall risk of OVA to staff by promoting timely intervention and consistent care planning for our patients at RMH.

Workforce Inclusion Policy

The RMH is committed to a diverse and inclusive workplace where all staff feel valued and supported. Aligned with the Gender Equality Act 2020, our Workforce Inclusion Policy focuses on measurable targets that drive real progress.

We are committed to building a stronger First Nations workforce across every part of our organisation. By working together through model of shared responsibility, we are creating fairer and more accessible pathways, addressing bias, removing barriers to participation, and focusing on the skills, knowledge, and experience that every person brings. Our First Nations Workforce Strategy 2025–2028 sets clear and measurable goals to guide this work, including increasing the RMH First Nations workforce representation to 1% by 2028.

The RMH is committed to embedding the core principles of cultural safety within our workforce to encourage critical self-reflection, addresses power imbalances, ensures freedom from racism,

and promotes equity in employment and career development. We continue to align with national and state initiatives, including Victoria's Aboriginal Workforce Strategy, while strengthening our workforce through the leadership, knowledge, and sovereignty of First Nations peoples, as outlined in our recently endorsed First Nations Cultural Safety and Anti-Racism Framework.

We also aim to raise the proportion of staff identifying as a person with disability to 6% by 2025. We have made moderate progress in this area to reflect ongoing efforts in workplace adjustments and inclusive management training.

Our Employee Experience Survey, People Matter, shows improvements in staff perceptions of inclusion and belonging, with the question 'I feel as if I belong at this organisation' achieving an 80% response, up two points from 2022. As we prepare for the next audit, we remain focused on embedding inclusion across all areas to ensure equitable outcomes and a workplace where everyone can thrive.

Occupational health and safety statistics

	2021-22	2022-23	2023-24	**2024-25**
The number of reported hazards / incidents for the year per 100 FTE	58.59	49.42	47.23	**47.67**
The number of "lost time" standard WorkCover claims for the year per 100 FTE	0.69	0.97	0.82	**0.85**
The average cost per WorkCover claim for the year	$163,064	$97,864	$127,277	**$87,613**

Occupational violence statistics

	2023-24	**2024-25**
WorkCover accepted claims with an occupational violence cause per 100 FTE	0.11	**0.052**
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,00,00 hours worked	0.66	**0.33**
Number of occupational violence incidents reported in Riskman	1096	**1424**
Number of occupational violence incidents reported in Riskman per 100 FTE	14.51	**18.61**
Percentage of occupational violence incidents reported in Riskman resulting in a staff injury, illness or condition	9.90%	**6.60%**

To enable comparable data, the 2023/24 information has been updated to align with the reporting methodology applied in 2024-25.

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 rating must be included. Code Grey reporting is not included, however, if an incident occurs during a planned or unplanned Code Grey, the incident must be included.
- **Accepted WorkCover claims** – Accepted WorkCover claims that were lodged in 2024-25.
- **Lost time** – is defined as absence from work for more than one full day due to injury, illness, or condition caused by an occupational violence incident or workplace accident.
- **Injury, illness or condition** – includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

Workforce information

The RMH is an equal opportunity employer, committed to providing a safe workplace that is free of harassment or discrimination. Staff are committed to our values as the principles of employment and conduct.

The following table discloses the full-time equivalent (FTE) of all active employees of the RMH as of June 2025 and year to date (YTD), with 2023-2024 data shown for comparative purposes.

	June current month FTE		Average monthly FTE	
Labour category	**2023-2024**	**2024-2025**	**2023-2024**	**2024-2025**
Nursing	3051	3001	2950	2981
Administration and clerical	1124	1114	1106	1091
Medical support	1003	987	977	983
Hotel and allied services	582	589	566	586
Medical officers	136	135	134	137
Hospital medical officers	770	792	790	789
Sessional clinicians	280	290	269	280
Ancillary staff (allied health)	822	821	764	805
Total FTE	**7,768**	7,729	7,556	7652

General information

Carers Recognition Act 2012

The RMH recognises the importance of partnering with patients, consumers, carers and families, for the best care experience and we continue to progress all practical measures to comply with relevant obligations under the Act.

RMH-wide initiatives that support these obligations include:

- Promoting the principles of the Act for people in care relationships who receive our services and to the wider community, for example through posters and fact sheets.
- Co-designing an inaugural Community Engagement Strategy 'In This Together' with patients, consumers, carers and community members in 2024. We partnered with the Australian Multicultural Health Collaborative to ensure we heard and listened to diverse community. members. The Community Engagement Action Plan for 2025-2028 includes actions related to carers and families and is currently being cocreated with people with a carer lived experience.
- Establishing ways to remunerate lived experience consumers and carers and community members involved in consultation and service improvement.
- Implementing Families and Carer as part of the healthcare Teams (FaCT) pilot program on two wards. This project supported family and carer participation in several aspects of care delivery including; oral hygiene, feeding, mobilising and orientation to time and place. The day of admission, the day of care planning and day of discharge were the key stages for improved communication with carers for their input into care planning and delivery.
- The carer perspective has been central to the Best Care of the Older Person project with a carer representative involved in the project implementation, the RMH staff learning forum, provision of feedback to the Department of Health about this involvement, has contributed to a video resource aimed at reducing hospital acquired functional decline and the codesign of consumer and carer information about a new model of care.
- The Family Communications Improvement project has a focus on optimising family and carer engagement in care through consistent and timely communication throughout a patient's hospital stay. The planned interdisciplinary initiative is designed to enhance transparency, collaboration and carer involvement in care planning and decision making. The implementation of tailored multi-modal communication strategies at defined timepoints will continue throughout 2025.

The RMH Mental Health Services initiatives include:

- A Family, Carers, Kin and Supporters Committee meets monthly to support clinical and lived experience workforce communication, community engagement and quality improvement. The Carer Advisory Group meets monthly to provide feedback and drive improvement. Carer lived experience staff and clinical specialists in family work provide colleagues and graduate programs with professional development.
- Carers and families are provided with information and resources, including written information, and events that offer families and carers support and explore topics of interest to them.
- Implementation of the Mental Health Services 'Family, Carers, Supporters Practice Domain', which includes family interventions provided across care teams, secondary consultation available to staff via a 'Family Help Desk' staffed by clinical specialists and carer lived experience leads, responding to family violence, offering individual and group family therapy and programs including support for young carers and consumers who are parents or caregivers.

Growth and development in 2024-25:

- We established the Director and Deputy Director of Carer and Consumer Lived Experience positions to ensure the carer voice is engaged in all levels at the RMH Mental Health Services.
- The RMH Mental Health Services carer lived experience workforce has grown, with the commencement of a new carer lived experience educator role and a new welcome carer lived experience role on the inpatient unit. The newly established inner northern community team, which uses the innovative one dialogue team approach, includes two carer lived experience practitioners.
- In 2024-25, lived experience staff and clinicians commenced working with the Mental Health and Wellbeing Commission to develop practice guidelines that support the Mental Health and Wellbeing (MHW) Act 2022 principles, including those that recognise families, carers and supporters. This collaboration will continue in 2025-26.
- The redeveloped John Cade inpatient unit, co-designed with consumers and carers opened in April 2024. The safe and appropriate spaces designed for carer peer support workers and clinical staff to meet with carers and families, including children and young people, have become established in 24-25 FY.
- The RMH continues to embed the MHW Act 2022 which includes recognising the vital role of carers:
  - Consumer and carer lived experience staff, clinicians and Act Implementation Leads provided advice, education, training and support for staff about the Act.
  - Carer lived experience staff provide education sessions for carers and families about the Act.

Opportunities for improvement being addressed through projects:

- Reviewing, updating and creating the content of information offered to families and carers, and transferring this to digital formats and using QR codes, to improve accessibility and reach.
- Improvement project to increase the uptake by consumers of Nominated Support Persons and Advanced Statement of Preferences provisions in the MHW Act 2022.
- Enhancing how EMR records carer and family contact details and enables safe sharing of health information with consumers and families using the health portal.
- Evaluating the effectiveness of team-based child and family safety champions.

Safe Patient Care Act 2015

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

Freedom of Information Act 1982

The *Victorian Freedom of Information Act 1982* provides a legally enforceable right of public access to information held by government agencies. During the 2024-25 year, all applications made to the RMH were processed in accordance with the Act. The RMH provides a report on these requests to the Office of the Victorian Information Commissioner (OVIC).

Applications and requests for information about making applications under the Act can be made via:

Email FOIrequest@mh.org.au

Postal application
Freedom of Information Officer
Health Information Services
PO Box 2155
The Royal Melbourne Hospital
Victoria 3050
Telephone (03) 9342 7224
Facsimile (03) 9139 3000

The cost of making an FOI application in 2024/2025 was $32.70. For the 2025/2026 financial year, it has increased to $33.60. The total production costs, also referred to as access fees, vary according to the number and types of documents required. Application forms are available for download from the website at thermh.org.au. More detailed information can be found on the website, including how the RMH processes FOI requests, publications and other material that can be inspected by the public.

The majority of FOI requests received are from solicitors on behalf of patients, the Transport Accident Commission (TAC), insurance companies and patients themselves. A small number are also received from media and government organisations.

2024-25 FOI applications	
Valid applications received	**3425**
From Members of Parliament	0
From media	2
FOI outcomes	**3396**
FOI access decisions	3128
- Granted in full	1229
- Granted in part	1898
- Denied in full	1
Withdrawn/not proceeded with	221
No record*	47
In progress at the end of the year	**318**

*No record refers to situations where a search identified no documents that fell within the scope of the FOI request

The RMH generated a total of 3396 FOI outcomes during the 12 months ended 30 June 2025. This number included outcomes from applications that commenced in previous years.

These outcomes included 3128 FOI decisions. There were 2082 decisions made within the statutory time periods. Of the decisions made outside the statutory time period, 998 were made within a further 45 days and 48 decisions were made in a period greater than this.

Of the total decisions made, 47 decisions were made after mandatory extensions had been applied or extensions were agreed upon by the applicant.

Of requests finalised, the average number of days (including extended timeframes) to decide a request was 29 days.

During 2024-25, 12 requests were subject to a complaint/internal review by Office of the Victorian Information Commissioner. One request is currently outstanding with the Victorian Civil and Administrative Tribunal (VCAT). No new requests progressed to VCAT during this time.

Public Interest Disclosure Act 2012

The RMH is committed to extend the protections under the Public Interest Disclosure Act 2012 (Vic) to individuals who make protected disclosures under that Act or who cooperate with investigations into protected disclosures. The procedure and brochure are available to all staff on the RMH intranet site and to the public at thermh.org.au

Gender Equality Act 2020

The RMH is committed to providing a great place to work and a great place to receive care for people of all genders, abilities, backgrounds, and identities. The Gender Equality Act 2020 provides guidance on key practices and indicators, yet we strive for equity, safety and belonging beyond mere compliance.

We have made strong progress through the 2021-2025 Action Plan, with all but one action complete or ongoing. The impact of our efforts include reducing our gender pay gap from 18.6% to 10%. Our campaign to promote the availability of family violence leave led to a 4-fold increase in access (12 to 60 people), and a 6% increase in perceptions that the RMH would support staff to take the leave if they needed it.

The appointment of a Sexual Safety Nurse Consultant, and the ensuing work has led to an increase in reports of perceived sexual harassment – increasing from 10% in 2021 to 16% in 2024, with the majority coming from patients or visitors. This reflects an improved understanding of what constitutes sexual harassment in healthcare and a belief that our leaders take the matter seriously. There has been a marked reduction in the percentage of People Matter Survey respondents reporting perceived sexual harassment from colleagues in the past 12 months, decreasing from 48% to 27%.

An increase in formal reporting of such incidents, along with improved satisfaction with how these matters are handled (72% satisfied, up from 53% in 2021), is further evidence of the impact of this work.

In the lead up to 16 Days of Activism Against Gender Based Violence, the RMH hosted a 'Men as Allies' panel which explores the value of and strategies for male allyship, which was chaired by Associate Professor Chris MacIsaac, Director Intensive Care Unit, and featured experts from the industry including OurWatch and Women's Health Victoria, and was well attended by people from across the organisation.

In March, the RMH led the International Women's Day Gender Equity in Healthcare Series across the Parkville precinct. This included a symposium featuring the Minster for Health and key researchers including representatives from the Centre for Sex and Gender Equity and Health and Medicine.

Active Bystander training continues to be rolled out across the RMH with more than 1200 staff trained to support positive, safe and inclusive cultures. We have developed new training packages to build the capability of staff. Of note are our LGBTIQA+ and Disability eLearn modules, both strongly shaped by staff and consumers with lived experience.

While we continue to support a range of initiatives, attention now turns to preparing for our next audit and developing our next 4-year plan.

We continue to explore ways to embed equity into our service and policy reviews to improve equitable health outcomes. We also track employee experiences each year through a gender and equity lens.

Building Act 1993

As required under the Building Act 1993, the RMH has obtained building permits for new capital works projects and Certificates of Occupancy or Certificates of Final Inspection, where applicable, for all completed projects. In addition to compliance with the Act, the RMH also seeks compliance with other regulatory bodies and codes, such as the Australasian Health Facility Design Guidelines, the Victorian Department of Health Fire Risk Management Guidelines, Disability Discrimination Act regulations, Cladding Safety Victoria and Victorian Health Building Authority (VHBA).

Registered Building Practitioners have been involved with all new building works projects and were supervised by either the relevant construction manager in liaison with the RMH Capital Projects department and/or independent project managers. Each building practitioner has supplied the required Building Registration Number. Building contractors include:

- MAW Building and Maintenance
- Icon Construction
- Built
- JThree Construction
- Formula One

National Competition Policy

The RMH continues to comply with the Victorian Government's Competitive Neutrality Policy. In addition, the Victorian Government's Competitive Neutrality pricing principles have been applied by the RMH from 1 July 2000 for all relevant business activities.

Local Jobs First Act 2003

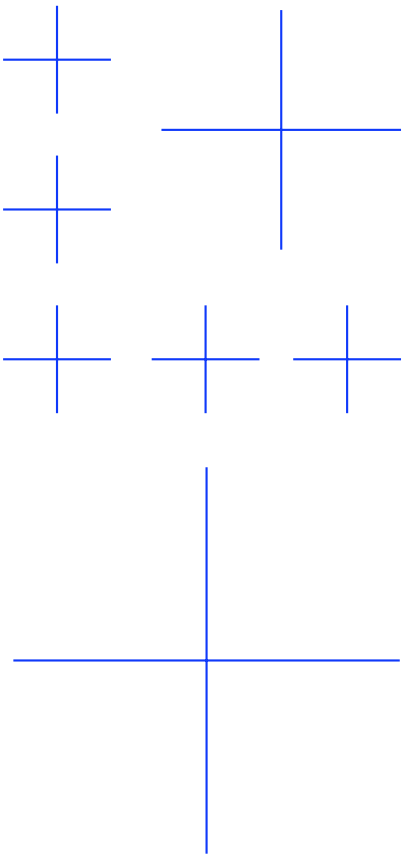
The RMH complies with the Local Jobs First Act 2003, which aims to provide opportunities to local business and therefore promote employment and business growth within Victoria.

- There was one strategic project in the metro region for which the Major Projects Skills Guarantee has been applied of $50m, resulting in 10.36 opportunities (870 hours) completed or to be completed by apprentices, trainees, or cadets on these projects.

The total number, of small- and medium-sized businesses engaged as part of the MPSG Project above as either the principal contractor or as part of the supply chain was 134 businesses, retaining 105,904 hours of employment and creating a further 18,776 hours of employment within the sector.

Car parking fees

The RMH complies with the Department of Health hospital circular on car parking. Fees and details of car parking fees and concession benefits are available at thermh.org.au/parking



Information and communication technology (ICT) expenditure

The total ICT expenditure incurred during 2024-25 is $73.7m (excluding GST) with the details shown below.

Business As Usual (BAU) ICT expenditure	**Non-business as usual (non BAU) ICT expenditure**		
Total (excluding GST)	Total = Operational expenditure and Capital expenditure (excluding GST)	Operational expenditure (excluding GST)	Capital expenditure (excluding GST)
61,233	12,428	-	12,428

Details of consultancies (under $10,000)

In 2024-25, there was no consultancy where the total fees payable to the consultant was less than $10,000.

Valued at less than $10,000

In 2024-25, there were five consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2024-25 in relation to these consultancies is $401,000 (excl. GST). Details are provided in the table on the next page.

Consultant	Purpose of consultancy	Start date	End date	Total approved project fee $'000 (excluding GST)	Expenditure 2023-24 $'000 (excluding GST)	Future expenditure $'000 (excluding GST)
The Trustee for Karabena Consulting	Improving cultural safety in Emergency Department and reducing variation in care for Aboriginal and/or Torres Strait Islander people	21/03/2024	10/09/2024	120	84	-
Federation of Ethnic Communities Councils of Australia	Development of the Royal Melbourne Health Community Engagement Strategy	08/05/2024	30/09/2024	20	20	-
Productivity Matters Pty Ltd	Proposal for the provision of the comprehensive Manual Handling Risk Reduction Program	01/07/2024	31/07/2024	62	62	-
Abstarr Consulting Pty Ltd	Design, development and implementation of Anti-racism and cultural Safety Framework	26/08/2024	30/04/2024	151	151	-
Bodycare Health and Wellbeing Pty Ltd	Audit of current bariatric training resources and response program	17/03/2025	30/06/2025	85	85	-

Disclosure of government advertising expenditure

The RMH did not undertake any government advertising campaigns with total media expenditure of $100,000 or greater in 2024-25.

Reviews and studies expenditure

The RMH has no review and/or study expenditures to disclose.

Grants and Transfer payments

Not applicable – the RMH did not administer any grants, transfer payments or Commercial-in-Confidence grants in 2024-25.

Social procurement framework

The RMH's social procurement framework (SPF) aims to ensure value-for-money considerations are not solely focused on price but encompass opportunities to deliver social and sustainable outcomes that benefit the Victorian community. The RMH engaged social benefit suppliers during the reporting period, and mainstream suppliers with social procurement commitments.

SPF objective	Outcome	Metric	Unit of measure	2024-25 (actual)
Opportunities for Victorian Aboriginal people	Employment of Victorian Aboriginal people by suppliers	Total number of Victorian Aboriginal people employed by suppliers on RMH contracts	Number	1
	Purchasing from Victorian Aboriginal businesses	Total spend with Victorian Aboriginal businesses[1]	$ (GST exclusive)	$328,165.65
		Number of Victorian Aboriginal businesses engaged	Number	16
Opportunities for Victorians with disability	Purchasing from Victorian social enterprises and Australian Disability Enterprises	Total spend with Victorian social enterprises led by a mission for people with disability and BuyAbility Social Enterprises	$ (GST exclusive)	$9,058
		Number of Victorian social enterprises[2] led by a mission for people with disability and Australian Disability Enterprises (ADEs) engaged	Number	0
Women's equality and safety	Adoption of family violence leave by suppliers	Number of suppliers that have implemented a family violence leave policy	Number	14
	Gender equality within suppliers	Number of suppliers that have a gender equality policy	Number	14
Opportunities for Victorian priority jobseekers	Purchasing from Victorian social enterprises	Total spend with Victorian social enterprises (led by a mission for job readiness and employment of Victorian priority jobseekers)	$ (GST exclusive)	$0'
		Percentage of spend with Victorian social enterprises (led by a mission for job readiness and employment of Victorian priority jobseekers) (out of total contract value for all RMH contracts)	Percentage	<1%
Supporting safe and fair workplaces	Purchasing from suppliers that comply with industrial relations laws and promote secure employment	Number of suppliers that attest to compliance with the supplier code of conduct	Number	3,155
		Proportion of suppliers who attest to comply with the Supplier Code of Conduct	Percentage	100%
Environmentally sustainable business practices	Adoption of sustainable business practices by suppliers	Suppliers that have clauses for environmentally sustainable business practices, such as application and achievement ISO standards and/or industry recognised standards	Percentage	100%
Implementation of the Climate Change Policy Objectives	Project-specific requirements to minimise greenhouse gas emissions	Suppliers with application of an Environmental Management Plan to identify and manage risks to achieving and maintaining required rating levels through the design, delivery and operational phases of a project	Percentage	100%

1. Victorian Aboriginal businesses verified by Kinaway and/or Supply Nation
2. Victorian social enterprises certified by Social Traders

Environmental performance

Strive for sustainability is one of the five strategic goals for the RMH, evidencing the level of commitment to sustainability held by the organisation. Providing excellent healthcare that is evidence-based, well-resourced and continually pushing the boundaries of medical science, all while reducing the significant impact of the healthcare industry on the environment, is a core goal of the RMH.

