The Royal Melbourne Hospital

Annual Report

2025-2026



About this report

This annual report outlines the operational and financial performance for the Royal Melbourne Hospital from 1 July 2025 to 30 June 2026.

The responsible Minister(s) for the reporting period was/were:

Minister for Health
Minister for Ambulance Services

The Hon Mary-Anne Thomas MP
(1 July 2025 to 15 April 2026)

Minister for Health
Minister for Ambulance Services
Minister for Water

The Hon Harriet Shing MP
(15 April 2026 to 30 June 2026)

Minister for Health Infrastructure

The Hon Melissa Horne MP
(1 July 2025 to 30 June 2026)

Minister for Mental Health
Minister for Ageing

The Hon Ingrid Stitt MP
(1 July 2025 to 30 June 2026)

Minister for Disability
Minister for Children

The Hon Lizzie Blandthorn MP
(1 July 2025 to 30 June 2026)

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.

The Royal Melbourne Hospital acknowledges the Kulin Nation as the Traditional Custodians of the land on which our services are located. We are committed to improving the health and wellbeing of First Nations people.

About the cover

Occupational Therapist Bronte says it is “amazing” to be part of patients’ journeys to recover enough to return home and back to doing what they were doing before they had to come to hospital.

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Report from the Chair and Chief Executive

We are delighted to present the Royal Melbourne Hospital's 2025-26 Annual Report on behalf of the Board of Directors and Executive team.

The past year for the Royal Melbourne Hospital (RMH) has been one focused on impact, performance and partnerships. In the face of sustained and growing demand, we have continued to deliver world-class care, while improving key access metrics for our community.

We have focused on continuous improvement, collaboration and, as ever, we are grateful for the extraordinary commitment of our people. From wards to our support services and research initiatives, together these efforts are ensuring the RMH is here for everyone in the Victorian community when it matters most.

Clinical excellence in action

At the centre of our success is a clear and sustained focus on clinical excellence. Across the RMH, multidisciplinary teams have continued to work together to deliver high-quality, evidence-based care, supported by integrated services that connect patients across acute, subacute and community settings.

A key highlight of 2025-26 was the launch of the Victorian Virtual Hospital in partnership with Austin Health, supported by the Victorian Government. At the RMH, a new virtual ward is supporting patients with heart failure and those recovering from cardiac surgery to recover safely at home, deploying remote monitoring and other digital tools. Instead of being admitted to hospital for an extended period, eligible patients are offered the opportunity to continue their recovery at home with wearable monitoring devices that track vital signs and progress.

Our commitment to clinical excellence was also demonstrated in the expansion of the *Enhanced Recovery After Surgery and Prehabilitation* (ERAS+) program for patients undergoing planned hip and knee replacement surgery. Through a coordinated, multidisciplinary approach, the program was able to reduce length of stay, increase early mobilisation and improve patient flow while maintaining high standards of safety and patient experience.

Through this coordinated approach, we are improving care for patients with complex needs and delivering measurable gains in both health outcomes and patient experience.

Championing access to care

Improving access to care has remained a key priority as demand for our services continues to grow. In 2025-26, the RMH experienced an increase in Emergency Department (ED) presentations of **6.3 per cent** year-on-year, with the number of patients admitted to hospital from the ED rising by **3.5 per cent**. In total, the RMH experienced a **3.6 per cent** increase in the number of patients cared for in hospital across 2025-26 when compared with 2024-25.

> At the centre of our success is a clear and sustained focus on clinical excellence. Across the RMH, multidisciplinary teams have continued to work together to deliver high-quality, evidence-based care, supported by integrated services that connect patients across acute, subacute and community settings.

In response, we have expanded capacity, improved patient flow and strengthened partnerships that help ensure patients receive care in the most appropriate setting.

Through the Victorian Virtual Hospital delivered in partnership with Austin Health, the RMH has also supported virtual ward rounds for regional neurology and haematology patients. Using innovative technology, this model supports regional hospitals to deliver world-class care with the help of our specialists. This means that patients in rural and regional hospitals can access specialist care without needing to be transferred to a metropolitan hospital far away from family, friends and loved ones.