The strategic goal is supported in detail by the RMH's Environmental Sustainability Strategy 2020-25. The strategy focuses on reducing greenhouse gas (GHG) emissions and waste generation, all while increasing the volume and quality of our healthcare services. The environmental performance report justifies how we are making improvements towards these goals.

This 2024-25 Annual Report also meets our requirements to report on GHG emissions and other environmental impacts in accordance with Financial Reporting Direction 24: Reporting of environmental data by government entities (FRD 24), as directed by the Department of Treasury and Finance Victoria. This report details the RMH's performance as a tier-2 entity under FRD 24. Public health services have been collecting environmental data via the Department of Health-managed Environmental Data Management System (EDMS) since 2015. This report was prepared using EDMS data and calculation methods, and as a result is dependent on the information in this EDMS. The EDMS emissions calculation for electricity-related activities uses the market-based method in 2024-25, as opposed to the location-based method used in previous FRD report versions.

Reporting boundary for environmental data

Where practicable to obtain, all operations and activities of Melbourne Health (operating as the Royal Melbourne Hospital) are included within the organisational boundary for the 2022-23, 2023-24 and 2024-25[1] reporting periods. Data is included for the four areas represented in the RMH's financial statements. The following areas account for more than 11 locations[2] throughout Victoria.

MH's reporting boundary includes data for the following facilities:

- The RMH Parkville
- The RMH Royal Park
- Aggregate non-residential facilities (Jane Bell House, Orygen, Norfolk Terrace CCU, 635 Elizabeth Street, Chelsea House, Waratah Clinics, Essendon Fields Dialysis)
- Aggregate residential facilities (Orygen, Cyril Jewell House, Boyne Russell House)

1. Where information is not practical to obtain estimations have been made.
2. The locations covered in this report vary year-on-year due to machinery of government changes and aggregation between health authorities.

Changes to the reporting boundary between 2023-24 and 2024-25 reports:

- Operations removed from the RMH control as of 1 July 2024: 362 Bell Street (as of 14 November 2024).

Normalisation factors

Normalising factors refer to indicators used to compare environmental performance over time; this allows for evaluation with changes in service delivery.

The VHBA designates normalisation factors for health services as follows:

- For energy consumption, emissions from energy use and production, and water consumption floor area and occupied bed days are deemed suitable normalisation factors.
- Per patient treated is the appropriate normalisation factor for waste generation.

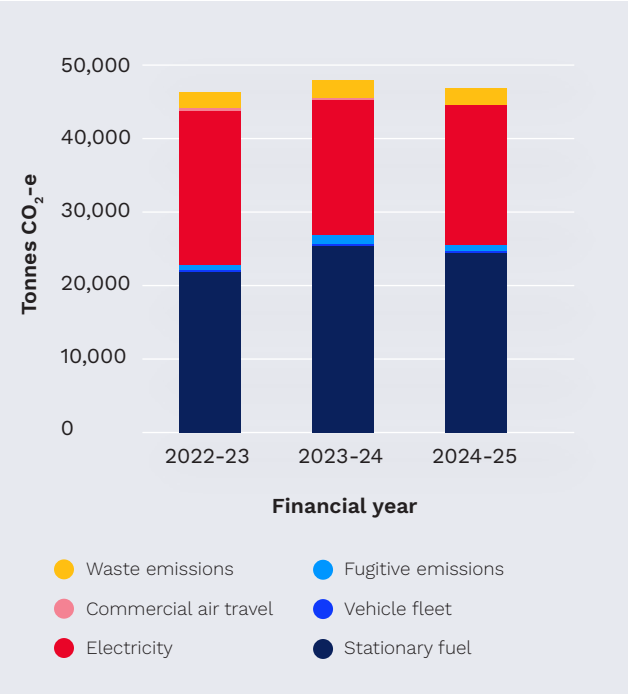
For this report normalisation data was obtained via:

- Floor area: provided to the RMH by the Department of Health's EDMS. Floor area is calculated using a gross floor area calculation approach and reported in metres squared.
- Patients treated: Provided internally by the RMH and calculated by the sum of inpatient bed days, residential age care bed days, separations, and the number of emergency presentations for the reporting period.

Greenhouse gas emissions

Graph 1 displays the RMH's total GHG emissions from 1 July 2022 to 30 June 2025.

GHG decreased by 2% between 2023-24 and 2024-25. Per patient treated emissions, decreased by 4% between 2023-24 and 2024-25, reflecting the increase in activity.



Emission scopes

The RMH reports GHG emissions via 'scopes' consistent with national and international reporting standards. Scope 1 emissions are from sources that the RMH owns or controls, such as burning fossil fuels in vehicles or machinery. Scope 2 emissions are indirect emissions from the RMH's use of purchased electricity. Scope 3 emissions are indirect emissions from sources the RMH does not control but does influence.

Scope 1

Scope 1 emissions decreased by 5% between 2023-24 and 2024-25, due to a reduction in medical gas use and fugitive emissions. The RMH vehicle fleet is continuously migrating to electric and hybrid vehicles, reducing emissions from fuel by 16% in 2024-25.

Scope 2

The RMH's scope 2 GHG emissions have increased 4% between 2023-24 and 2024-25. This is due to the co-generation plant running less hours during this financial year increasing the RMH's dependence on grid electricity.

Scope 3

The RMH currently reports scope 3 emissions from corporate air travel and waste disposal only. Total scope 3 emissions have decreased 3% between 2023-24 to 2024-25. Corporate air travel has decreased by 61% this financial year. Waste emissions have decreased by 6% and overall waste generated is the lowest in the three reporting years.

Indicator - GHG emissions	2022-23	2023-24	2024-25
Total Scope 1 GHG emissions (Tonnes CO^2-e)[1]	**23,059.78**	**27,005.63**	**25,679.62**
Type of gas			
Carbon Dioxide	22,167.09	25,605.33	24,954.79
Methane	42.46	49.32	48.14
Nitrous Oxide	14.17	15.88	15.31
Fugitive emissions[1]	836.069	1335.13	661.38
Activity source			
Stationary fuel	21,825.96	25,380.16	24,773.49
Vehicle fleet	397.75	290.34	244.75
Fugitive emissions[1]	836.069	1335.13	661.38
Total Scope 2 GHG emissions (Tonnes CO^2-e)	**21,016.95**	**18,471.42**	**19,140.61**
Electricity	21,016.95	18,471.42	19,140.61
Total Scope 3 GHG emissions from commercial air travel and waste disposal (Tonnes CO^2-e)	**2,593.45**	**2,747.83**	**2,292.43**
Commercial air travel	316.66	523.47	203.30
Waste emissions	2,276.79	2,224.36	2,089.13
Total GHG emissions (Tonnes CO^2-e)	**46,670.18**	**48,224.89**	**47,112.67**

3. Fugitive emissions include medical gases and for the second time, the RMH is reporting on emissions from air conditioning and electrical equipment. Data is only partially captured at this point.

Fugitive emissions

Medical gases

Nitrous oxide is a potent GHG, with global warming potential approximately three hundred times that of carbon dioxide. Leaks from ageing or unused medical gas pipework can contribute significantly to a hospital's carbon footprint and can go undetected for years. Even small, continuous leaks can result in emissions equivalent to several tonnes of CO_2 annually. Within the healthcare sector, nitrous oxide use has emerged as a standout issue in emissions reduction efforts. In collaboration with the RMH Anaesthetic team, leaks in the pipeline were detected and repaired and by the end of this financial year RMH Theatres, ED and Cath Lab have all made the shift to bottled supply of nitrous oxide. Melbourne Private Hospital, which is part of the precinct pipeline network, has agreed to make the switch to bottled as above, enabling the decommissioning of the main nitrous oxide pipeline infrastructure at the RMH Parkville in the near future.

Refrigerants, air-conditioning, fire suppressants and other purchased gases

Data was not readily available to estimate the greenhouse gas emissions associated with refrigerants, air-conditioning, fire suppressants and other purchased gases in previous years. The RMH is in the process of developing an inventory of refrigerant, air-conditioning and fire suppressant equipment and collaborating with suppliers to obtain the necessary data. Partial data was available to report emissions from refrigerants and electrical equipment for the past two financial years, which has increased our total fugitive emissions reported.

Indicator - Fugitive emissions (tCO_2-e)	2022-23	2023-24	2024-25
Desflurane (l)	3.572	0	0
Sevoflurane (l)	59.437	61.59	60.32
Nitrous oxide (volume m^3)	773.06	451.59	569.74
Medical Gas (Scope 1 emission) (Tonnes CO_2-e)	**836.069**	**513.18**	**569.74**
Refrigerant R22 (kg)			16.72
Refrigerant R32 (kg)			8.5
Refrigerant R134A (kg)		203	2.6
Refrigerant R404A (kg)		18	3.5
Electrical equipment SF6 (kg)		642.7	0
Refrigerants and electrical equipment (Scope 1 emission) (Tonnes CO_2-e)[1]	**0**	**863.7**	**31.32**
Total Fugitive emissions (Scope 1 emission) (Tonnes CO_2-e)	**836.069**	**1376.88**	**661.38**

1. GWPs used to calculate tonnes of CO2-e emissions: desflurane (893); sevoflurane (49); nitrous oxide (265). The RMH is reporting on fugitive emissions from refrigerants, air-conditioning and electrical equipment for the second time this financial year. Data is currently only partially available from our suppliers. GWPs used to calculate tonnes of CO2-e emissions: R22 (1,760); R32 (677); R134A (1,300); R404A (3,943); SF6 (23,500). Method 2 was used to calculate refrigerant emissions.

Energy use

Energy use at the RMH comprises electricity production and consumption, stationary fuel use and transportation. Total energy use has decreased 1% between 2023-24 to 2024-25.

Indicator - Energy use	2022-23	2023-24	2024-25
Total energy use (MJ)	**564,613,119**	**635,132,004**	**627,224,830**
Renewable[6]	20,657,370	19,235,703	20,459,140
Non-renewable	543,955,749	615,896,301	606,765,690
Total units of energy used normalised by patient treated	979	1,145	1,115
Total units of energy used normalised by floor area	3,508	3,958	3,897
Total units of energy used nor-malised by floor area	3,508	3,958	3,897
Total energy used from electricity (MJ)	135,294,180	138,489,122	142,866,274

6. This includes electricity consumption attributable to the LRET, as reflected by the Renewable Power Percentage (RPP) and E10 Fuels.

Electricity production and consumption

Electricity production from co-generation and solar at 3 RMH sites has increased by 2% in 2024-25. Electricity consumption increased by 3% in 2024-25.

Indicator - Electricity production and consumption	2022-23	2023-24	2024-25
Total electricity consumption (MWh)	**37,581.72**	**38,471.70**	**39,685.08**
Purchased[1]	30,593.96	28,084.02	28,938.15
Self-generated	6,987.75	10,387.68	10,746.92
On-site electricity generated (MWh)	**8,329.07**	**12,293.45**	**12,574.56**
– Consumption behind-the-meter	6,987.75	10,387.68	10,746.92
– Exports	1,341.31	1,905.77	1,827.63
On-site installed generation capacity (MW)			
Co-generation[1]	12	12	12
Solar PV[2]	-	0.31	0.31
Diesel backup generators	8.84	8.84	8.84
Total electricity offsets (MWh)[3]	**-**		
Renewable Power Percentage (MWh)	5,751.76	5,268.37	5,295.78

1. Purchased electricity includes a small percentage of electricity not directly purchased but from outside the organisation. This energy is primarily from buildings which the RMH is the lessor or lessee but for which sub-metering devices are not installed. This amount is deemed to be immaterial and therefore has not been separately reported. The RMH owns part of the transmission and distribution networked used to distribute electricity throughout the RMH Parkville campus. Energy losses occur as electricity is distributed along the network. A proportion of this electricity comes from the RMH owned cogeneration plant. The transmission and distribution losses from cogeneration electricity are not counted as total emissions from this are accounted under scope 1 stationary energy. However, transmission and distribution losses from purchased electricity are included.
2. The RMH has installed three solar systems through a grant funded by the Department of Health. The systems were installed during FY 2023-24 at Boyne Russel House, Cyril Jewel House and the RMH Royal Park. All three systems are operational.
10. Climate Active Market Based methodology dictates that the percentage of electricity consumption attributable to the LRET, as reflected by the Renewable Power Percentage (RPP), for a given reporting year, is assigned an emission factor of zero in the carbon account.

Stationary fuel

Natural gas use decreased by 3% in 2024-25. This decrease can be attributed to a reduction of electricity production in the RMH Parkville co-generation plant. A spend base estimate is used to calculate generator diesel consumption. In 2023-24 a large amount of diesel fuel was purchased to fill the tanks resulting in an 81% increase. No diesel was purchased in 2024-25 as diesel purchased in 2023-24 was being consumed.

Indicator - stationary fuel	2022-23	2023-24	2024-25
Total fuels used in buildings and machinery (MJ)[1]	**423,463,870.40**	**492,360,434.60**	**480,758,657.00**
Buildings	423,463,870.40	492,360,434.60	480,758,657.00
Natural gas	423,203,312.50	491,887,577.20	480,758,657.00
Diesel (generator)[2]	260,557.90	472,857.40	0
Machinery	-	-	-
GHG emissions from stationary fuel consumption (Tonnes CO2-e)	**21,825.96**	**25,380.16**	**24,773.49**
Natural gas	21,807.67	25,346.97	24,773.49
Diesel (generator)	18.29	0.19	0

1. Building energy consumption includes fuel used in heating, cooling, cooking, and cogeneration. Machinery energy consumption is any item of plant or equipment that uses fuel for a defined process that is not already counted in buildings or vehicles.
2. A spend base estimate is being used for diesel generator fuel use.

Transportation

To reduce emissions from our vehicle fleet, the RMH installed 32 electric vehicle chargers with the help of a DTF grant at RHM Parkville and RMH Royal Park in 2023. Electric and hybrid vehicles are continuing to increase and by the end of FY 2024-25 comprised 70% of our fleet. The total number of vehicles owned has continued to decrease during the reporting period, due to the on-going disaggregation of mental health sites.

Indicator - vehicles	2022-23	%	2023-24	%	2024-25	%
Number and proportion of vehicles	**202**	**100%**	**194**	**100%**	**185**	**100%**
Road vehicles	199	98.50%	193	99.48%	184	99.46%
Passenger vehicles (other than omnibuses)	198	98.00%	192	98.97%	184	99.46%
Internal combustion engine	179	86.60%	163	65.98%	151	81.62%
– Petrol	155	76.70%	105	54.12%	56	30.27%
– Diesel	20	9.90%	23	11.86%	10	5.41%
– Hybrid	4	2.00%	35	18.04%	85	45.95%
Range extended electric vehicle	19	9.41%	29	14.95%	33	17.84%
Buses (omnibuses) (petrol internal combustion engine)	1	0.50%	1	0.52%	0	0.00%
Goods vehicles (internal combustion engine)	1	0.50%	1	0.52%	0	0.00%
– Petrol	0	0.00%	0	0.00%	0	0.00%
– Diesel	1	0.50%	1	0.52%	0	0.00%
Non-road vehicles	**3**	**1.50%**	**1**	**0.52%**	**1**	**0.54%**
Electric forklift	2	1.00%	-	-	0	0%
Cart (no fuel)	1	0.50%	1	0.52%	1	0.54%

Total transport energy used has decreased by 16% in 2024-25. Energy from all fuel types has dropped as more electric vehicles have joined the fleet. Electricity consumption for charging EVs has increased by 41%.

Total emissions from the vehicle fleet decreased by 16% in 2024-25. Corporate air travel decreased by 58% in 2024-25.

Indicator - Transport energy	2022-23	2023-24	2024-25
Total energy used in transportation (MJ)	**5,853,171**	**4,273,159**	**3,599,899**
Road Vehicles (MJ)	5,853,171	4,273,159	3,599,899
– Petrol	4,977,365	3,665,546	3,027,637
– Petrol E10	50,511	31,133	29,063
– Diesel	825,295	575,769	543,199
Electricity (MWh)[1]	10.98	23.30	32.84
Charged at Victorian Government facilities	10.98	23.30	32.84
Not charged at Victorian Government facilities	-	-	0
Non-Road Vehicles	-		0
Electricity (MWh)	-		0
GHG emissions from vehicle fleet (tonnes CO_2 e)	**397.76**	**290.34**	**244.75**
Road Vehicles	**397.76**	**290.34**	**244.75**
– Petrol	336.57	247.87	204.73
– Petrol E10	3.08	1.95	1.77
– Diesel	58.11	40.53	38.25
Electricity[(13)]	**9.33**	**15.33**	**21.73**
Total distance travelled by commercial air travel (passenger km)	**1,167,925**	**2,093,710**	**881,629**

1. Usage and associated electricity emissions from electric vehicle (EV) charging at the RMH sites are not added to Transport or Transport GHG emission totals, as accounted under indicator Electricity Consumption. EV charging began in May 2023. No vehicles were charged at external facilities.

Sustainable buildings and infrastructure

Australia's harsh climate and scarce water resources mean the development of sustainable buildings is an economic and environmental necessity. Recent extreme weather events demonstrate the importance of addressing climate change risk across the RMH's operations, including when it comes to the design and management of buildings and infrastructure assets. Where possible, the RMH aligns to the Victorian Health Building Authority's Guidelines for sustainability in capital works.

The two major facilities of the RMH have received National Australian Built Environment Rating System (NABERS) environmental performance ratings:

NABERS RATING

Name of building	Building type	Rating Scheme	Rating
Royal Melbourne Hospital Parkville	Acute Hospital	NABERS - Energy	4 stars
Royal Melbourne Hospital Parkville	Acute Hospital	NABERS - Water	4 stars
Royal Melbourne Hospital Royal Park	Sub-Acute Hospital	NABERS - Energy	3 stars
Royal Melbourne Hospital Royal Park	Sub-Acute Hospital	NABERS - Water	5.5 stars

Water consumption

Water consumption increased by 21% in 2024-25. This increase was impacted by several construction projects at the RMH Parkville which required additional water consumption as the fire system had to be drained repeatedly. In November and December 2024, drain downs were performed every second day, emptying the Main Block fire system as a result of capital projects. In additions, a water leak at the RMH Royal Park in an empty building contributed to the overall increase.

To improve our water efficiency and to quickly identify leaks, the RMH joined the Victorian Government's WaterSmart program in early 2025. The RMH is now able to monitor water use in real time at the RMH Parkville, the RMH Royal Park, Jane Bell House, and Cyril Jewell House through the VicFacilities online portal and receives high water use alerts via email. This program is funded by the Victorian Government at no cost to the RMH for 36 months.

Indicator - Water Consumption	2022-23	2023-24	2024-25
Total water consumption (potable water) (kilolitres)	253,545.84	236,641.45	285,360.09
Kilolitres of metered water consumed normalised by per patient treated	0.46	0.43	0.51
Kilolitres of metered water consumed normalised by floor area	1.59	1.47	1.77

Waste and recycling

Waste management and recycling are key priorities in our Environmental Strategy. Focus areas include efforts to eliminate single-use items, reduce clinical waste, as well as maximise recycling and minimise waste sent to landfill. The RMH collected waste data from invoices and reports from its waste management providers.

This financial year we focused on correct segregation of clinical waste. The sustainability team in conjunction with IPSS implemented several initiatives including new posters, staff training, reorganising bin rooms and the gloves are off campaign to reduce unnecessary glove use. Clinical waste generation decreased by 13% in 2024-25 over the previous financial year.

Total waste disposed has decreased by 2% in 2024-25 over 2023-24, general waste to landfill decreased by 7% and recycling decreased by 9%.

Indicator - Waste weights	2022-23	% of total	2023-24	% of total	2024-25	% of total
Total units of waste disposed (kg and %)[1]	**2,672,663**	**100**	**2,627,335**	**100**	**2,413,160**	**100**
Landfill						
General waste[2]	**1,320,051**	**50.25**	**1,350,557**	**51.42**	**1,261,946**	**52.29**
Offsite treatment	**440,051**	**16.75**	**369,157**	**14.05**	**326,314**	**13.35**
Clinical waste - incinerated	26,978	1.03	26,783	1.02	33,325	1.38
Clinical waste - sharps	30,613	1.17	26,803	1.02	25,146	1.05
Clinical waste - treated	382,460	14.56	315,571	12.01	267,843	10.91
Recycling/recovery (disposal)	**912,561**	**34.74**	**907,621**	**34.53**	**829,157**	**34.36**
Batteries	5,155	0.20	2,012	0.08	3,616	0.15
Cardboard	477,710	18.19	474,653	18.07	435,306	18.04
Commingled	153,876	5.86	147,983	5.63	100,195	4.15
E-waste	2,550	0.10	745	0.03	3,238	0.13
Fluorescent tubes	1,161	0.04	966	0.04	784	0.03
Grease traps	76,400	2.91	109,980	4.19	107,700	4.46
Mattresses	1,025	0.04	3,050	0.12	662	0.03
Metals	28,800	1.10	29,195	1.11	28,943	1.20
Organics (food)	56,278	2.14	34,442	1.31	15,850	0.66
Other recycling[3]					970	0.04
Paper (confidential)	106,281	4.05	100,231	3.82	126,458	5.24
PVC	2,446	0.09	3,935	0.13	3,656	0.15
Sterilization wraps[4]	879	0.03	390	0.01	1,652	0.07
Toner and print cartridges			39	0.00	127	0.01

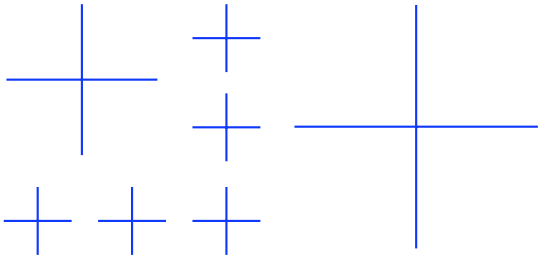
1. The RMH facilities include a mixture of office-based and non-office-based activity. As such, it is not practicable to separate waste usage into office and non-office-based activity.
2. This does not include municipal waste collected in council collections from our smaller sites.
3. X-Rays and DVT sleeves
4. Sterilisation wraps were still recycled in 2022-23; however, the waste supplier did not capture data. As such, this activity has been estimated for 2022-23.

Percentage of sites which are covered by dedicated collection services for[1]	2022-23	% of total	2023-24	% of total	2024-25	% of total
Streams	**Sites**	**%**	**Sites**	**%**	**Sites**	**%**
Printer cartridges	12	75%	13	100%	12	100%
Batteries	2	12%	2	15%	2	17%
E-waste	16	100%	13	100%	12	100%

1. The number of sites reduced from 21 to 16 in 2022-23, from 16 to 13 in 2023-24 and from 13 to 12 in 2024-25.

   The RMH has maintained a recycling rate of above 34% per cent during the reporting period and GHG emissions from waste continue to decrease. The reduction in clinical waste generation continues post pandemic.

Indicator - Waste trends	2022-23	2023-24	2024-25
Total units of waste disposed normalised by patient treated (kg/PT)	4.64	4.74	4.29
Total waste to landfill per patient treated	2.29	2.44	2.24
Total waste to offsite treatment per patient treated	0.76	0.67	0.57
Total waste recycled per patient treated	1.58	1.64	1.47
Total units of waste disposed normalised by floor area (kg/M2)	16.61	16.31	14.99
Total waste to landfill per M2	8.20	8.39	7.84
Total waste to offsite treatment per M2	2.73	2.29	2.00
Total waste recycled and reused per M2	5.67	5.63	5.15
Recycling Rate (%)	34.14%	34.55%	34.36%
GHG emissions associated with waste disposal (Tonnes CO2-e)	2,276.79	2,224.36	2,089.13

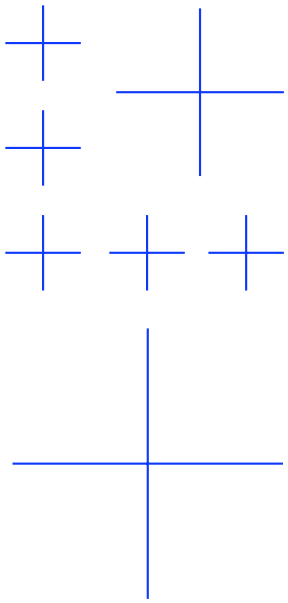


Additional information available on request

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

- statement that declarations of pecuniary interests have been duly completed by all relevant officers;
- details of shares held by senior officers 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 RMH;
- details of major external reviews carried out on the RMH;
- details of major research and development activities undertaken by the RMH;
- 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 RMH to develop community awareness of the RMH 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 RMH and details of time lost through industrial accidents and disputes;
- a list of major committees sponsored by the RMH, the purposes of each committee and the extent to which those purposes have been achieved; and
- details of all consultancies and contractors including:
  - i) consultants/contractors engaged;
  - ii) services provided; and
  - iii) expenditure committed to for each engagement

This information is available on request from:
Executive Assistant to the RMH Chief Executive
The RMH Chief Executive Office
Phone: (03) 9342 7762



Disclosure index

The annual report of the RMH is prepared in accordance with all relevant Victorian legislation.

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

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Financial summary

The key financial performance measure monitored by the Department of Health and the Royal Melbourne Hospital Management is the Operating result.

The RMH achieved its break even Statement of Priorities Target in 2024-25, by recording a minor surplus of $0.2m. This result was due to the significant increase in patient activity during 2024-25 driving revenue growth of 5.6% and cost growth being contained to 3.6%.

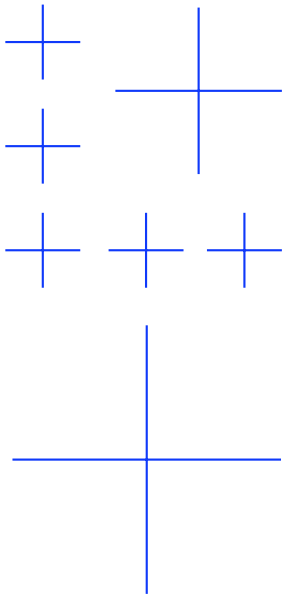
These outcomes contributed to the improved position on the previous financial year and the ability to deliver a break even operating result in 2024-25.

	2025	2024	2023	2022	2021
	$m	$m	$m	$m	$m
Operating Result*	0.2	**(27.5)**	**0.4**	**0.4**	**0.02**
Total Revenue	1,820.7	1,723.6	1,757.0	1,652.1	1,560.2
Total Expenses	1,809.5	1,747.1	1,706.7	1,681.9	1,576.0
Net Result from Transactions	**11.2**	**(23.5)**	**50.3**	**(29.8)**	**(15.8)**
Other Economic Flows	(2.7)	(3.5)	(13.4)	2.3	23.5
Net Result	**8.5**	**(27.0)**	**37.0**	**(27.5)**	**7.7**
Total Assets	1,703.0	1,651.4	1,514.7	1,490.8	1,409.5
Total Liabilities	648.7	605.6	644.0	686.0	577.2
Net Assets/Total Equity	**1,054.3**	**1,045.8**	**870.6**	**804.8**	**832.3**

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

Reconciliation between the Net Result reported in the Comprehensive Operating Statement to the Operating Result as agreed in the Statement of Priorities

	2024-25
	$m
Operating Result	**0.2**
Capital purpose income	104.3
COVID 19 State Supply Arrangements	
- Assets received free of charge or for nil consideration under the State Supply Arrangements	2.0
- State supply items consumed up to 30 June 2025	(2.0)
Assets provided free of charge or for nil consideration	(0.2)
Assets received free of charge or for nil consideration	0.7
Expenditure for capital purposes	(2.7)
Investment Income	8.9
Depreciation and amortisation	(98.1)
Finance costs	(1.8)
Net Gain/(Loss) on Non-Financial Assets	0.4
Net Gain/(Loss) on Financial Instruments	(5.4)
Other Gains/(Losses) from Other Economic Flows	2.2
Net Result	**8.5**



Modern Slavery Statement for 2024-25

Melbourne Health
ABN 73 802 706 972

Trading as the
Royal Melbourne Hospital

Financial Year 2024-2025

The RMH recognises that modern slavery practices are major violations of human rights and serious crimes, where coercion, threats, or deception are used to exploit victims and undermine or deprive them of their freedom and must be stamped out in all its various forms.

Modern Slavery Statement for 2024-25

This Modern Slavery Statement (Statement) is made pursuant to the Commonwealth Modern Slavery Act 2018 (the Act) by Melbourne Health

ABN 73 802 706 972 operating as the Royal Melbourne Hospital (RMH). The RMH is a health service registered under the Health Services Act 1988 (Victoria) and does not own or control any other entities. This statement relates to the financial year period from 1 July 2024 to 30 June 2025.

In making this Statement, the RMH recognises that modern slavery practices are major violations of human rights and serious crimes, where coercion, threats, or deception are used to exploit victims and undermine or deprive them of their freedom and must be stamped out in all its various forms.

The RMH commits to its ongoing responsibility to identify and act against modern slavery risks to maintain a responsible and transparent supply chain.

Overview

Modern slavery practices are major violations of human rights and serious crimes, where coercion, threats, or deception are used to exploit victims and undermine or deprive them of their freedom. Modern slavery practices include trafficking in persons, slavery, slavery-like practices (including forced labour and forced marriage) and the worst forms of child labour (including using children for prostitution or in hazardous work).

Modern slavery can occur in any country. The Global Slavery Index estimates there are currently 50 million victims of modern slavery worldwide, 10 million more than in 2018 when the Index started. In the private economy there are 17.4 million victims exploited. Most of these victims are in the Asia-Pacific region, where the supply chains of a significant number of Australian-based businesses have operations. Modern slavery can occur in any sector or industry, and at any point in a supply chain, with a recent study showing a total of 159 goods from 78 countries being linked to modern slavery.

Structure, operations, and supply chain

The RMH was created, and incorporated as a Metropolitan Health Service pursuant to the Health Services (Governance) Act 2000 and an associated Order by the Governor in Council dated 28 June 2000.

Details of our operations can be found from page 4 onwards of this annual report and by visiting our website https://www.thermh.org.au/about

To provide care, the RMH relies on suppliers of various specialised goods and services; from personal protective equipment to state of the art medical equipment. The RMH, as a public health service in Victoria, is mandated to purchase a large portion of its goods and services through collective purchasing agreements established by HealthShare Victoria (HSV).

This means that the RMH and other public health services in Victoria are heavily dependent on the processes and policies HSV has established to identify and manage modern slavery risks in its supply chains. See the attached link for further information on HSV's role in identifying and managing modern slavery risks across its collective agreements: healthsharevic.org.au/purchasing-policies-and-compliance/modern- slavery/

Modern slavery risks in the health care sector

Exploited workers are present in a wide range of sectors and at any stage of a supply chain. Most forced labour occurs in the lowest tiers of a supply chain, such as in the extraction of raw materials and the production of goods.

Within the healthcare sector, this is represented by industries such as garment production, surgical instruments, and electronic health care equipment. At the local operational level, service industries such as cleaning, security and catering represent a high-risk of workforce exploitation due to the predominance of low-skilled and migrant labour which are characteristic of these sectors.

Often the garment industries operate in locations where laws protecting human rights do not exist, are weak or are not enforced, leading to exploited workers with minimal avenue for redress. The sourcing of raw materials used in the production of surgical instruments and electronic goods and the significant use of labour hire companies in the production of pharmaceuticals contributes to exposing the medical goods sector to high risk.

This is exacerbated by other risk factors including high-risk geographies from which these goods are sourced, the vulnerable populations used to produce the goods, and the arrangements under which these vulnerable populations are accessed, contributes to significant risk of human rights abuses. Australia continues to be reliant on these imports from global supply chains for the supply of these essential goods to health services.

In Australia, extended life expectancy and an ageing population is expected to grow demand for healthcare goods and services in the years ahead, further increasing the risk of modern slavery within complex global supply chains.

Key actions taken to assess and address risks

Over the 2024-25 reporting period, the RMH has taken the following actions to identify and address modern slavery risks in its supply chain:

- Undertaken its first annual supplier risk assessment of suppliers engaged directly RMH
- Risk assessed a list of 37 suppliers which together represents just over 50% of RMH's total FY 2024-25 spend with directly contracted suppliers.
- Achieved a 70% response rate
- Continued to collaborate with HSV and our suppliers, to explore options to create longer-term solutions to reduce the modern slavery risks in their supply chain by engaging directly with suppliers and provide feedback on their progress.
- Maintained Mandatory Minimum Standards
- All tenders have mandatory minimum standards, all suppliers with annual revenue of at least $100 million are requested to submit an annual modern slavery statement.

People and training

As part of our ongoing training and development we have participated in a series of monthly community of learning sessions and conducted training across the RMH procurement team and explored raising awareness across the wider hospital, to highlight the importance of identifying and addressing modern slavery risks in our supply chain.

Tools and policies

We have developed a modern slavery framework and policy which includes a statement on combatting modern slavery in supply chains and an environmental, social and governance (ESG) risk assessment tool, which incorporates assessment of modern slavery risks. Monitoring compliance with policy shows commitment to improving an organisation's modern slavery risk. 81% of the suppliers assessed as having a modern slavery policy, have mechanisms in place to ensure compliance with the policy.

Remedy

Having a remedy process in place is vital to an organisations' ability to respond to instances of modern slavery in a transparent and predictable manner. A total of 81% of responding suppliers state they have a process in place to deal with allegations of modern slavery.

Supplier due diligence

We have included modern slavery questions in our market engagement documentation as part of due diligence process and to gain a greater understanding of our supply chains and obtained ongoing commitment from Suppliers to the Victorian Government; Supplier Code of Conduct, which requires suppliers to proactively identify,

address and report on modern slavery risks in their business operations and supply chains buyingfor. vic.gov.au/supplier-code-conduct.

Having a dedicated team member assists with raising visibility within an organisation on the existence of modern slavery risk. 92% of responding suppliers has a dedicated team member to oversee modern slavery.

Effectiveness of our actions

As noted above, we have taken steps to build upon our modern slavery framework. In 2025 we completed our fourth supplier risk assessments, expanded to include directly engaged suppliers, and implemented supplier Mandatory Minimum Standards.

As part of our supplier risk assessment process, the RMH notifies its suppliers via an email of their risk rating. This is beneficial, providing early feedback to suppliers and raising awareness of actions suppliers have taken to mitigate their modern slavery risk, and the impact of this on their risk rating. We have also requested high risk-rated suppliers provide a copy of their modern slavery policy for our review in addition to screening potential suppliers pre-engagement for modern slavery risk. Suppliers are at different stages of the modern slavery risk journey, and our aim is to uplift suppliers' risk mitigation capacity and actions through education and awareness at this point in time.

Risk rating	Percent of total
Low	35%
Medium	42%
High	23%
Non-response	0%
Total	**100%**

Next steps and closing statement

The implementation of the modern slavery framework is an iterative process. Over the next 12 months, the RMH will embed the modern slavery framework further by:

- Continuing to collaborate with high and very high-risk suppliers.
- Continue to conduct dedicated sessions for suppliers to discuss risk management, share best practices, and provide further guidance.
- Ongoing collaboration with HSV to undertake modern slavery risk-assessment with additional suppliers not covered under a HSV collective agreement.

We continue to build on our modern slavery framework by acknowledging that modern slavery risks exist in our supply chain, identifying those risks wherever possible and taking meaningful steps to address them.

This Statement was approved by the Board of Melbourne Health on 29 August 2025.

Linda Bardo Nicholls AO
Chair

Attestations and declarations

Financial Management Compliance Attestation

I, Linda Bardo Nicholls, AO, on behalf of the Board, certify that Melbourne Health has no Material Compliance Deficiency with respect to the applicable Standing Directions under the Financial Management Act 1994 and Instructions.

Linda Bardo Nicholls AO
Board Chair

Data Integrity Declaration

I, Shelley Dolan, certify that Melbourne Health has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Melbourne Health has critically reviewed these controls and processes during the year.

Professor Shelley Dolan
Chief Executive
Melbourne
29 August 2025

Conflict of Interest Declaration

I, Shelley Dolan, certify that Melbourne Health has put in place appropriate internal controls and processes to ensure that it 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 Melbourne Health 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.

Professor Shelley Dolan
Chief Executive
Melbourne
29 August 2025

Integrity, Fraud and Corruption Declaration

I, Shelley Dolan, certify that Melbourne Health has put in place appropriate internal controls and processes to ensure that Integrity, Fraud and Corruption risks have been reviewed and addressed at Melbourne Health during the year.

Professor Shelley Dolan
Chief Executive
Melbourne
29 August 2025

Compliance with Health Share Victoria (HSV) Purchasing Policies

I, Shelley Dolan, certify that the Melbourne Health has put in place appropriate internal controls and processes to ensure that it has materially complied with all requirements set out in the HSV Purchasing Policies including mandatory HSV collective agreements as required by the Health Services Act 1988 (Vic) and has critically reviewed these controls and processes during the year.

Professor Shelley Dolan
Chief Executive
Melbourne
29 August 2025

Statement of priorities

The Statement of Priorities is the key accountability agreement between the RMH and the Minister for Health. This annual agreement ensures delivery of, or substantial progress towards, the key shared objectives of financial viability, improved access and quality of service provision.

Part A

Part A of the Statement of Priorities usually sets our strategic goals and are aligned with Department of Health directives/reforms and healthcare policy. For 2024-2025 the Minister requested the RMH focus on 10 immediate and ongoing priorities:

Excellence in clinical governance

Strengthen all clinical governance systems, as per the Victorian Clinical Governance Framework, to ensure safe, high-quality care, with a specific focus on building and maintaining a strong safety culture, identifying, reporting, and learning from adverse events, and early, accurate recognition and management of clinical risk to and deterioration of all patients.	Improve paediatric patient outcomes by implementing the "ViCTOR track and trigger" observation chart and escalation system whenever children have observations taken	**Status: Achieved** **Commentary:** The RMH is an adult-based health service. However, when paediatric patients present to the RMH, age-based observation (ViCTOR) charts are available within our EMR including inbuilt escalation alerts to support identification and escalation of deterioration.
Improve access to timely emergency care by implementing strategies that improve whole of system patient flow to reduce emergency department wait times and improve ambulance to health service handover times.	Implement initiatives that support early discharge of patients to appropriate settings to improve timely patient access to care	**Status: Achieved** **Commentary:** Following the release of the Victorian Government Standards for Safe and Timely Ambulance and Emergency Care for Victorians the RMH ED implemented a number of changes including an expansion of acute treatment cubicles and an escalation process for ambulance transfer. These changes, implemented in March 2025, have seen the ambulance handover times improve by more than 10% this year, achieving 70% of ambulances offloaded within 40 minutes of arrival.

Strategic priority	Health service deliverable	The RMH response
Improve access to timely emergency care by implementing strategies that improve whole of system patient flow to reduce emergency department wait times and improve ambulance to health service handover times. *[continued]*	Implement initiatives that support early discharge of patients to appropriate settings to improve timely patient access to care *[continued]*	In 2025 the RMH continued its participation in the Victorian Department of Health Timely Emergency Care Collaborative and has sustained the overall improvement in timely care reducing our multiday Length of Stay (LOS) from 9.1 days in 2023-24 by 0.5 days (5%) to 8.6 days in 2024-25. The General Medicine service continued to implement new models of care to support earlier and safe discharge through the introduction of a fast follow-up virtual clinic whereby all patients receive a virtual check in post discharge. This year the Collaborative has focussed on improving care for the older >65 years adult with the RMH implementing several initiatives aimed at reducing LOS in subacute wards at the RMH Royal Park, improving timely access to ambulatory rehabilitation and the introduction of a new Rapid Assessment and Care of the Elderly Unit.
	Implement and ongoing evaluation the RMH Digital Coordination centre to better coordinate flow within RMH and improve timely patient access to care.	**Status: Achieved** **Commentary:** The RMH's DCC, the first of its kind in a Victorian health service, was established in August 2023. The DCC was designed to bring together situational awareness through informatics and key staff from a variety of teams who have an impact or can influence patient access and flow. This multi-disciplinary team work collaboratively utilising informatics tools to analyse real time data to identify problems and opportunities to improve access and flow and implement actions to make a difference. Formal evaluations of the RMH DCC were completed at 3 months and 12 months. Since implementation, the RMH has experienced fewer days in capacity and demand escalation, improved access, higher activity, and a safer and calmer hospital. The RMH has seen continuous improvement across key access and flow metrics, including: • reduction in ED admitted LOS • reduction in inpatient LOS • ability to maintain increased planned and unplanned activity and; • the implementation of a flexible bed model to open and close capacity to meet demand. With the two-year anniversary approaching, the DCC is firmly embedded as a critical part of business-as-usual operations with work underway to further expand the functions of the DCC. The team monitor data daily and through monthly KPIs to monitor ongoing performance and implement continuous improvement.