Strengthening partnerships

Our position within the Parkville precinct and established relationships with regional and interstate health services ensures partnerships continue to be one of the RMH's greatest strengths. The establishment of the Parkville Local Health Service Network (LHSN) on 1 July 2025 represented an important step towards more streamlined, coordinated and equitable care for the communities we serve.

The central LHSN team is located at the RMH, helping deliver better care and contribute to a more connected health system. We have also continued to support the transition of the Orygen Specialist Program to the Parkville Youth Mental Health and Wellbeing Service (PYMHWS), which officially launched on 1 July 2025, helping deliver on the vision of the Royal Commission into Victoria's Mental Health System and strengthen access to mental health care for young people.

Research and innovation that makes a difference

The RMH continues to play a leading role in research and innovation, helping turn scientific discovery into real-world benefits for patients and communities. In the past year, we have spearheaded world-first research into brain cancer, using the pioneering Brain Perioperative platform. Together with our partners at The Brain Cancer Centre, this work is providing more tailored treatments – and hope – to people with brain cancer and their families.

The commencement of patient recruitment at the Snow Centre Clinical Research Unit marked an important milestone in bringing world-leading immune disease research closer to clinical practice. Delivered in partnership with WEHI and supported by Snow Medical Research Foundation, this initiative exemplifies how we are accelerating the journey from discovery to patient care.

Meanwhile, the Department of Allergy and Immunology was named a World Allergy Organisation Centre of Excellence. It is the only adult service in Australia to receive this distinction, highlighting our outstanding contribution to clinical care, research and education.

The expertise of many of our clinicians was recognised internationally, with research featured in prestigious medical publications including *Nature*, *The New England Journal of Medicine* and *The Lancet*. Their findings spanned areas including telemedicine, stroke care, infection treatment, pneumonia prevention and oral health, helping to shape healthcare best-practice around the world.

A sustainable health service

Looking to the future, we are continuing to build our capability as a scalable, sustainable health service, with a particular focus on digital health initiatives.

We appointed a Chief Transformation Officer and a Chief Strategy Officer to lead this important work, and have invested in digital infrastructure, analytics and data to enable a more connected and efficient health service. In addition, important initiatives such as the ongoing work of the Digital Coordination Centre (DCC) are strengthening the way we use data to understand activity, monitor performance and plan for the future.

Sustainability remains a key priority, and we are proud of the progress made across our organisation. During 2025-26, a targeted Food Services Sustainability project reduced food and packaging waste by 52.5 tonnes annually while generating significant cost savings.

We also continued to reduce our environmental footprint through initiatives such as the Infection Prevention and Surveillance Service's "Gloves Off!" campaign, which has lowered unnecessary glove use, reduced plastic waste and delivered ongoing savings while maintaining safe standards of care.

We were also able to achieve significant reductions in emissions and water use in 2025-26 through the decommissioning of the RMH Parkville cogeneration plant. The RMH Parkville now receives all electricity from the grid, with our electricity contract with the State Electricity Commission (SEC) including offsets for all emissions from electricity. This resulted in the RMH achieving a net zero emissions target in 2025-26 for electricity consumption for all sites covered by the SEC contract.

Putting patients first

We are pleased to be advancing new models of care that improve both efficiency and the patient experience. Launched in early 2026, the Living Donor Centre brings together nephrologists, surgeons, nurse coordinators and social workers within a single, coordinated service, creating a more streamlined and supportive experience for people participating in the donor journey.

In its first months of operation, the centre supported 42 donor consultations, progressed three patients into paired kidney exchange and scheduled three live donation surgeries. Beyond improving access and coordination, the model is also generating valuable data and supporting co-designed research aimed at further enhancing donor care and recovery.

A commitment to equity

We remain equally focused on delivering compassionate, person-centred care. Equity is fundamental to our mission and informs how we deliver care, make decisions and shape our organisational culture.

During the year, we continued to strengthen our approach to health equity, working closely with staff, consumers and lived experience partners to better understand and address barriers to care. This work is informing the development of our Health Equity Roadmap and helping ensure our services meet the needs of the diverse communities we serve.