Strategic priority	Health service deliverable	The RMH response
Improve mental health and wellbeing outcomes by implementing Victoria's new and expanded Mental Health and Wellbeing system architecture and services.	Commission and operationalise 20 new inpatient mental health beds and the Mental Health and AOD hub in the RMH Emergency Department to improve timely access to care for consumers.	**Status: Achieved** **Commentary:** As part of the Department of Health P144 Expansion of Inpatient Mental Health Beds Project, the RMH opened an additional 14 new inpatient mental health beds incrementally between March to November 2024. Eight of these beds are intensive care beds doubling our capacity to care for higher acuity patients. This purpose-built inpatient facility provides a much improved therapeutic and healing environment for consumers experiencing mental illness. With this expanded capacity an additional 106 consumers have received care and we have improved access for mental health consumer with a reduction of 24-hour ED stays from an average of 17 per month last financial year to 5 per month this financial year. The Mental Health and Alcohol and Other Drugs Hub opened in early 2024 and included 12 new purpose-built short stay spaces for consumers presenting with mental health, alcohol, and other drug disorders. This year we have seen an increase in the patients treated through the Hub by 100% – with an average of 436 consumers per month.
	Engage in one or more mental health improvement program of Safer Care Victoria – elimination of restrictive intervention, improving sexual safety, implementation of the zero suicide framework and reducing compulsory treatment.	**Status: Achieved and ongoing** **Commentary:** The RMH mental health inpatient unit joined the Safer Care Victoria two-year program, Reducing Restrictive Interventions Collaborative in March this year. The Unit has commenced testing several changes ideas with the overall aim to reduce the average LOS from 10 hours to five over the next 12 months. The RMH has two members of staff including our Director of Lived Experience on the expert reference group for the Safer Care Victoria implementing zero suicide framework.
Maintain a commitment to delivering equitable access to planned surgery and drive reform in alignment with the Planned Surgery Reform Blueprint.	Implement and scale same day surgery models of care in line with Safer Care Victoria's Expanding Day Surgery recommendations.	**Status: Achieved** **Commentary:** The RMH implemented a same-day surgery model across 2023-2024 encompassing five key planned procedures: laparoscopic cholecystectomy, hernia repair, anterior cruciate ligament reconstruction, single-level lumbar laminectomy & discectomy, and haemorrhoidectomy. In June 2025, the model was expanded to include two additional procedures – laparoscopic appendicectomy and perianal and skin abscess interventions as well as emergency presentations. This transition from overnight admission to same-day discharge resulted in a total bed day saving of 415 days.

Strategic priority	Health service deliverable	The RMH response
Maintain a commitment to delivering equitable access to planned surgery and drive reform in alignment with the Planned Surgery Reform Blueprint. *[continued]*	Implement and expand surgical partnership with private providers and West Metro HSP health services to reduce planned surgery and endoscopy waiting lists at the RMH.	**Status: Achieved** **Commentary:** In January 2025 the RMH established additional surgical lists using theatre capacity at Peter MacCallum Cancer Centre to treat 95 patients. The RMH continued our partnerships with Melbourne Private Hospital, Victoria Parade Surgical Centre and the Epworth so that 353 additional patients received their surgery during the 2024-25 financial year. The RMH continued to work with the Werribee Mercy Hospital Rapid Access Hub to complete 940 endoscopy procedures.
	Implement reform initiatives that support improved surgery throughput and optimisation of theatre resources at the RMH.	**Status: Achieved** **Commentary:** The RMH commenced regular Saturday High Intensity Theatre (HIT) lists in October 2024. These lists focus on completing planned surgery that is lower complexity allowing for a higher volume of patients to be treated. More than 550 patients received their care on these HIT lists. The RMH established a Surgical Utilisation Reform and Efficiency working group to oversee optimisation of theatre resources and has implemented several initiatives including; changes to theatre template schedules to create all day lists and to better separate emergency and planned surgery where possible and created new theatre efficiency dashboards to track on-time starts and overruns.
Operate within a budget		
Develop and implement a health service Budget Action Plan (BAP) in partnership with the Department to manage cost growth effectively to ensure the efficient operation of the health service.	Deliver on the key initiatives as outlined in the BAP.	**Status: Achieved** **Commentary:** The RMH has successfully delivered and exceeded its BAP financial target in 2024/25. The internal RMH Financial Sustainability Committee oversees all initiatives in this area. The benefits have arisen from a combination of revenue generation with focus on private billing and other commercial revenue opportunities, improved productivity and procurement opportunities.
	Utilise data analytics and performance metrics to identify areas of inefficiency and waste and make evidence-based decisions to improve financial sustainability and operational performance.	**Status: Achieved** **Commentary:** The RMH Clinical Operations monitors its activities via multiple productivity measures on a daily, weekly and monthly basis, these measures are developing in their maturity and have contributed to the financial benefits achieved in 2024/25. A number of enhancements to analytical reporting tools and automation were made in 2024/2025 to drive further productivity opportunities including a focus on LOS level of EFT by unit, and surgical consumable products and prosthetics. The Facilities Management team have also utilised a number of AI tools to drive productivity with a notable example being the way clinical waste is managed resulting in improved financial and environmental outcomes.

Strategic priority	Health service deliverable	The RMH response
Improving equitable access to healthcare and wellbeing		
Enhance the provision of appropriate and culturally safe services, programs, and clinical trials for and as determined by Aboriginal people, embedding the principles of self determination.	Partner with Aboriginal community-controlled health organisations, respected Aboriginal leaders and Elders, and Aboriginal communities to deliver healthcare improvements	**Status: Achieved and ongoing** **Commentary:** Formal MOU established with VAHS, Community Consultation undertaken with Aboriginal led consultancy in relation to First Nations Experieince in ED.
	Promote a culturally safe welcoming environment with Aboriginal cultural symbols and spaces demonstrating, recognising, celebrating and respecting Aboriginal communities and culture.	**Status: Achieved and ongoing** **Commentary:** Acknowledgement of Country signs located across all key large meeting areas including Executive offices. Scoping and funding for First Nations mural artwork undertaken wiith delivery of project in late 2025.
	Identify and prioritise the health, wellbeing and service needs of the Aboriginal catchment population and service users – including improved patient identification, emergency care, discharge planning and outpatient service models to provide culturally safe care.	**Status: Ongoing** **Commentary:** First Nations dashboard completed - outlining key KPIs.
Expand the delivery of high-quality cultural safety training for all staff to align with the Aboriginal and Torres Strait Islander cultural safety framework. This training should be delivered by independent, expert, community-controlled organisations or a Kinaway or Supply Nation certified Aboriginal business.	Implement mandatory cultural safety training and assessment for all staff in alignment with the Aboriginal and Torres Strait Islander cultural safety framework, and developed and/ or delivered by independent, expert, and community-controlled organisations, Kinaway or Supply Nation certified Aboriginal businesses.	**Status: Achieved and ongoing** **Commentary:** Collaborated with ABSTARR Consulting to develop the RMH's first Anti-Racism and Cultural Safety Framework Developed new First Nations workforce Strategy 2025-2028. ABSTARR delivered specific cultural safety training to Board, Executive and Senior leadership to support the development of the Anti Racism and Cultural Safety Framework. They also delivered specific cultural safety training to medical and nursing staff in the ED, utilising case scenarios to develop a broader understanding

Strategic priority	Health service deliverable	The RMH response
A stronger workforce		
Improve employee experience across four initial focus areas to assure safe, high-quality care: leadership, health and safety, flexibility, and career development and agility.	Deliver programs to improve employee experience across four initial focus areas: leadership, safety and wellbeing, flexibility, and career development and agility.	**Status: Ongoing** **Commentary:** The RMH offers established programs focused on capability and leadership including the Melbourne Way Leadership program delivered in association with the University of Melbourne. Further, a dedicated wellbeing team of mental health professionals supports critical incidents, individual employee wellbeing and is working on improving systems of psychosocial risk. The RMH maintains its commitment to supporting workforce equity and inclusion through the implementation of our Workforce Equity Action Plan. Psychological safety initiatives continue to be a focus, including a new program aimed at empowering bystanders to improve our speak-up culture. Active bystander workshops provide staff with valuable opportunities to develop skills in speaking up and showing support when they observe inappropriate behaviour. Empowering staff to speak up and enabling leaders to create psychological safety for others to do so is fundamental to workplace safety, wellbeing, and positive employee experience. The RMH established a new anti-racism working group focused on addressing racism and improving safety for staff from non-English speaking and other cultural backgrounds. This initiative will build momentum and drive meaningful change in the coming years.
	Develop future workforce capability to provide a supported, growing and fit for purpose health workforce through the development of targeted workforce plans for nursing, medicine, allied health and support services	**Status: Ongoing** **Commentary:** Capability is a core focus across the RMH with a both a centralised team working on learning and growth mindset initiatives as well as having specific craft group functions to support the unique needs of our clinical and support staff. Steps are being taken to enable a more integrated approach to capability and workforce planning across the Precinct which will continue to further strengthen our planning for the future.

Strategic priority	Health service deliverable	The RMH response
	Implement and expand RMH leadership development plan.	**Status: Ongoing** **Commentary:** Leadership capability development remains a key priority for the RMH, recognising the central role our leaders play in creating positive and safe employee experiences while building psychosocial and psychological safety. This year, the RMH partnered with Melbourne Business School to deliver a flagship leadership program to 50 leaders. We also actively encouraged leaders to participate in both internally-facilitated programs and external initiatives, such as the University of Melbourne Bastas Program, that provide relevant support across all leadership levels. Internally, the RMH expanded its 'Leadership Fundamentals' offerings to include additional topics focusing on both operational and human skills essential for success. More than 60 sessions were made available to all staff, with more than 700 employees participating. Additionally, the People and Culture team facilitated at least 30 tailored Leadership Fundamentals sessions for intact teams. An organisational leadership coaching program was implemented this year, enabling leaders to access one-on-one coaching support through trained People and Culture team members.
Explore new and contemporary models of care and practice, including future roles and capabilities	Continuing to support the implementation of medium and long-term priorities of the Mental Health Workforce Strategy.	**Status: Ongoing** **Commentary:** There are a number of initiatives implemented to support the medium and long-term priorities for the mental health workforce. Overcoming challenges in recruiting and retaining appropriately skilled staff across disciplines is a key focus. The plan involves recruitment activity for nurses to be centralised within Nursing Workforce Unit; the development of a Learning and Development strategy for the workforce to provide a structure that focuses at capability building and an interprofessional from approach; close collaboration and engagement with RMH corporate services, including the Communications team to develop a recruitment campaign to attract local and international mental health nurses; the establishment of a wellbeing strategy, acknowledging the challenges of the work in mental health, and ensuring appropriate support mechanisms are in place and utilised; and longer term establishing a Nursing Workforce Plan focused on attraction, retention and workforce wellbeing.

Strategic priority	Health service deliverable	The RMH response
Moving from Competition to Collaboration		
Engage in integrated planning and service design approaches while assuring consistent and strong clinical governance with partners to connect the system to deliver seamless and sustainable care pathways and build sector collaboration.	Work with our Parkville Health Service partners to establish Pathology Network West (PNW).	**Status: Ongoing** **Commentary:** The RMH continues to lead and collaborate with Parkville partners to establish Pathology Network West, consolidating services to deliver more efficient, coordinated diagnostic services across the western region. The partners commenced a project to implement a new laboratory system which, when it goes live in 2026, will be a key enabler of the new PNW.
	Provide leadership of and active collaboration within the West Metro Health Service Partnership (WMHSP) to deliver agreed HSP priorities.	**Status: Ongoing** **Commentary:** The RMH played a leadership role in the WMHSP as Chair and funder, providing extensive corporate support and actively championing the HSP. The RMH also participated in several WMHSP projects in 2024-25, including the Aboriginal Health Improvement Initiative, the Residential-in-Reach project, our Primary Care and Population Health Committee and the Safer Together program. The RMH also continued to partner with WMHSP members to extend and expand the work previously done through the elective surgery program that ended in June 2024. For example, use of the regional endoscopy hub at Werribee Mercy Hospital.
	Partner with mental and wellbeing services in the local region to implement mental health reform.	**Status: Ongoing** **Commentary:** The RMH worked with the the newly established Parkville Youth Mental Health and Wellbeing Service (PYMHWS) to transition the Orygen Specialist Program from 1 July 2025. The RMH continues to collaborate with local mental health and wellbeing providers Jesuit Services and Wellways to support the implementation of the Department of Health Mental Health Workforce Capability Framework “Our Workforce, Our Future”.

Part B

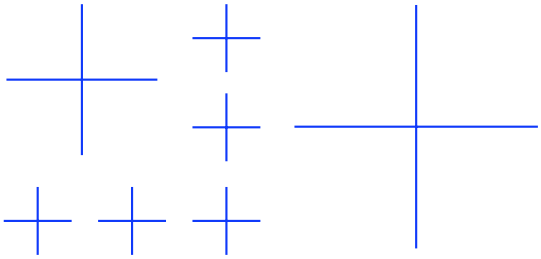
Key Performance Measure	Target	Value
Infection prevention and control		
Percentage of healthcare workers immunised for influenza	94%	94.2%
Continuing care		
Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations	≥ 0.645	0.701
Adverse events		
Percentage of reported sentinel events for which a root cause analysis (RCA) report was submitted within 30 business days from notification of the event	All RCA reports submitted within 30 business days	75%
Aged Care		
Public sector residential aged care services overall star rating	Minimum rating of 3 stars	4 stars
Patient experience		
Percentage of patients who reported positive experiences of their hospital stay	95%	Q1 92.2% Q2 93.3% Q3 91.8% Q4 data not available
Aboriginal Health		
The gap between the number of Aboriginal patients who discharged against medical advice2 compared to non-Aboriginal patients	0%	4.21%
The gap between the number of Aboriginal patients who 'did not wait' presenting to hospital emergency departments non-Aboriginal patients	0%	9.74%
Mental Health		
Mental Health Patient experience		
Percentage of families/carers reporting a ‘very good’ or ‘excellent’ overall experience of the service	80%	NA – Statewide Survey did not take place in 2024-25
Percentage of families/carers who report they ‘always’ or ‘usually’ felt their opinions as a carer were respected	90%	NA – Statewide Survey did not take place in 2024-25
Percentage of mental health consumers reporting they ‘usually’ or ‘always’ felt safe using this service	90%	NA – Statewide Survey did not take place in 2024-25

Key Performance Measure	Target	Value
Mental Health follow-ups, readmissions, and seclusions		
Percentage of consumers followed up within 7 days of separation – Inpatient	88%	95.11%
Percentage of consumers re-admitted within 28 days of separation - Inpatient	< 14%	11.5%
Rate of seclusion episodes per 1,000 occupied bed days - Inpatient	≤ 6	6.78
Organisational culture		
People matter survey – Percentage of staff with an overall positive response to safety culture survey questions	80%	78%
Planned Surgery		
Percentage of urgency category 1 planned surgery patients admitted within 30 days	100%	100%
Percentage of all planned surgery patients admitted within the clinically recommended time	94%	81.62%
Number of patients admitted from the planned surgery waiting list	10,500	9,946
Percentage of patients on the waiting list who have waited longer than clinically recommended time for their respective triage category	25% proportional improvement from prior year: ≤ 29.8%	38.38%
Optimisation of surgical inpatient length of stay (LOS), including through the use of virtual and home-based pre- and post-operative models of care	Reduction in average LOS for surgical patients by 2% on 23-24 performance: ≤ 1.87	1.86
Emergency Care		
Percentage of patients transferred from ambulance to emergency department within 40 minutes	4% improvement on 23-24 performance: ≥ 61.9%	69.90%
Number of patients with a length of stay in the emergency department greater than 24 hours	0	59
Mean ED length of stay (admitted) in minutes	7% improvement on 23-24 performance: ≤ 319	314.14
Mean ED length of stay (non-admitted) in minutes	3% improvement on 23-24 performance: ≤ 218	219.45
Inpatient length of stay in minutes	3% improvement on 23-24 performance: ≤ 3197.95	2,990

Key Performance Measure	Target	Value
Mental Health		
Percentage of mental health-related emergency department presentations with a length of stay of less than 4 hours	65%	53%
Percentage of departures from emergency departments to a mental health bed within 8 hours	80%	45%
Number of admitted mental health occupied bed days	30,368	25,535
Specialist Clinics		
Percentage of patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe4	95%	89.72%
Home Based Care		
Percentage of admitted bed days delivered at home	Equal to or better than prior year result: ≥ 10.59%	10.82%

Effective financial management

Key Performance Measure	Target	Result
Operating result ($M)	0.00	0.2 Achieved
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	0.8 Achieved
Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June	5% movement in forecast revenue and expenditure forecasts	Achieved



Part C

Funding type	2024-25 activity achievement
Consolidated activity funding	
Acute admitted, subacute admitted, emergency services, non-admitted NWAU	154,702
Acute admitted mental health NWAU	6,774
Acute Admitted	
Acute admitted DVA	356
Acute admitted TAC	7,403
Subacute/non-acute, admitted and non-admitted	
Subacute - DVA	41
Transition care - bed days	6,978
Transition care - home days	13,715
Aged care	
Residential aged care	23,109
Mental Health and Drug Services	
Mental health ambulatory	151,214
Mental health subacute	9,378
Other	
Health workforce	369

Financial statements

How this report is structured

Melbourne Health presents its audited general purpose financial statements for the financial year ended 30 June 2025 in the following structure to provide users with the information about Melbourne Health's stewardship of the resources entrusted to it.

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

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

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

We further state that, in our opinion, the information set out in the 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 2025 and the financial position of Melbourne Health at 30 June 2025.

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

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

Linda Bardo Nicholls AO
Board Chair

Melbourne
29 August
2025

Professor Shelley Dolan
Chief Executive

Melbourne
29 August
2025

Paul Urquhart
Chief Corporate Officer

Melbourne
29 August
2025

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Melbourne Health

Opinion	I have audited the financial report of Melbourne Health (the health service) which comprises the: • balance sheet as at 30 June 2025 • 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 material accounting policy information • 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 2025 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 (including Independence Standards)* (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.

Auditor's responsibilities for the audit of the financial report

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

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

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

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

MELBOURNE
4 September 2025

Simone Bohan
as delegate for the Auditor-General of Victoria

Melbourne Health
Comprehensive operating statement
For the financial year ended 30 June 2025

	Note	Total 2025 $'000	Total 2024 $'000
Revenue and income from transactions			
Revenue from contracts with customers	2.1	1,243,118	910,375
Other sources of income	2.1	577,600	813,211
Total revenue and income from transactions		**1,820,718**	**1,723,586**
Expenses from transactions			
Employee expenses	3.1	(1,268,065)	(1,220,625)
Finance costs	6.1	(1,882)	(1,898)
Depreciation and amortisation	4.3	(98,087)	(103,268)
Other operating expenses	3.1	(441,305)	(439,523)
Other non-operating expenses	3.1	(175)	18,260
Total expenses from transactions		**(1,809,514)**	**(1,747,054)**
Net result from transactions - net operating balance		**11,204**	**(23,468)**
Other economic flows included in net result			
Net gain/(loss) on sale of non-financial assets		427	(422)
Net gain/(loss) on financial instruments		(5,385)	(5,374)
Net gain/(loss) on disposal of share in joint arrangements		-	(733)
Other gains/(losses) from other economic flows		2,215	2,999
Total other economic flows included in net result		**(2,743)**	**(3,530)**
Net result		**8,461**	**(26,998)**
Other economic flows - other comprehensive income			
Items that will not be reclassified to net result			
Changes in property, plant and equipment revaluation surplus		-	207,765
Total other comprehensive income		**-**	**207,765**
Comprehensive result		**8,461**	**180,767**

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

Melbourne Health
Balance sheet
As at 30 June 2025

	Note	Total 2025 $'000	Total 2024 $'000
Financial assets			
Cash and cash equivalents	6.2	179,202	162,738
Receivables	5.1	115,947	82,311
Contract assets	5.2	15,947	12,443
Investments	5.3	21,524	19,293
Total financial assets		**332,620**	**276,785**
Non-financial assets			
Prepayments		29,968	24,436
Inventories	5.4	23,782	22,934
Property, plant and equipment	4.1	1,287,727	1,293,406
Intangible assets	4.2	28,866	33,801
Total non-financial assets		**1,370,343**	**1,374,577**
Total assets		**1,702,963**	**1,651,362**
Liabilities			
Payables	5.5	209,426	190,927
Contract liabilities	5.6	22,467	18,175
Borrowings	6.1	56,820	60,143
Employee benefits	3.1(b)	353,529	330,506
Other liabilities	5.7	6,505	5,856
Total liabilities		**648,747**	**605,607**
Net assets		**1,054,216**	**1,045,755**
Equity			
Property, plant and equipment revaluation surplus		904,322	904,322
Restricted specific purpose surplus		89	157
Contributed capital		332,260	332,260
Accumulated surplus/(deficit)		(182,455)	(190,984)
Total equity		**1,054,216**	**1,045,755**

This balance sheet should be read in conjunction with the accompanying notes.

Melbourne Health
Cash flow statement
For the financial year ended 30 June 2025

	Note	Total 2025 $'000	Total 2024 $'000
Cash flows from operating activities			
Operating grants from State Government		1,351,369	1,234,117
Operating grants from Commonwealth Government		69,714	62,394
Capital grants from State Government		64,464	48,595
Capital grants from Commonwealth Government		400	400
Patient and hospital fees received		74,740	69,496
Donations and bequests received		5,511	6,561
GST received from/(paid to) ATO[(i)]		52,545	55,823
Interest and investment income received		15,672	12,245
External recoveries		41,952	54,688
Other receipts		147,092	144,052
Total receipts		***1,823,459***	***1,688,371***
Payments to employees		(1,209,955)	(1,148,763)
Non salary labour costs		(31,367)	(29,973)
Payments for supplies and consumables		(230,008)	(258,279)
Payments for medical indemnity insurance		(16,423)	(14,267)
Payments for repairs and maintenance		(48,223)	(42,941)
Finance costs		(1,882)	(1,898)
Other payments		(202,484)	(172,960)
Total payments		***(1,740,342)***	***(1,669,081)***
Net cash flows from/(used in) operating activities	8.1	**83,117**	**19,290**
Cash flows from investing activities			
Proceeds from sale of non-financial assets		843	918
Purchase of non-financial assets		(58,945)	(67,440)
Purchase of financial assets		(1,146)	(504)
Net cash flows from/(used in) investing activities		**(59,248)**	**(67,026)**
Cash flows from financing activities			
Receipt of accommodation deposits		2,091	2,857
Repayment of accommodation deposits		(1,445)	(494)
Repayment of principal portion of lease liabilities		(8,051)	(7,924)
Net cash flows from/(used in) financing activities		**(7,405)**	**(5,561)**
Net increase/(decrease) in cash and cash equivalents held		**16,464**	**(53,297)**
Cash and cash equivalents at beginning of year		162,738	216,035
Cash and cash equivalents at end of year	6.2	**179,202**	**162,738**

This statement should be read in conjunction with the accompanying notes.
[(i)] GST received from/paid to the Australian Taxation Office is presented on a net basis.

Melbourne Health
Statement of changes in equity
For the financial year ended 30 June 2025

	Property, plant and equipment revaluation surplus	Restricted specific purpose surplus	Contributed capital	Accumulated surplus/(deficit)	Total
	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2023	**696,557**	**1,023**	**337,904**	**(164,852)**	**870,632**
Net result for the year	-	-	-	(26,998)	(26,998)
Other comprehensive income for the year	207,765	-	-	-	207,765
Transfer from/(to) accumulated surplus/(deficit)	-	(866)	-	866	-
Capital contribution transfer to another health service[(i)]	-	-	(5,644)	-	(5,644)
Balance at 30 June 2024	**904,322**	**157**	**332,260**	**(190,984)**	**1,045,755**
Net result for the year	-	-	-	8,461	8,461
Transfer from/(to) accumulated surplus/(deficit)	-	(68)	-	68	-
Balance at 30 June 2025	**904,322**	**89**	**332,260**	**(182,455)**	**1,054,216**

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

(i) Transfer of property, plant and equipment resulting from mental health disaggregation to Western Health in 2024 via Contributed Capital.

Note 1: About this report

Structure

These financial statements represent the audited general purpose financial statements of Melbourne Health for the year ended 30 June 2025.

This section explains the basis of preparing the financial statements.

Note 1.1: Basis of preparation

These general purpose financial statements have been prepared in accordance with the *Financial Management Act 1994* (FMA) and applicable Australian Accounting Standards (AASs), which include interpretations, issued by the Australian Accounting Standards Board (AASB).

Where appropriate, those AASs paragraphs applicable to not-for-profit entities have been applied. Accounting policies selected and applied in these financial statements ensure the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

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

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

The financial statements have been prepared on a going concern basis (refer to Note 1.5 Economic dependency).

The financial statements are presented 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 Melbourne Health on 29 August 2025.

Note 1.2: Material accounting judgements and estimates

Management makes judgements and estimates when preparing the financial statements.

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

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

The material accounting judgements and estimates used, and any changes thereto, are identified at the beginning of each section where applicable and relate to the following disclosures:

- Note 2.1: Revenue and income from transactions
- Note 3.1: Expenses incurred in the delivery of services
- Note 4.1: Property, plant and equipment
- Note 4.2: Intangible assets
- Note 4.3: Depreciation and amortisation
- Note 4.4: Impairment of assets
- Note 5.1: Receivables
- Note 5.2: Contract assets
- Note 5.5: Payables
- Note 5.6: Contract liabilities
- Note 6.1(a): Lease liabilities
- Note 7.4: Fair value determination

Note 1.3: 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 Melbourne Health and their potential impact when adopted in future periods is outlined below:

Standard	Adoption Date	Impact
AASB 2022-10: *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities*	Reporting periods beginning on or after 1 January 2024. In accordance with FRD 103, Melbourne Health will apply Appendix F of AASB 13 prospectively, in the next formal asset revaluation or interim revaluation (whichever is earlier).	Melbourne Health is yet to assess the impact of adopting this standard.
AASB 2024-2: *Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments*	Reporting periods beginning on or after 1 January 2026.	Adoption of this standard is not expected to have a material impact.
AASB 18: *Presentation and Disclosure in Financial Statements*	Reporting periods beginning on or after 1 January 2028.	Melbourne Health is yet to assess the impact of adopting this standard.

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

Note 1.4: Reporting entity

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

Melbourne Health's principal address is:

c/o The Royal Melbourne Hospital
300 Grattan St
Parkville VIC 3050.

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

Note 1.5: Economic dependency

Melbourne Health is a public health service governed and managed in accordance with the *Health Services Act 1988* and its results form part of the Victorian General Government consolidated financial position. Melbourne Health provides essential services and is predominantly dependent on the continued financial support of the State Government, particularly the Department of Health, and the Commonwealth funding via the National Health Reform Agreement (NHRA). The State of Victoria plans to continue Melbourne Health operations and on that basis, the financial statements have been prepared on a going concern basis.

Note 1.6: Administrative restructure

Mental health disaggregation

On 1 July 2023, pursuant to a Victorian Government Gazette, Melbourne Health effected the transfer of certain properties associated with mental health services and their attaching rights and liabilities to Western Health.

The transfer of these properties was effected as a restructuring of administrative arrangements per FRD 119 *Transfers through contributed capital* and was accounted for as a capital transfer during 2023-24.

The net assets transferred was accounted for as a reduction of contributed capital as per below:

	$'000
Plant and equipment	819
Land and buildings	4,824
Total	5,644

In addition to the above transfer, employee leave liability ($16.2m) and the related Long Service Leave (LSL) receivable balance ($6.7m) of the staff whose employment was transferred to Western Health was accounted for via the comprehensive operating statement as they were not covered by the Victorian Government Gazette.

The remaining transfer of staff for Northern Health also took place during 2023-24, resulting in transfer of employee leave liability ($2.1m) and the related LSL receivable balance ($0.9m).

Note 2: Funding delivery of our services

Melbourne Health's overall objective is to deliver programs and services that support and enhance the wellbeing of all Victorians. Melbourne Health is predominantly funded by grant funding for the provision of services. Melbourne Health also receives income from the supply of services.

Structure

2.1 Revenue and income from transactions

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	Description
Identifying performance obligations	Melbourne Health applies judgement 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 Melbourne Health to recognise revenue as or when the health service 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	Melbourne Health applies 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	Melbourne Health applies judgement to determine when its obligation to construct an asset is satisfied. Costs incurred is used to measure the health service's progress as this is deemed to be the most accurate reflection of the stage of completion.
Assets and services received free of charge or for nominal consideration	Melbourne Health applies judgement to determine the fair value of assets and services received free of charge or for nominal value.

-

Note 2.1: Revenue and income from transactions

	Note	Total 2025 $'000	Total 2024 $'000
Revenue from contracts with customers*	2.1 (a)	1,243,118	910,375
Other sources of income*	2.1 (b)	577,600	813,211
Total revenue and income from transactions		**1,820,718**	**1,723,586**

* Movement between categories is primarily due to Mental Health grants moving from fixed grants in 2024 to activity based funding in 2025.

Note 2.1 (a): Revenue from contracts with customers

	Total 2025 $'000	Total 2024 $'000
Government grants (State) - Operating	1,051,059	728,704
Government grants (Commonwealth) - Operating	69,637	65,779
Patient and resident fees	37,630	36,745
Private practice fees	43,429	41,337
Commercial activities[(i)]	21,789	20,050
Research income	19,574	17,760
Total revenue from contracts with customers	**1,243,118**	**910,375**
Melbourne Health disaggregates revenue by the timing of revenue recognition.		
Goods and services transferred to customers:		
At a point in time	1,137,709	807,261
Over time	105,409	103,114
Total revenue from contracts with customers	**1,243,118**	**910,375**

[(i)] Commercial activities represent business activities which Melbourne Health enters into to support its operations.

How we recognise revenue from contracts with customers

Government operating grants

Revenue from government operating grants that are enforceable and contain sufficiently specific performance obligations are accounted for as revenue from contracts with customers under AASB 15.

In contracts with customers, the ‘customer’ is typically a funding body, who is the party that promises funding in exchange for Melbourne Health’s goods or services. Melbourne Health’s 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 Melbourne Health's revenue streams, with information detailed below relating to Melbourne Health's significant revenue streams:

Government grant	Performance obligation
Activity Based Funding (ABF) paid as National Weighted Activity Unit (NWAU)	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 a point in time, which is when a patient is discharged.
Other Victorian and Commonwealth funding	Melbourne Health receives various funding streams from both the Victorian and Commonwealth government departments. The performance obligations are defined in accordance with the levels of activity agreed to within each funding agreement. Revenue is recognised at a point in time, which is when the service is provided.

Patient and resident fees

Patient and resident fees are charges that can be levied on patients for some services they receive. Patient and resident fees are recognised at a point in time when the performance obligation, the provision of services, is satisfied, except where the patient and resident fees relate to accommodation charges. Accommodation charges are calculated daily and are recognised over time, to reflect the period accommodation is provided.

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 items such as car park income, clinical trial income, ethics review fees, training and seminar fees, breast-screen service and external service agreements. Commercial activity revenue is recognised at a point in time, upon provision of the goods or service to the customer.

Note 2.1 (b): Other sources of income

	Note	Total 2025 $'000	Total 2024 $'000
Operating activities			
Government grants (State) - Operating		313,136	551,360
Government grants (State) - Capital		95,800	91,909
Government grants (Commonwealth) - Capital		400	400
Other capital purpose income		16,894	16,017
Assets and services received free of charge or for nominal consideration	2.1 (c)	8,153	9,032
Salary and other recoveries		28,692	43,157
Other income from operating activities		90,496	81,062
Total operating activities		**553,571**	**792,937**
Non-operating activities			
Interest		14,525	11,791
Dividends		1,146	454
Rental income		8,358	8,029
Total non operating activities		**24,029**	**20,274**
Total other sources of income		**577,600**	**813,211**

How we recognise other sources of income

Government operating grants

Melbourne Health recognises income of not-for-profit entities under AASB 1058 where it has been earned under arrangements that are either not enforceable or linked to sufficiently specific performance obligations.

Income from grants without any sufficiently specific performance obligations or that are not enforceable, is recognised when Melbourne Health has an unconditional right to receive cash which usually coincides with receipt of cash. On initial recognition of the asset, Melbourne Health recognises any related contributions by owners, increases in liabilities, decreases in assets or revenue (related amounts) in accordance with other Australian Accounting Standards. Related amounts may take the form of:

- contributions by owners, in accordance with AASB 1004 *Contributions*
- revenue or contract liability arising from a contract with a customer, in accordance with AASB 15 *Revenue from Contracts with Customers*
- a lease liability in accordance with AASB 16 *Leases*
- a financial instrument, in accordance with AASB 9 *Financial Instruments*
- a provision, in accordance with AASB 137 *Provisions, Contingent Liabilities and Contingent Assets*.

Capital grants

Where Melbourne Health receives a capital grant it recognises a liability, equal to the financial asset received less amounts recognised under other Australian Accounting Standards.

Income is recognised in accordance with AASB 1058 progressively as the asset is constructed which aligns with Melbourne Health's obligation to construct the asset. The progressive percentage of costs incurred is used to recognise income, as this most accurately reflects the stage of completion.

Rental income

Rental income 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	
	2025 $'000	**2024 $'000**
Within one year	806	4,595
Within one to two years	725	517
Within two to three years	508	451
Within three to four years	27	291
Within four to five years	-	27
After five years	10	10
Total undiscounted future lease payments receivable	**2,076**	**5,891**

Dividend income

Dividend income is recognised when the right to receive payment is established. Dividends represent the income arising from Melbourne Health'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 (c): Fair value of assets and services received free of charge or for nominal consideration

	Total 2025 $'000	**Total 2024 $'000**
Cash donations and gifts	5,511	6,561
Plant and equipment	665	-
Personal protective equipment and other consumables	1,977	2,471
Total fair value of assets and services received free of charge or for nominal consideration	**8,153**	**9,032**

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 Melbourne Health obtains 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.

Plant and equipment

Melbourne Health received equipment from Monash Health during 2024-25.

Personal protective equipment

Under the State Supply Arrangement, HealthShare Victoria supplies personal protective equipment to Melbourne Health for nil consideration.

Non-cash contributions from the Department of Health

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

Supplier	Description
Victorian Managed Insurance Authority	The Department of Health purchases non-medical indemnity insurance for Melbourne Health 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.
Victorian Health Building Authority	The Department of Health made payments to the Victorian Health Building Authority to fund capital works projects during the year ended 30 June 2025, on behalf of Melbourne Health.
Department of Health	Long Service Leave (LSL) funding is recognised upon finalisation of movements in LSL liability in line with the long service leave funding arrangements with the Department of Health.

Note 3: The cost of delivering our services

This section provides an account of the expenses incurred by Melbourne Health in delivering services and outputs. In Note 2, the funds that enable the provision of services were disclosed and in this note the costs associated with the provision of services are disclosed.

Structure

3.1 Expenses incurred in the delivery of services

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	Description
Classifying employee benefit liabilities	Melbourne Health applies judgement when classifying its employee benefit liabilities. Employee benefit liabilities are classified as a current liability if Melbourne Health 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 Melbourne Health 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	Melbourne Health applies material judgement when measuring its employee benefit liabilities. Melbourne Health applies judgement to determine when it expects its employee entitlements to be paid. With reference to historical data, if the health service 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: • an inflation rate of 4.25% (as issued by DTF), reflecting the future wage and salary levels. • durations of service and employee departures, which are used to determine the estimated value of long service leave that will be taken in the future, for employees who have not yet reached the vesting period. The estimated rates are between 19.88% (representing employees with less than 1 year of service) and 79.39% (representing employees becoming entitled to long service leave within a year). • discounting at the rate of 4.20%, as determined with 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 incurred in the delivery of services

	Note	Total 2025 $'000	Total 2024 $'000
Employee expenses	3.1(a)	1,268,065	1,220,625
Other operating expenses	3.1(d)	441,305	439,523
Other non-operating expenses	3.1(d)	175	(18,260)
Total expenses incurred in the delivery of services		1,709,545	1,641,888

Note 3.1 (a): Employee expenses

	Total 2025 $'000	Total 2024 $'000
Salaries and wages	944,560	917,130
On-costs	276,725	257,681
Agency expenses and external contract staff	27,108	26,541
Fee for service medical officer expenses	4,221	3,484
WorkCover premium	15,451	15,789
Total employee expenses	**1,268,065**	**1,220,625**

How we recognise employee expenses

Employee expenses include salaries and wages, fringe benefits tax, leave entitlements, termination payments, WorkCover payments and agency expenses.

Note 3.1 (b): Employee benefits in the balance sheet

	Total 2025 $'000	Total 2024 $'000
Current employee benefits and related on-costs		
Accrued days off		
Unconditional and expected to be settled wholly within 12 months [(i)]	3,252	3,075
	3,252	**3,075**
Annual leave		
Unconditional and expected to be settled wholly within 12 months [(i)]	94,699	72,609
Unconditional and expected to be settled wholly after 12 months [(ii)]	14,782	29,428
	109,481	**102,037**
Long service leave		
Unconditional and expected to be settled wholly within 12 months [(i)]	19,662	18,746
Unconditional and expected to be settled wholly after 12 months [(ii)]	155,435	145,510
	175,097	**164,256**
Other employee benefits		
Unconditional and expected to be settled wholly within 12 months [(i)]	985	977
	985	**977**
Provisions related to employee benefit on-costs		
Unconditional and expected to be settled wholly within 12 months [(i)]	16,081	12,463
Unconditional and expected to be settled wholly after 12 months [(ii)]	23,313	23,789
	39,394	**36,252**
Total current employee benefits and related on-costs	**328,209**	**306,597**
Non-current employee benefits and related on-costs		
Conditional long service leave	22,267	21,026
Provisions related to employee benefit on-costs	3,053	2,883
Total non-current employee benefits and related on-costs	**25,320**	**23,909**
Total employee benefits and related on-costs	**353,529**	**330,506**

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

Provision for related on-costs movement schedule

	Total 2025 $'000	Total 2024 $'000
Carrying amount at start of year	**39,135**	**38,013**
Additional provisions recognised	22,209	17,911
Amounts incurred during the year	(18,630)	(16,428)
Net gain/(loss) arising from revaluation of long service liability	(267)	(361)
Carrying amount at end of year	**42,447**	**39,135**

How we recognise employee benefits

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.

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 sick leave is taken.

Annual leave and accrued days off

Liabilities for annual leave and accrued days off are recognised in the provision for employee benefits as 'current liabilities' because Melbourne Health 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 Melbourne Health expects to wholly settle within 12 months; or
- present value – if Melbourne Health 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 Melbourne Health does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

- nominal value – if Melbourne Health expects to wholly settle within 12 months; or
- present value – if Melbourne Health 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 e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flows in the net result.

Provisions

Employment on-costs such as payroll tax, workers compensation and superannuation are not employee benefits. They are disclosed separately as a component of the provision for employee benefits when the employment to which they relate has occurred.

Note 3.1 (c): Superannuation

	Paid contribution for the year		Contribution outstanding at year end	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Defined benefit plans[(i)]:				
Emergency Services and State Super (ESSSuper)	112	125	3	3
Aware Super defined benefit	2	197	11	34
Defined contribution plans:				
HESTA	31,418	29,087	3,819	3,533
Aware Super	46,919	44,585	6,022	5,146
Other	22,695	18,867	3,051	2,473
Total	**101,146**	**92,861**	**12,906**	**11,189**

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

How we recognise superannuation

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

Defined benefit superannuation plans

A defined benefit plan provides 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 Melbourne Health to the superannuation plans in respect of the services of current Melbourne Health 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.

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

The Department of Treasury and Finance discloses the State's defined benefits liabilities in its disclosure for administered items. However, superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of Melbourne Health.

The names, details and amounts expensed in relation to the major employee superannuation funds and contributions made by Melbourne Health are disclosed above.

Defined contribution superannuation plans

Defined contribution (i.e. accumulation) superannuation plan expenditure 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 names, details and amounts expensed in relation to the major employee superannuation funds and contributions made by Melbourne Health are disclosed above.

Note 3.1 (d): Other operating and non-operating expenses

		Total 2025 $'000	Total 2024 $'000
Pharmaceutical supplies		68,233	64,281
Medical and surgical supplies (including prostheses)		98,830	93,371
Diagnostic and radiology supplies		38,304	39,001
Other supplies and consumables		25,700	54,730
Expenses related to short term leases		1,668	1,767
Expenses related to leases of low value assets		3,197	3,266
Other administrative expenses		67,095	63,511
Fuel, light, power and water		11,235	10,518
Repairs and maintenance		8,077	7,802
Maintenance contracts		40,146	35,037
Medical indemnity insurance		16,423	14,267
Expenditure for capital purposes		11,708	17,678
Other operating expenses		50,689	34,294
Total other operating expenses		441,305	439,523
Assets transferred for nil consideration [(i)]		175	-
Liabilities transferred for nil consideration [(i)]	1.6	-	(18,260)
Total other non-operating expenses		**175**	**(18,260)**

[(i)] Building and leave entitlements transferred to Western Health and Northern Health resulting from mental health disaggregation.

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.

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.

The following lease payments are recognised on a straight-line basis:

- short term leases – leases with a term of twelve months or less, and
- low value leases – leases with the underlying asset's fair value (when new, regardless of the age of the asset being leased) is no more than $10,000.

Other operating expenses

Other operating expenses generally represent the day-to-day running costs incurred in normal operations.

The Department of Health also makes certain payments on behalf of Melbourne Health. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and also recording a corresponding expense.

Other non-operating expenses

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

Note 4: Key assets to support service delivery

Melbourne Health 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 Melbourne Health to be utilised for delivery of those services.

Structure

4.1 Property, plant and equipment

4.2 Intangible assets

4.3 Depreciation and amortisation

4.4 Impairment of assets

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	Description
Estimating useful life of property, plant, equipment and intangible assets	Melbourne Health assigns an estimated useful life to each item of property, plant, equipment and intangible asset. This is used to calculate depreciation of the asset. Melbourne Health 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 useful life of right-of-use assets	The useful life of each right-of-use asset is typically the respective lease term, except where Melbourne Health is reasonably certain to exercise a purchase option contained within the lease, in which case the useful life reverts to the estimated useful life of the underlying asset. Melbourne Health applies judgement to determine whether or not it is reasonably certain to exercise such purchase options.
Identifying indicators of impairment	At the end of each year, Melbourne Health assesses impairment by evaluating the conditions and events specific to the health service that may be indicative of impairment triggers. Where an indication exists, Melbourne Health tests the asset for impairment. Melbourne Health considers a range of information when performing its assessment, including: • 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 Melbourne Health 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, Melbourne Health applies judgement and estimate to determine the recoverable amount of the asset.

Material judgements and estimates	Description
Classification of land with no lease agreements in place	In the absence of formal lease agreements, Melbourne Health has recognised all Crown Land as property, plant and equipment instead of right-of-use concessionary land as: • Melbourne Health is responsible for all maintenance, insurance and other holding costs • Melbourne Health has the right to use the assets indefinitely, unless a ministerial change occurs • the assets are held and used as property, plant and equipment in substance.

Note 4.1: Property, plant and equipment

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Land at fair value - Crown	302,035	302,035	-	-	302,035	302,035
Land at fair value - Freehold	28,830	28,830	-	-	28,830	28,830
Concessionary land at cost	9	9	-	-	9	9
Concessionary buildings at cost	47,685	47,685	(8,259)	(6,882)	39,426	40,803
Buildings at fair value	802,493	781,036	(80,340)	(15,278)	722,153	765,758
Buildings works in progress at cost	33,473	4,660	-	-	33,473	4,660
Leasehold improvements	31,381	30,909	(7,986)	(4,823)	23,395	26,086
Plant, equipment and vehicles at fair value	301,379	277,442	(195,884)	(176,114)	105,495	101,328
Plant, equipment and vehicles works in progress at cost	32,911	23,897	-	-	32,911	23,897
Total property, plant and equipment	**1,580,196**	**1,496,503**	**(292,469)**	**(203,097)**	**1,287,727**	**1,293,406**

How we recognise property, plant and equipment

Items of property, plant and equipment are initially measured at cost and are subsequently measured at fair value less accumulated depreciation and impairment. 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.

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

Note 4.1 (a): Reconciliations of carrying amount by class of asset

	Note	Land - Crown	Land - Freehold	Land - Concessionary	Buildings - Concessionary	Buildings	Buildings WIP	Leasehold improvements	Plant, equipment and vehicles	Plant, equipment and vehicles WIP	Total
		$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2023		**217,547**	**23,690**	**9**	**42,180**	**608,688**	**69,078**	**19,043**	**114,143**	**7,386**	**1,101,764**
Additions		-	-	-	-	22,578	16,612	10,989	27,490	19,442	97,111
Lease incentive		-	-	-	-	(1,366)	-	-	-	-	(1,366)
Disposals		-	-	-	-	(6,405)	-	-	(1,518)	-	(7,923)
Assets received/(provided) free of charge		-	-	-	-	-	-	-	5	-	5
Revaluation increments/(decrements)		87,297	5,140	-	-	115,328	-	-	-	-	207,765
Net transfers between classes		-	-	-	-	95,452	(80,968)	(35)	(12,447)	(2,931)	(929)
Asset transfers via contributed capital		(2,809)	-	-	-	(1,172)	(62)	(842)	(723)	-	(5,608)
Depreciation	4.3	-	-	-	(1,377)	(67,345)	-	(3,069)	(25,622)	-	(97,413)
Balance at 30 June 2024	4.1	**302,035**	**28,830**	**9**	**40,803**	**765,758**	**4,660**	**26,086**	**101,328**	**23,897**	**1,293,406**
Additions		-	-	-	-	592	32,742	472	18,845	33,892	86,543
Disposals		-	-	-	-	-	-	-	(415)	-	(415)
Assets received/(provided) free of charge		-	-	-	-	-	(48)	-	665	-	617
Net transfers between classes		-	-	-	-	20,865	(3,881)	-	7,894	(24,878)	-
Depreciation	4.3	-	-	-	(1,377)	(65,062)	-	(3,163)	(22,822)	-	(92,424)
Balance at 30 June 2025	4.1	**302,035**	**28,830**	**9**	**39,426**	**722,153**	**33,473**	**23,395**	**105,495**	**32,911**	**1,287,727**

Land and Buildings Carried at Valuation

Fair value assessments have been performed for all classes of assets in this purpose group and the decision was made that the movements were not material (less than or equal to 10%). As such, an independent or managerial revaluation was not required per FRD 103. In accordance with FRD 103, Melbourne Health has elected to apply the practical expedient in FRD 103 Non-Financial Physical Assets and has therefore not applied the amendments to AASB 13 *Fair Value Measurement*. The amendments to AASB 13 will be applied at the next scheduled independent revaluation, which is planned to be undertaken in 2029, in accordance with Melbourne Health's revaluation cycle.

Note 4.1 (b): Right-of-use assets included in property, plant and equipment

The following tables are right-of-use assets included in the property, plant and equipment balance, presented by subsets of land, buildings and plant and equipment.

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Concessionary land	9	9	-	-	9	9
Concessionary buildings	47,685	47,685	(8,259)	(6,882)	39,426	40,803
Buildings at fair value	58,576	58,527	(20,737)	(15,278)	37,839	43,249
Plant, equipment and vehicles at fair value	23,427	19,631	(14,855)	(12,508)	8,572	7,123
Total right-of-use assets	**129,697**	**125,852**	**(43,851)**	**(34,668)**	**85,846**	**91,184**

	Right-of-use concessionary land	Right-of-use concessionary buildings	Right-of-use - buildings	Right-of-use - PPE, F&F & V*	Total
	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2023	**9**	**42,180**	**49,877**	**6,290**	**98,356**
Additions	-	-	646	3,919	4,565
Lease incentive	-	-	(1,366)	-	(1,366)
Disposals	-	-	(6,405)	(453)	(6,858)
Revaluation increments/(decrements)	-	-	5,484	-	5,484
Depreciation	-	(1,377)	(4,987)	(2,633)	(8,997)
Balance at 30 June 2024	**9**	**40,803**	**43,249**	**7,123**	**91,184**
Additions	-	-	48	4,837	4,885
Disposals	-	-	-	(329)	(329)
Depreciation	-	(1,377)	(5,458)	(3,059)	(9,894)
Balance at 30 June 2025	**9**	**39,426**	**37,839**	**8,572**	**85,846**

* Right-of-use property plant and equipment, furniture and fittings and vehicles

How we recognise right-of-use assets

Initial recognition

When Melbourne Health enters a contract, which provides the health service with the right to control the use of an identified asset for a period of time in exchange for payment, this contract is considered a lease.

Unless the lease is considered a short-term lease or a lease of a low-value asset, (refer to Note 6.1 for further information) the contract gives rise to a right-of-use asset and corresponding lease liability, which is recognised at the lease commencement date.

The right-of-use asset is initially measured at cost and comprises the initial measurement of the corresponding lease liability, adjusted for:

- any lease payments made at or before the commencement date
- any initial direct costs incurred, and
- less any lease incentive received.

Subsequent measurement

Right-of-use assets are subsequently measured at fair value, with the exception of right-of-use asset arising from leases with significantly below-market terms and conditions, which are subsequently measured at cost less accumulated depreciation and accumulated impairment losses where applicable.

Melbourne Health has applied the exemption permitted under FRD 104 *Leases*, consistent with the optional relief in AASB 16.Aus25.1. Under this exemption, Melbourne Health is not required to apply fair value measurement

requirements to right-of-use assets arising from leases with significantly below-market terms and conditions, where those leases are entered into principally to enable the entity to further its objectives.

Right-of-use assets are also adjusted for certain remeasurements of the lease liability (for example, when a variable lease payment based on an index or rate becomes effective).

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

Note 4.2: Intangible assets

	Gross carrying amount		Accumulated depreciation		Net carrying amount	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Post office license	70	70	-	-	70	70
Software	100,872	100,695	(72,777)	(67,114)	28,095	33,581
Software works in progress at cost	701	150	-	-	701	150
Total intangible assets	**101,643**	**100,915**	**(72,777)**	**(67,114)**	**28,866**	**33,801**

Note 4.2 (a): Reconciliations of carrying amount by class of asset

	Note	Software Costs Capitalised $'000	Software Costs Work in Progress $'000	Post Office License $'000	Total $'000
Balance at 1 July 2023		**39,425**	**-**	**70**	**39,495**
Additions		86	150	-	236
Reclassified to expenses		(40)	-	-	(40)
Asset transfers via Contributed Capital		(35)	-	-	(35)
Amortisation	4.3	(5,855)	-	-	(5,855)
Balance at 30 June 2024	4.2	**33,581**	**150**	**70**	**33,801**
Additions		177	551	-	728
Amortisation	4.3	(5,663)	-	-	(5,663)
Balance at 30 June 2025	4.2	**28,095**	**701**	**70**	**28,866**

How we recognise intangible assets

Intangible assets represent identifiable non-monetary assets without physical substance such as patents, trademarks, and computer software and development costs (where applicable).

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 on which it is incurred.

Subsequent measurement

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

Note 4.3: Depreciation and amortisation

	Total 2025 $'000	Total 2024 $'000
Depreciation		
Concessionary buildings	1,377	1,377
Buildings at fair value	65,062	67,345
Leasehold improvements	3,163	3,069
Plant, equipment and vehicles at fair value	22,822	25,622
Total depreciation	**92,424**	**97,413**
Amortisation		
Software	5,663	5,855
Total amortisation	**5,663**	**5,855**
Total depreciation and amortisation	**98,087**	**103,268**

How we recognise depreciation and amortisation

Depreciation

All buildings, plant and equipment and other non-financial physical assets (excluding items under land) 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.

Right-of-use assets are depreciated over the lease term or useful life of the underlying asset, whichever is the shortest. Where a lease transfers ownership of the underlying asset or the cost of the right-of-use asset reflects that the health service anticipates to exercise a purchase option, the specific right-of-use asset is depreciated over the useful life of the underlying asset.

Amortisation

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

Useful lives of non-current assets

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

	2025	2024
Buildings	1 to 55 years	4 to 51 years
Leasehold improvements	10 years	10 years
Plant, equipment and vehicles (including leased assets)	3 to 10 years	3 to 10 years
Intangible assets	3 to 10 years	3 to 10 years

Note 4.4: Impairment of assets

How we recognise impairment

At the end of each reporting period, Melbourne Health 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.

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, Melbourne Health 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, Melbourne Health estimates the recoverable amount of the cash-generating unit to which the asset belongs.

Melbourne Health did not record any impairment losses for the year ended 30 June 2025 (30 June 2024: Nil).

Note 5: Other assets and liabilities

This section sets out those assets and liabilities that arose from Melbourne Health's operations.

Structure

5.1 Receivables

5.2 Contract assets

5.3 Investments

5.4 Inventories

5.5 Payables

5.6 Contract liabilities

5.7 Other liabilities

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	Description
Estimating the provision for expected credit losses	Melbourne Health 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 Melbourne Health has received funding to construct an identifiable non-financial asset, such funding is recognised as deferred capital grant income until the underlying asset is constructed. Melbourne Health applies judgement when measuring the deferred capital grant income balance, which references the estimated stage of completion at the end of each financial year.
Measuring contract liabilities	Melbourne Health applies 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 health service 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

	Note	Total 2025 $'000	Total 2024 $'000
Current receivables			
Contractual			
Inter hospital debtors		11,707	10,413
Trade receivables		13,471	10,149
Patient fees		9,132	9,288
Allowance for impairment losses	5.1(a)	(4,344)	(3,332)
Amounts receivable from governments and agencies		25,054	5,427
Total contractual receivables		**55,020**	**31,945**
Statutory			
GST receivable		8,617	8,731
Total statutory receivables		**8,617**	**8,731**
Total current receivables		**63,637**	**40,676**
Non-current receivables			
Contractual			
Long service leave - Department of Health		52,310	41,635
Total contractual receivables		**52,310**	**41,635**
Total non-current receivables		**52,310**	**41,635**
Total receivables		**115,947**	**82,311**
Financial assets classified as receivables (Note 7.1)			
Total receivables		115,947	82,311
Provision for impairment		4,344	3,332
GST receivable		(8,617)	(8,731)
Total financial assets classified as receivables	7.1	**111,674**	**76,912**

How we recognise receivables

Receivables consist of:

- **Contractual receivables** include debtors that relate to the provision of goods and services. These receivables are classified as financial instruments and are categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. Melbourne Health 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** include 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. Melbourne Health applies AASB 9 *Financial Instruments* 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 the nominal amounts due for settlement within 30 days from the date of recognition.

Note 5.1 (a): Movement in the allowance for impairment losses of contractual receivables

	Total 2025 $'000	Total 2024 $'000
Balance at the beginning of the year	**3,332**	**2,196**
Increase in allowance	6,455	6,582
Amounts written off during the year	(5,443)	(5,446)
Balance at the end of the year	**4,344**	**3,332**

Impairment losses of contractual receivables

Refer to Note 7.2 (a) Credit risk for Melbourne Health's contractual impairment losses.

Note 5.2: Contract assets

	Note	Total 2025 $'000	Total 2024 $'000
Current			
Contract assets		15,947	12,443
Total current contract assets		15,947	12,443
Total contract assets	5.2(a)	**15,947**	**12,443**

Note 5.2 (a): Movement in contract assets

	Total 2025 $'000	Total 2024 $'000
Balance at the beginning of the year	**12,443**	**14,261**
Add: Additional costs incurred that are recoverable from the customer	15,947	12,443
Less: Transfer to revenue recognition	(12,443)	(14,261)
Total contract assets	**15,947**	**12,443**

How we recognise contract assets

Contract assets relate to Melbourne Health'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 and at this time an invoice is issued. Contract assets are expected to be recovered during the next financial year.

Note 5.3: Investments

	Capital fund		Total	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Non-current				
Financial assets at fair value through net result				
Foundation investments managed by VFMC	21,524	19,293	21,524	19,293
Total non-current financial assets	21,524	19,293	21,524	19,293
Total investments	**21,524**	**19,293**	**21,524**	**19,293**

How we recognise investments

Melbourne Health's investments are made in accordance with Standing Direction 3.7.2 - Treasury Management, including the Central Banking System.

Melbourne Health manages its investments in accordance with an investment policy approved by the Board.

Investments are recognised when Melbourne Health 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.

Information regarding impairment is disclosed in Note 7.2(a).

Note 5.4: Inventories

	Total 2025 $'000	Total 2024 $'000
Aids and appliances at cost	95	109
Medical and surgical consumables at cost	4,112	4,274
Pharmacy supplies at cost	3,561	3,037
Pathology supplies at cost	1,780	2,139
Land and building - Home Lottery*	14,234	13,375
Total inventories	**23,782**	**22,934**

* The land and buildings are for four properties held in 2025 and 2024.

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 5.5: Payables

	Note	Total 2025 $'000	Total 2024 $'000
Current payables			
Contractual			
Payables		16,555	14,437
Accrued salaries and wages		62,119	58,996
Accrued expenses		54,962	51,116
Deferred grant income	5.5(a)	55,091	57,176
Inter - hospital creditors		14,200	7,475
Amounts payable to governments and agencies		5,372	328
Total contractual payables		**208,299**	**189,528**
Statutory			
GST payable		1,127	1,399
Total statutory payables		**1,127**	**1,399**
Total current payables		**209,426**	**190,927**
Total payables		**209,426**	**190,927**
Financial liabilities classified as payables (Note 7.1)			
Total payables		209,426	190,927
Deferred grant income		(55,091)	(57,176)
GST payable		(1,127)	(1,399)
Total financial liabilities classified as payables	7.1	**153,208**	**132,352**

How we recognise payables

Payables consist of:

- **Contractual payables** include payables that relate to the purchase of 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 Melbourne Health prior to the end of the financial year that are unpaid.

- **Statutory payables** include 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 usually Net 30 days.

Maturity analysis of payables

Please refer to Note 7.2(b) for the maturity analysis of payables.

Note 5.5 (a) Movement in deferred grant income

	Total 2025 $'000	Total 2024 $'000
Opening balance of deferred grant income	**57,176**	**49,568**
Grant consideration received during the year	356,104	602,806
Deferred grant income recognised as income during the year	(358,189)	(595,198)
Closing balance of deferred grant income	**55,091**	**57,176**

How we recognise deferred grant income

Capital

Grant consideration was received from the Department of Health, Victorian Infrastructure Delivery Authority and Department of Transport and Planning for various capital projects.

Capital grant income is recognised progressively as the asset is constructed or paid for, since this is the time when Melbourne Health satisfies its obligations. The progressive percentage of costs incurred is used to recognise income because this most closely reflects the percentage of completion of the building works. As a result, Melbourne Health has deferred recognition of a portion of the grant consideration received as a liability for the outstanding obligations.

Melbourne Health expects to recognise all of the remaining deferred capital grant income for capital works in future years.

Operating

Grant consideration was received from the State and Commonwealth Government in support of hospital activity and operations. Grant income is recognised as service obligations are met. Differences in the number of some services provided may be adjusted in the funding provided annually. The remaining grant revenue is recognised when the service obligations are delivered in the following year.

Note 5.6: Contract liabilities

	Note	Total 2025 $'000	Total 2024 $'000
Current			
Contract liabilities		22,467	18,175
Total contract liabilities	5.6(a)	**22,467**	**18,175**

Note 5.6 (a): Movement in contract liabilities

	Total 2025 $'000	Total 2024 $'000
Opening balance of contract liabilities	**18,175**	**17,124**
Add payments received for performance obligations yet to be completed during the period	15,223	11,256
Less revenue recognised in the reporting period for the completion of a performance obligation	(10,931)	(10,205)
Total contract liabilities	**22,467**	**18,175**

How we recognise contract liabilities

Contract liabilities include consideration received in advance from customers for various services or projects before a related performance obligation is satisfied.

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

Note 5.7: Other liabilities

	Note	Total 2025 $'000	Total 2024 $'000
Current monies held in trust			
Patient monies		130	127
Refundable accommodation deposits		6,375	5,729
Total other liabilities		**6,505**	**5,856**
Represented by:			
Cash assets	6.2	6,505	5,856
Total		**6,505**	**5,856**

How we recognise other liabilities

Refundable Accommodation Deposits (RAD)/Accommodation Bond liabilities

RADs/accommodation bonds are non-interest-bearing deposits made by some aged care residents to Melbourne Health upon admission. These deposits are liabilities which fall due and payable when the resident leaves the home. As there is no unconditional right to defer payment for 12 months, these liabilities are recorded as current liabilities.

RAD/accommodation bond liabilities are recorded at an amount equal to the proceeds received, net of retention and any other amounts deducted from the RAD/accommodation bond in accordance with the *Aged Care Act 1997*.

Note 6: How we finance our operations

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

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

6.4 Non-cash financing and investing activities

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	Description
Determining if a contract is or contains a lease	Melbourne Health applies judgement to determine if a contract is or contains a lease by considering if the health service: • has the right-to-use an identified asset • has the right to obtain substantially all economic benefits from the use of the leased asset and • 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	Melbourne Health applies judgement when determining if a lease meets the short-term or low value lease exemption criteria. Melbourne Health estimates the fair value of leased assets when new. Where the estimated fair value is less than $10,000, the health service applies the low-value lease exemption. Melbourne Health 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, Melbourne Health applies the short-term lease exemption.
Discount rate applied to future lease payments	Melbourne Health discounts its lease payments using the interest rate implicit in the lease. If this rate cannot be readily determined, which is generally the case for the health service's lease arrangements, Melbourne Health uses its incremental borrowing rate, which is the amount the health service would have to pay to borrow funds necessary to obtain an asset of similar value to the right-of-use asset in a similar economic environment with similar terms, security and conditions. For leased land and buildings, Melbourne Health estimates the incremental borrowing rate to be between 0% and 5.72%. For leased plant, equipment, furniture, fittings and vehicles, the implicit interest rate is between 1.03% and 5.88%.
Assessing the lease term	The lease term represents the non-cancellable period of a lease, combined with periods covered by an option to extend or terminate the lease if Melbourne Health is reasonably certain to exercise such options.

Material judgements and estimates	Description
	Melbourne Health determines the likelihood of exercising such options on a lease-by-lease basis through consideration of various factors including: • If there are significant penalties to terminate (or not extend), Melbourne Health is typically reasonably certain to extend (or not terminate) the lease. • If any leasehold improvements are expected to have a significant remaining value, Melbourne Health is typically reasonably certain to extend (or not terminate) the lease. • Melbourne Health considers historical lease durations and the costs and business disruption to replace such leased assets.

Note 6.1: Borrowings

	Note	Total 2025 $'000	Total 2024 $'000
Current borrowings			
Lease liabilities [(i)]	6.1 (a)		
Motor vehicles leased from VicFleet		1,674	1,248
Other leases		7,700	7,105
Total current borrowings		**9,374**	**8,353**
Non-current borrowings			
Lease liabilities [(i)]	6.1 (a)		
Motor vehicles leased from VicFleet		2,973	2,387
Other leases		44,473	49,403
Total non-current borrowings		**47,446**	**51,790**
Total borrowings	7.1	**56,820**	**60,143**

(i) Secured by the assets leased. Leases are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

How we recognise borrowings

Borrowings refer to interest bearing liabilities mainly raised through lease liabilities.

Borrowings are classified as financial instruments. Interest bearing liabilities are classified at amortised cost and recognised at the fair value of the consideration received less directly attributable transaction costs and subsequently measured at amortised cost using the effective interest method.

Maturity analysis of borrowings

Please refer to Note 7.2 (b) for the maturity analysis of borrowings.

Interest expense

	Total 2025 $'000	Total 2024 $'000
Interest on lease liabilities	1,882	1,898
Total interest expense	**1,882**	**1,898**

Interest expense includes interest component of lease repayments. Interest expense is recognised in the period in which it is incurred.

Melbourne Health recognises borrowing costs immediately as an expense, even where they are directly attributable to the acquisition, construction or production of a qualifying asset.

Defaults and breaches

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

Note 6.1 (a): Lease liabilities

Melbourne Health's lease liabilities are summarised below:

	Total 2025 $'000	Total 2024 $'000
Current lease liabilities		
Lease liability	9,374	8,353
Total current lease liabilities	9,374	8,353
Non-current lease liabilities		
Lease liability	47,446	51,790
Total non-current lease liabilities	47,446	51,790
Total lease liabilities	**56,820**	**60,143**

The following table sets out the maturity analysis of lease liabilities, showing the undiscounted lease payments to be made after the reporting date.

	Total 2025 $'000	Total 2024 $'000
Not longer than one year	10,729	9,909
Longer than one year but not longer than five years	35,399	33,417
Longer than five years	17,238	27,209
Minimum future lease liabilities	**63,366**	**70,535**
Less unexpired finance expenses	(6,546)	(10,392)
Present value of lease liabilities	**56,820**	**60,143**

How we recognise lease liabilities

A lease is defined as a contract, or part of a contract, that conveys the right for Melbourne Health to use an asset for a period of time in exchange for consideration.

To apply this definition Melbourne Health ensures the contract meets the following criteria:

- the contract contains an identified asset, which is either explicitly identified in the contract or implicitly specified by being identified at the time the asset is made available to Melbourne Health and for which the supplier does not have substantive substitution rights;
- Melbourne Health has the right to obtain substantially all of the economic benefits from use of the identified asset throughout the period of use, considering its rights within the defined scope of the contract and Melbourne Health has the right to direct the use of the identified asset throughout the period of use; and
- Melbourne Health has the right to take decisions in respect of 'how and for what purpose' the asset is used throughout the period of use.

Melbourne Health's lease arrangements consist of the following:

Type of asset leased	Lease term
Concessionary land	1 to 99 years*
Concessionary buildings	1 to 40 years*
Buildings at fair value	1 to 40 years
Plant, equipment and vehicles at fair value	1 to 7 years

* Refer to 'Leases with significantly below market terms and conditions' section below for details.

All leases are recognised on the balance sheet, with the exception of low value leases (less than $10,000) and short-term leases of less than 12 months. Melbourne Health has elected to apply the practical expedients for short-term leases and leases of low-value assets. As a result, no right-of-use asset or lease liability is recognised for these leases, instead lease payments are recognised as an expense on a straight-line basis over the lease term, within "other operating expenses" (refer to Note 3.1 (d)).

The following low value and short term lease payments are recognised in profit or loss:

Type of payment	Description of payment	Type of leases captured
Low value lease payments	Leases where the underlying asset's fair value, when new, is no more than $10,000	Computer equipment, medical equipment
Short-term lease payments	Leases with a term less than 12 months	Buildings used for less than 12 months

Initial measurement

The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using the interest rate implicit in the lease if that rate is readily determinable or Melbourne Health's incremental borrowing rate. Our lease liability has been discounted by rates of between 0% to 5.88%.

Lease payments included in the measurement of the lease liability comprise the following:

- fixed payments (including in-substance fixed payments) less any lease incentive receivable;
- variable payments based on an index or rate, initially measured using the index or rate as at the commencement date;
- amounts expected to be payable under a residual value guarantee; and
- payments arising from purchase and termination options reasonably certain to be exercised.

In determining the lease term, management considers all facts and circumstances that create an economic incentive to exercise an extension option, or not exercise a termination option. Extension options (or periods after termination options) are only included in the lease term and lease liability if the lease is reasonably certain to be extended (or not terminated).

The assessment is reviewed if a significant event or a significant change in circumstances occurs which affects this assessment and that is within the control of the lessee.

Subsequent measurement

Subsequent to initial measurement, the liability will be reduced for payments made and increased for interest. It is remeasured to reflect any reassessment or modification, or if there are changes in the substance of fixed payments.

When the lease liability is remeasured, the corresponding adjustment is reflected in the right-of-use asset, or profit and loss if the right-of-use asset is already reduced to zero.

Leases with significantly below market terms and conditions

Melbourne Health holds lease arrangements which contain significantly below-market terms and conditions, which are principally to enable the health service to further its objectives. These are commonly referred to as concessionary lease arrangement.

The nature and terms of such lease arrangements, including Melbourne Health's dependency on such lease arrangements is described below:

Description of leased asset	Our dependence on lease	Nature and terms of lease
Leasing Parkville campus site from The Minister for Environment and Climate Change on behalf of the Crown in right of the State of Victoria	Melbourne Health's dependence on this lease is considered medium.	The lease duration is 99 years starting from 23/11/2011 with an annual peppercorn rental of $104.00 payable at the request of the landlord.
Leasing part of Level 10 of the Peter McCallum Cancer Centre Building	The leased property is used for a scientific laboratory. Melbourne Health's dependence on this lease is considered medium.	The lease duration is 25 years starting from 14/06/2016 with an annual peppercorn rental of $1.00 payable at the request of the landlord.
Leasing floors within the Doherty Institute	The leased property is used for teaching, training, research and public health activities in human infectious diseases. Melbourne Health's dependence on this lease is considered high.	The lease duration is 40 years starting from 17/02/2014 with upfront rental payment in years 1-7 and an annual peppercorn rental of $1.00 thereafter for the remaining term of the lease.

Note 6.2: Cash and cash equivalents

	Note	Total 2025 $'000	Total 2024 $'000
Cash on hand (excluding monies held in trust)		23	24
Cash at bank - central banking system (excluding monies held in trust)		172,674	156,858
Total cash held for operations		**172,697**	**156,882**
Cash at bank - central banking system (monies held in trust)		6,505	5,856
Total cash held as monies held in trust		**6,505**	**5,856**
Total cash and cash equivalents	7.1	**179,202**	**162,738**

Note 6.3: Commitments for expenditure

30 June 2025	Less than 1 year $'000	1-5 Years $'000	Over 5 years $'000	Total $'000
Capital expenditure commitments	20,684	-	-	20,684
Operating expenditure commitments	49,965	64,184	4,770	118,919
Non-cancellable short term and low value lease commitments	1,054	1,481	70	2,605
Total commitments (inclusive of GST)	**71,703**	**65,665**	**4,840**	**142,208**
Less GST recoverable				(12,928)
Total commitments (exclusive of GST)				**129,280**

30 June 2024	Less than 1 year $'000	1-5 Years $'000	Over 5 years $'000	Total $'000
Capital expenditure commitments	30,290	-	-	30,290
Operating expenditure commitments	55,128	49,219	4,166	108,513
Non-cancellable short term and low value lease commitments	694	1,153	140	1,987
Total commitments (inclusive of GST)	**86,112**	**50,372**	**4,306**	**140,790**
Less GST recoverable				(12,921)
Total commitments (exclusive of GST)				**127,869**

How we disclose our commitments

Our commitments relate to expenditure and short term and low value leases.

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. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

Short term and low value leases

Melbourne Health discloses short term and low value lease commitments which are excluded from the measurement of right-of-use assets and lease liabilities. Refer to Note 6.1 for further information.

Note 6.4: Non-cash financing and investing activities

	Total 2025 $'000	Total 2024 $'000
Assumption and transfer out of liabilities [(i)]	4,885	(1,906)
Restructuring of administrative arrangements [(ii)]	-	(5,643)
Total non-cash financing and investing activities	**4,885**	**(7,549)**

[(i)]Assumption of liabilities: During the reporting period Melbourne Health assumed right-of-use liabilities amounting to $4.9m (2024: $4.7m) and transferred out nil liabilities (2024: $6.6m due to disaggregation of mental health services to Western Health). The assumption and transfer out of these liabilities are not reflected in the cash flow statement.

[(ii)]Relates to the transfer of properties resulting from administrative restructure of mental health services to Western Health in 2024 of $5.6m via contributed capital and is not reflected in the cash flow statement (refer to Note 1.6).

Note 7: Risks, contingencies and valuation uncertainties

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

Material judgements and estimates

This section contains the following material judgements and estimates:

Material 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, Melbourne Health has assumed the current use is its highest and best use. Accordingly, characteristics of the health service's assets are considered, including condition, location and any restrictions on the use and disposal of such assets. Melbourne Health 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 Melbourne Health's specialised land, non-specialised land and non-specialised buildings are measured using this approach. Where assets are held to meet Community Service Obligations (CSOs), such as the delivery of public health services, adjustments may be made to reflect the reduced marketability or alternative use of these assets, in recognition of the operational restrictions and obligations attached to them. • 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 Melbourne Health's specialised buildings, furniture, fittings, plant, equipment and vehicles are measured using this approach. • Income approach, which converts future cash flows or income and expenses to a single undiscounted amount. Melbourne Health does not use this approach to measure fair value. Melbourne Health selects a valuation technique which is considered most appropriate, and for which there is sufficient data available to

Material judgements and estimates	Description
	measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs. Subsequently, Melbourne Health applies judgement to categorise and disclose such assets within a fair value hierarchy (refer to Note 7.4).

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

Financial instruments: Categorisation

30 June 2025	Note	Financial assets at amortised cost $'000	Financial assets at fair value through net result $'000	Financial liabilities at amortised cost $'000	Total $'000
Contractual financial assets					
Cash and cash equivalents	6.2	179,202	-	-	179,202
Receivables	5.1	111,674	-	-	111,674
Investments and other financial assets	5.3	-	21,524	-	21,524
Total financial assets		**290,876**	**21,524**	**-**	**312,400**
Financial liabilities					
Payables	5.5	-	-	153,208	153,208
Borrowings	6.1	-	-	56,820	56,820
Other financial liabilities - refundable accommodation deposits	5.7	-	-	6,375	6,375
Other financial liabilities - patient monies held in trust	5.7	-	-	130	130
Total financial liabilities		**-**	**-**	**216,533**	**216,533**

30 June 2024	Note	Financial assets at amortised cost $'000	Financial assets at fair value through net result $'000	Financial liabilities at amortised cost $'000	Total $'000
Contractual financial assets					
Cash and cash equivalents	6.2	162,738	-	-	162,738
Receivables	5.1	76,912	-	-	76,912
Investments and other financial assets	5.3	-	19,293	-	19,293
Total financial assets		**239,650**	**19,293**	**-**	**258,943**
Financial liabilities					
Payables	5.5	-	-	132,352	132,352
Borrowings	6.1	-	-	60,143	60,143
Other financial liabilities - refundable accommodation deposits	5.7	-	-	5,729	5,729
Other financial liabilities - patient monies held in trust	5.7	-	-	127	127
Total financial liabilities		**-**	**-**	**198,351**	**198,351**

How we categorise financial instruments

Categories of financial assets

Financial assets are recognised when Melbourne Health becomes party to the contractual provisions to the instrument. For financial assets, this is at the date Melbourne Health 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 costs if both of the following criteria are met and the assets are not designated as fair value through net result:

- the assets are held by Melbourne Health solely 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 subsequently measured at amortised cost using the effective interest method less any impairment.

Melbourne Health recognises the following assets in this category:

- cash and deposits; and
- receivables (excluding statutory receivables).

Financial assets at fair value through net result

Melbourne Health 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 different basis.

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.

Melbourne Health has designated all managed investments as fair value through net result.

Categories of financial liabilities

Financial liabilities are recognised when Melbourne Health 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.

Melbourne Health recognises the following liabilities in this category:

- payables (excluding statutory payables and deferred grant income);
- borrowings (including finance lease liabilities); and
- other liabilities (including monies held in trust).

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
- Melbourne Health 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
- Melbourne Health has transferred its rights to receive cash flows from the asset and either:
    - has transferred substantially all the risks and rewards of the asset, or
    - has neither transferred nor retained substantially all the risks and rewards of the asset but has transferred control of the asset.

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

Melbourne Health's main financial risks include credit risk, liquidity risk, interest rate risk and equity price risk. Melbourne Health manages these financial risks in accordance with its treasury policy.

Primary responsibility for the identification and management of financial risks rests with the Accountable 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. Melbourne Health's exposure to credit risk arises from the potential default of a counter party on their contractual obligations resulting in financial loss to Melbourne Health. Credit risk is measured at fair value and is monitored on a regular basis.

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

In addition, Melbourne Health does not engage in hedging for its contractual financial assets and mainly holds cash and deposits at bank. Melbourne Health's policy is to only engage with banks that are on the state centralised banking system panel.

Provision of impairment for contractual financial assets is recognised when there is objective evidence that Melbourne Health 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.

Contractual 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 Melbourne Health's maximum exposure to credit risk without taking account of the value of any collateral obtained.

There has been no material change to Melbourne Health's credit risk profile in 2024-25.

Impairment of financial assets under AASB 9 *Financial Instruments*

Melbourne Health records the allowance for expected credit loss for the relevant financial instruments, in accordance with AASB 9 *Financial Instruments* 'Expected Credit Loss' approach. Subject to AASB 9 *Financial Instruments,* the impairment assessment includes Melbourne Health's contractual receivables.

Other financial assets mandatorily measured or designated at fair value through net result are not subject to an impairment assessment under AASB 9.

Credit loss allowance is classified as other economic flows in the net result.

Contractual receivables at amortised cost

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

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

30 June 2025	Note	Current $'000	Less than 1 month $'000	1–2 months $'000	2–3 months $'000	3+ months $'000	Total $'000
Overseas patient fees receivables:							
Expected loss rate		0%	50%	100%	100%	100%	
Gross carrying amount of contractual receivables		739	1,095	387	525	2,320	5,066
Loss allowance	5.1	**-**	**548**	**387**	**525**	**2,320**	**3,780**
Other patient fees receivables:							
Expected loss rate		2%	6%	9%	12%	24%	
Gross carrying amount of contractual receivables		247	1,404	627	386	1,404	4,068
Loss allowance	5.1	**5**	**84**	**56**	**46**	**337**	**528**
Trade debtors (sundry debtors only):							
Expected loss rate		0%	0%	0%	0%	5%	
Gross carrying amount of contractual receivables		15,151	2,342	1,441	454	725	20,113
Loss allowance	5.1	**-**	**-**	**-**	**-**	**36**	**36**
Total loss allowance		**5**	**632**	**443**	**571**	**2,693**	**4,344**

30 June 2024	Note	Current $'000	Less than 1 month $'000	1–2 months $'000	2–3 months $'000	3+ months $'000	Total $'000
Overseas patient fees receivables:							
Expected loss rate		0%	50%	100%	100%	100%	
Gross carrying amount of contractual receivables		1,210	1,146	1,400	163	687	4,606
Loss allowance	5.1	**-**	**573**	**1,400**	**163**	**687**	**2,823**
Other patient fees receivables:							
Expected loss rate		2%	6%	9%	12%	24%	
Gross carrying amount of contractual receivables		1,112	1,048	828	652	1,042	4,682
Loss allowance	5.1	**22**	**63**	**75**	**78**	**250**	**488**
Trade debtors (sundry debtors only):							
Expected loss rate		0%	0%	0%	0%	5%	
Gross carrying amount of contractual receivables		13,388	2,279	684	474	421	17,246
Loss allowance	5.1	**-**	**-**	**-**	**-**	**21**	**21**
Total loss allowance		**22**	**636**	**1,475**	**241**	**958**	**3,332**

Statutory receivables at amortised cost

Melbourne Health's non-contractual receivables arising from statutory requirements are not financial instruments. However, they are nevertheless recognised and measured in accordance with AASB 9 *Financial Instruments* requirements as if those receivables are financial instruments.

Statutory receivables are considered to have low credit risk, considering 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.

Melbourne Health is exposed to liquidity risk mainly through the financial liabilities as disclosed in the balance sheet. The health service manages its liquidity risk by:

- providing ongoing cash forecasts to the Department of Health to ensure additional funding cash flows are available if required.
- maintaining an adequate level of uncommitted funds that can be drawn at short notice to meet its short-term obligations.
- holding investments that are readily tradeable in the financial markets.
- careful maturity planning of its financial obligations based on forecasts of future cash flows.

Melbourne Health's exposure to liquidity risk is deemed insignificant based on prior periods' data and current assessment of risk. Refer to Note 1.5 Economic dependency.

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

				Maturity dates				
30 June 2025	**Note**	**Carrying amount $'000**	**Nominal amount $'000**	**Less than 1 month $'000**	**1-3 months $'000**	**3 months - 1 year $'000**	**1-5 years $'000**	**Over 5 years $'000**
Financial liabilities at amortised cost								
Payables	5.5	153,208	153,208	151,417	1,549	242	-	-
Borrowings	6.1	56,820	56,820	805	1,431	6,810	31,463	16,311
Other Financial Liabilities - Refundable Accommodation	5.7	6,375	6,375	350	293	1,831	3,901	-
Other Financial Liabilities - Patient monies held in trust	5.7	130	130	130	-	-	-	-
Total financial liabilities [(i)]		**216,533**	**216,533**	**152,702**	**3,273**	**8,883**	**35,364**	**16,311**

				Maturity dates				
30 June 2024	**Note**	**Carrying amount $'000**	**Nominal amount $'000**	**Less than 1 month $'000**	**1-3 months $'000**	**3 months - 1 year $'000**	**1-5 years $'000**	**Over 5 years $'000**
Financial liabilities at amortised cost								
Payables	5.5	132,352	132,352	130,917	954	481	-	-
Borrowings	6.1	60,143	60,143	745	1,361	6,087	28,838	23,112
Other Financial Liabilities - Refundable Accommodation	5.7	5,729	5,729	-	350	1,000	4,379	-
Other Financial Liabilities - Patient monies held in trust	5.7	127	127	127	-	-	-	-
Total financial liabilities [(i)]		**198,351**	**198,351**	**131,789**	**2,665**	**7,568**	**33,217**	**23,112**

(i) Ageing analysis of financial liabilities excludes statutory financial liabilities (i.e GST payable), deferred grant income and contract liabilities - income in advance.

Note 7.2 (c): Market risk

Melbourne Health's exposures to market risk whilst limited are primarily through interest rate risk and equity price risk. Objectives, policies and processes used to manage each of these risks are disclosed below.

Sensitivity disclosure analysis and assumptions

Melbourne Health's sensitivity to market risk is determined based on the observed range of actual historical data for the preceding five-year period. Melbourne Health'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 1.5% up or down and
- a change in the top ASX 200 index of 20% 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. Melbourne Health 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. Melbourne Health has minimal exposure to cash flow interest rate risks through cash and deposits that are at floating rate.

Equity risk

Melbourne Health is exposed to equity price risk through its investments in managed investments. Such investments are allocated and traded to match Melbourne Health's investment objectives.

Melbourne Health's sensitivity to equity price risk is set out below.

		-20%	+20%
30 June 2025	**Carrying amount $'000**	**Net result $'000**	**Net result $'000**
Contractual financial assets			
Investments	21,524	(4,305)	4,305
Total impact	**21,524**	**(4,305)**	**4,305**

		-20%	+20%
30 June 2024	**Carrying amount $'000**	**Net result $'000**	**Net result $'000**
Contractual financial assets			
Investments	19,293	(3,859)	3,859
Total impact	**19,293**	**(3,859)**	**3,859**

Note 7.3: Contingent assets and contingent liabilities

At balance date, the Board is not aware of any contingent assets or 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 Melbourne Health.

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 Melbourne Health, 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.

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
- Right-of-use assets

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.

Melbourne Health determines whether transfers have occurred between levels in the hierarchy by re-assessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period. There have been no transfers between levels during the period.

Melbourne Health 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 Melbourne Health's independent valuation agency for property, plant and equipment.

Identifying unobservable inputs (level 3) fair value measurements

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

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

Note 7.4 (a): Fair value determination of investments

	Note	Carrying amount 30 June 2025 $'000	Fair value measurement at end of reporting period using: Level 1 $'000	Level 2 $'000	Level 3 $'000
Managed investments	5.3	21,524	-	21,524	-
Total financial assets held at fair value through net result		**21,524**	**-**	**21,524**	**-**
Total investments at fair value		**21,524**	**-**	**21,524**	**-**

		Carrying amount 30 June 2024 $'000	Fair value measurement at end of reporting period using: Level 1 $'000	Level 2 $'000	Level 3 $'000
Managed investments	5.3	19,293	-	19,293	-
Total financial assets held at fair value through net result		**19,293**	**-**	**19,293**	**-**
Total investments at fair value		**19,293**	**-**	**19,293**	**-**

How we measure fair value of investments

Managed investment funds

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

Melbourne Health 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.

Melbourne Health classifies these funds as Level 2.

Note 7.4 (b): Fair value determination of non-financial physical assets

	Note	Carrying amount 30 June 2025	Fair value measurement at end of reporting period using: Level 1 [(i)]	Level 2 [(i)]	Level 3 [(i)]
		$'000	$'000	$'000	$'000
Non-specialised land at fair value		28,830	-	28,830	-
Specialised land at fair value		302,035	-	-	302,035
Total land at fair value	4.1	**330,865**	**-**	**28,830**	**302,035**
Non-specialised buildings at fair value		49,692	-	11,852	37,840
Specialised buildings at fair value		672,461	-	3,500	668,961
Total building at fair value	4.1	**722,153**	**-**	**15,352**	**706,801**
Plant, equipment and vehicles at fair value		105,495	-	-	105,495
Total plant, equipment and vehicles at fair value	4.1	**105,495**	**-**	**-**	**105,495**
Total non-financial physical assets at fair value		**1,158,513**	**-**	**44,182**	**1,114,331**

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

	Note	Carrying amount 30 June 2024	Fair value measurement at end of reporting period using: Level 1 [(i)]	Level 2 [(i)]	Level 3 [(i)]
		$'000	$'000	$'000	$'000
Non-specialised land at fair value		28,830	-	28,830	-
Specialised land at fair value		302,035	-	-	302,035
Total land at fair value	4.1	**330,865**	**-**	**28,830**	**302,035**
Non-specialised buildings at fair value		56,419	-	13,170	43,249
Specialised buildings at fair value		709,339	-	3,900	705,439
Total building at fair value	4.1	**765,758**	**-**	**17,070**	**748,688**
Plant, equipment and vehicles at fair value		101,328	-	-	101,328
Total plant, equipment and vehicles at fair value	4.1	**101,328**	**-**	**-**	**101,328**
Total non-financial physical assets at fair value		**1,197,951**	**-**	**45,900**	**1,152,051**

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

How we measure fair value of non-financial physical assets

The fair value of non-financial physical assets reflects their highest and best use, considering whether market participants would use the asset similarly or sell it for that purpose. This assessment takes into account the asset's characteristics and any physical, legal, or contractual restrictions.

Melbourne Health assumes the current use reflects highest and best use unless market or other factors indicate otherwise. Potential alternative uses are only considered when it is virtually certain that restrictions will no longer apply.

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, Melbourne Health perform a fair value assessment to estimate possible changes in value 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 non-financial physical assets has changed by 10% or more since the last revaluation (whether that be the most recent independent valuation or fair value assessment). 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 since the last independent valuation, being equal to or in excess of 40%, Melbourne Health would obtain an interim independent valuation prior to the next scheduled independent valuation.

AASB 2022-10 *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities* amended AASB 13 by adding Appendix F *Australian implementation guidance for not-for-profit public sector entities*. Appendix F explains and illustrates the application of the principles in AASB 13 on developing unobservable inputs and the application of the cost approach. These clarifications are mandatorily applicable annual reporting periods beginning on or after 1 January 2024. FRD 103 permits Victorian public sector entities to apply Appendix F of AASB 13 in their next scheduled formal asset revaluation or interim revaluation (whichever is earlier).

An independent valuation of Melbourne Health's non-financial physical assets was performed by the VGV on 30 June 2024. Fair value assessments have therefore been performed for all classes of assets in this purpose group at 30 June 2025 and the decision was made that the movements were not material (less than or equal to 10%). As such, an independent revaluation was not required per FRD 103. In accordance with FRD 103, Melbourne Health will apply Appendix F of AASB 13 prospectively in its next scheduled formal revaluation in 2029 or interim revaluation process (whichever is earlier). Melbourne Health does not expect the impact to be material to the financial statements.

There were no changes in valuation techniques throughout the period to 30 June 2025.

Non-specialised land, non-specialised buildings

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

For non-specialised land and non-specialised buildings, an independent valuation was performed by 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 2024.

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.

During the reporting period, Melbourne Health 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 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 reflects 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 considers 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 Melbourne Health, the current 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 Melbourne Health's specialised land and specialised buildings was performed by the Valuer-General Victoria. The effective date of the valuation is 30 June 2024.

Furniture, fittings, plant and equipment

Furniture, fittings, plant and equipment (including medical equipment, computers and communication equipment) are held at fair value. When plant and equipment is specialised in use, such that it is rarely sold other than as part of a going concern, the current replacement cost is used to estimate the fair value.

Reconciliation of level 3 fair value measurement [(i)]

	Note	Land	Buildings	Plant, equipment and vehicles
		$'000	$'000	$'000
Balance at 1 July 2023		**241,237**	**608,688**	**114,143**
Additions		-	22,578	27,490
Transfers in (out) of Level 3		(28,830)	(17,070)	-
Lease incentive		-	(1,366)	-
Net transfers between classes		-	95,452	(12,447)
Assets received/(provided) free of charge		-	-	5
Asset transfers via Contributed Capital		(2,809)	(1,172)	(723)
Gains/(losses) recognised in net result				
- Depreciation		-	(67,345)	(25,622)
- Disposals		-	(6,405)	(1,518)
Items recognised in other comprehensive income				
- Revaluation		92,437	115,328	-
Balance at 30 June 2024 [(ii)]	7.4(b)	**302,035**	**748,688**	**101,328**
Additions		-	541	18,845
Net transfers between classes		-	20,865	7,894
Assets received/(provided) free of charge		-	-	665
Gains/(losses) recognised in net result				
- Depreciation		-	(63,293)	(22,822)
- Disposals		-	-	(415)
Balance at 30 June 2025 [(ii)]	7.4(b)	**302,035**	**706,801**	**105,495**

(i) Classified in accordance with the fair value hierarchy, refer note 7.4

(ii) Excludes assets under construction and leasehold assets.

Fair value determination of level 3 fair value measurement

Asset class	Likely valuation approach	Significant inputs (Level 3 only)
Specialised land	Market/Direct Comparison Approach adjusted for unobservable inputs, CSO allowance	Sales evidence, Unit of value by comparative basis ($ psm), adjusted for Community Service Obligation (CSO) allowance (30% to 35%)
Non-specialised buildings	Market/Direct Comparison Approach	Unit of value by comparative basis ($ psm)
Specialised buildings	Cost Approach/Depreciation Replacement Cost (DRC)	Cost approach using best available evidence from recognised building cost indicators and or Quantity Surveyors and examples of current costs.
Plant, equipment and vehicles	Current replacement cost approach	Cost per unit Useful life of Plant, equipment and vehicles

Note 8: Other disclosures

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

Structure

Note 8.1: Reconciliation of net result to net cash flows from operating activities

	Note	Total 2025 $'000	Total 2024 $'000
Net result		8,461	(26,998)
Non-cash movements:			
Net (gain)/loss from disposal of non-financial assets		(427)	422
Net (gain)/loss from disposal of share in joint arrangements		-	733
Revaluation of financial assets at fair value through profit or loss		(1,085)	(1,216)
Depreciation and amortisation	4.3	98,087	103,268
Allowance for impairment losses of contractual receivables		1,012	1,136
DH non cash grants		(23,930)	(29,944)
Assets provided free of charge		175	-
Assets received free of charge		(734)	(49)
Other non cash movements		274	6,321
Movements in assets and liabilities:			
(Increase)/Decrease in receivables and contract assets		(38,152)	5,963
(Increase)/Decrease in inventories		(848)	(9,281)
(Increase)/Decrease in prepayments		(5,533)	(704)
Increase/(Decrease) in payables and contract liabilities		22,791	(37,402)
Increase/(Decrease) in employee benefits		23,023	7,057
Increase/(Decrease) in other liabilities		3	(16)
Net cash inflow/(outflow) from operating activities		**83,117**	**19,290**

Note 8.2: Responsible persons disclosures

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

	Period
The Honourable Mary-Anne Thomas MP:	
Minister for Health	01 Jul 2024 - 30 Jun 2025
Minister for Ambulance Services	01 Jul 2024 - 30 Jun 2025
Former Minister for Health Infrastructure	01 Jul 2024 - 19 Dec 2024
The Honourable Ingrid Stitt MP:	
Minister for Mental Health	01 Jul 2024 - 30 Jun 2025
Minister for Ageing	01 Jul 2024 - 30 Jun 2025
The Honourable Lizzie Blandthorn MP:	
Minister for Children	01 Jul 2024 - 30 Jun 2025
Minister for Disability	01 Jul 2024 - 30 Jun 2025
The Honourable Melissa Horne MP:	
Minister for Health Infrastructure	19 Dec 2024 - 30 Jun 2025
Governing Board	
Ms Linda Bardo Nicholls AO (Chair of the Board)	01 Jul 2024 - 30 Jun 2025
Ms Emma Skinner	01 Jul 2024 - 30 Jun 2025
Mr Eugene Arocca	01 Jul 2024 - 30 Jun 2025
Mr Gregory Tweedly	01 Jul 2024 - 30 Jun 2025
Professor Jane Gunn AO*	01 Jul 2024 - 30 Jun 2025
Ms Kylie Bishop	01 Jul 2024 - 30 Jun 2025
Professor Mary O'Reilly	01 Jul 2024 - 30 Jun 2025
Mr Peter Funder	01 Jul 2024 - 30 Jun 2025
Ms Philippa Connolly	01 Jul 2024 - 30 Jun 2025
Mr Sam Lobley*	01 Jul 2024 - 30 Jun 2025
Accountable Officer	
Professor Shelley Dolan (Chief Executive Officer)	01 Jul 2024 - 30 Jun 2025

* Non paid board members

Remuneration of responsible persons

The number of responsible persons is shown in their relevant income bands:

Income band	Total 2025 No.	Total 2024 No.
$0 - $9,999*	2	1
$30,000 - $39,999	-	2
$50,000 - $59,999	1	-
$60,000 - $69,999	6	6
$110,000 - $119,999	1	1
$500,000 - $509,999	-	1
$630,000 - $639,999	1	-
Total numbers	**11**	**11**

* Non paid board members

	Total 2025 $'000	Total 2024 $'000
Total remuneration received or due and receivable by responsible persons from the reporting entity amounted to:	**1,192**	**1,067**

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 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 executive officers (including Key Management Personnel disclosed in note 8.4)	**Total remuneration**	
	Total 2025 $'000	**Total 2024 $'000**
Short-term employee benefits	4,036	3,341
Post-employment benefits	341	281
Other long-term benefits	150	132
Total remuneration [(i)]	**4,527**	**3,754**
Total number of executives	14	13
Total annualised employee equivalent (AEE) [(ii)]	11.0	10.0

(i) The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of Melbourne Health under AASB 124 *Related Party Disclosures* and are also reported within Note 8.4 Related Parties.

(ii) Annualised employee equivalent is based on the time fraction worked 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.

Termination benefits

Termination of employment payments, such as severance packages.

Other factors

Several factors affected total remuneration payable to executives over the year. A number of employment contracts were completed and renegotiated and one executive resigned in the past year.

Note 8.4: Related parties

Melbourne Health is a wholly owned and controlled entity of the State of Victoria. Related parties of Melbourne Health 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 State of Victoria's financial statements.

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

Key management personnel

The Board of Directors and the Executive Directors of Melbourne Health are deemed to be KMPs. This includes the following:

KMPs	Position Title
Ms Linda Bardo Nicholls AO (Chair)	Chair of the Board
Ms Emma Skinner	Board Member
Mr Eugene Arocca	Board Member (Resigned 30 June 2025)
Mr Gregory Tweedly	Board Member (Resigned 30 June 2025)
Professor Jane Gunn AO*	Board Member (Resigned 30 June 2025)
Ms Kylie Bishop	Board Member
Professor Mary O'Reilly	Board Member
Mr Peter Funder	Board Member
Ms Philippa Connolly	Board Member
Mr Sam Lobley*	Board Member
Professor Shelley Dolan	Chief Executive Officer
Ms Ellen Flint	Chief People Officer | People, Culture, Security and Safety (Resigned 19 Sep 24)
Mr Maurice Davoli	Acting Chief People Officer | People, Culture, Security and Safety (From 20 Sep 24 to 18 Oct 24)
Ms Amanda Armstrong	Chief People and Communications Officer (Joined 21 Oct 24)
Dr Fergus Kerr	Chief Medical Officer
Professor Jo Douglass	Executive Director, Research
Ms Fleur Katsmartin	Chief Legal Officer | Corporate Secretary, Legal and Medico-Legal Services
Mr George Cozaris	Chief Information Officer | Executive Director, Digital Innovation
Ms Jackie McLeod	Chief Operating Officer
Adj Prof Kethly Fallon	Chief Nursing Officer
Mr Paul Urquhart	Chief Corporate Officer | Chief Financial and Procurement Officer, Infrastructure and Clinical Support Services
Mr Robert Rothnie	Chief Redevelopment Officer
Ms Samantha Plumb	Chief Quality Officer | Quality, Informatics and Improvement
Ms Sue Parkes	Executive Director, The RMH Foundation
Ms Suyin Ng	Executive Director of West Metro Health Service Partnership

* Non paid board members

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 - KMPs	Total 2025 $'000	Total 2024 $'000
Short-term employee benefits	5,119	4,306
Post-employment benefits	429	364
Other long-term benefits	171	150
Total [(i)]	**5,719**	**4,820**

[(i)] KMPs are also reported in Note 8.2 Responsible persons or Note 8.3 Remuneration of executives

Significant transactions with government-related entities

Melbourne Health received funding from the Department of Health of $1,406.4m (2024: $1,334.3m), funding from Victorian Infrastructure Delivery Authority for the MRI relocation project of $9.7m (2024: $8.8m) and funding from Department of Transport and Planning for the Parkville Precinct redevelopment project $5.4m (2024: nil). The Department of Health also paid $23.9m (2023: $29.9m) of construction costs on behalf of Melbourne Health.

Expenses incurred by Melbourne Health in delivering services and outputs are in accordance with HealthShare Victoria requirements. Goods and services including 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 Victorian Managed Insurance Authority.

The Standing Directions of the Minister for Finance require Melbourne Health to hold cash (in excess of working capital) in accordance with the State's centralised banking arrangements.

Goods and services including accounts payable and payroll are provided to other Victorian Health Service Providers on commercial terms.

Transactions with KMPs and other related parties

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

Outside of normal citizen type transactions with Melbourne Health, all other related party transactions that involved KMPs, their close family members or their personal business interests have been entered into on an arm's length basis. Transactions are disclosed when they are considered material to the users of the financial report in making and evaluating decisions about the allocation of scarce resources.

There were no related party transactions with Cabinet Ministers required to be disclosed in 2025 (2024: none).

There were no related party transactions required to be disclosed for Melbourne Health Board of Directors, Chief Executive Officer and Executive Directors in 2025 (2024: none).

Note 8.5: Remuneration of auditors

	Total 2025 $'000	Total 2024 $'000
Victorian Auditor-General's Office		
Audit of the financial statements	222	213
Total remuneration of auditors	**222**	**213**

Note 8.6: Ex-gratia expenses

Melbourne Health has made the following ex-gratia expenses:	Total 2025 $'000	Total 2024 $'000
Compensation payment	42	-
Total ex-gratia expenses	**42**	**-**

Includes ex-gratia for both individual items and in aggregate that are greater than or equal to $5,000.

Ex gratia expenses are the voluntary payments of money or other non-monetary benefit (e.g. a write off) that are not made either to acquire goods, services or other benefits for the entity or to meet a legal liability, or to settle or resolve a possible legal liability of or claim against the entity.

Note 8.7: Events occurring after the balance sheet date

As an outcome of the recommendations from the Royal Commission into Victoria's Mental Health System, the governance of Orygen Specialist Program which is operated by Melbourne Health will be transferred to Parkville Youth Mental Health and Wellbeing Service effective 1 July 2025.

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 Melbourne Health.

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.

Property, plant and equipment revaluation surplus

The property, plant and equipment revaluation surplus arises on the revaluation of land, buildings and right-of-use assets. The revaluation surplus is not normally transferred to the accumulated surpluses/(deficits) on derecognition of the relevant asset.

Restricted specific purpose reserve

Restricted specific purpose reserve are funds where Melbourne Health has possession or title to the funds but has no discretion to amend or vary the restriction and/or condition underlying the funds.

The Royal Melbourne Hospital

thermh.org.au