We proudly reaffirmed our commitment to improving outcomes for First Nations peoples through the launch of our First Nations Anti-Racism and Cultural Safety Framework on National Sorry Day. Developed in partnership with Aboriginal Health leadership, the framework provides a clear direction for addressing systemic barriers and strengthening cultural safety across the organisation.

In parallel, we continue to lead in culturally responsive care initiatives. The First Nations Cancer Coordinator Toolkit, launched in partnership with Western and Central Melbourne Integrated Cancer Services, is the first resource of its kind in Australia. Co-designed with Aboriginal community governance, it supports culturally safe care, advocacy and

education to improve engagement and access for First Nations patients. These efforts build on the RMH's active participation in NAIDOC celebrations and community events across the Parkville precinct.

We are also taking a leadership role in addressing inequities in care more broadly. Through initiatives such as our International Women's Day Symposium and a new partnership with the Women's, we are helping to advance the understanding of how gender influences health outcomes and identify opportunities to reduce disparities in care.

Thanking our people

Most critically, our workforce remains at the heart of everything we do. We continue to invest in leadership development, wellbeing initiatives and new models of care that enable staff to work to the full scope of their practice.

We extend a sincere thank you to everyone who contributes to the RMH's success – from our nurses and doctors to our allied health departments, clinical and non-clinical support staff, volunteers, and consumers and lived experience representatives.

We also acknowledge the gracious support of our philanthropic community, who help to unlock the potential of the RMH to be a place of innovation, compassion and community, serving people from every walk of life.

Without you, we could not deliver meaningful impact, advance research, or support innovation that makes such a difference to all who walk through our doors. We are grateful to our community for their trust and partnership and are proud to provide care for more than 250,000 Victorians every year.

Lastly, we would like to take a moment to acknowledge the RMH Board and Executive for their leadership over the past 12 months and thank the Department of Health for their ongoing support and willingness to work together. We would also like to acknowledge the support and engagement of relevant health and mental health portfolio Ministers across 2025-26.

Together, we will continue to build on these achievements, delivering exceptional care today while shaping a stronger, more equitable and sustainable health service for the future.



Linda Bardo Nicholls AO
Board Chair



Professor Shelley Dolan
Chief Executive

> We extend our sincere thank you to everyone who contributes to the RMH's success – from our nurses and doctors to our allied health departments, clinical and non-clinical support staff and volunteers.

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 2026.

Linda Bardo Nicholls AO
Board Chair
Melbourne
26 August 2026



About the Royal Melbourne Hospital

Driven by exceptional care, world-leading innovation, and the needs of the community, the RMH has been serving Victorians since 1848 as the state's first public hospital.

Today, the RMH is proud to be one of the largest health providers in the state and recognised across the world for excellence, providing a comprehensive range of services and research opportunities.

With a workforce approaching 12,000 people, the RMH has a significant presence across Melbourne. Services are delivered through its major health service locations in Parkville and Royal Park, mental health services throughout the inner north-west, residential aged care facilities at Cyril Jewell House in Keilor East and Boyne Russell House in Brunswick, and dialysis centres in Elizabeth Street, Essendon Fields and Coburg.

The RMH is a designated statewide provider for services including trauma and stroke, and leads centres of excellence in several key specialties including neurosciences, nephrology, oncology, cardiology, endocrine and virtual health.

Strategically positioned in the world-leading Parkville health precinct, the RMH partners with brilliant thinkers from across other medical, research and education institutions to set new benchmarks in health excellence.

This includes the world-renowned Peter Doherty Institute for Infection and Immunity, a joint venture between the RMH and the University of Melbourne. Strong collaborations with WEHI, The Florey Institute of Neuroscience and Mental Health (The Florey), and health service partners across the precinct help translate research discoveries into better care for patients.

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 2025-26 were:

Mrs Linda Bardo Nicholls AO – Chair
Appointed May 2018

Ms Nicole Bartholomeusz
Appointed July 2025

Ms Kylie Bishop
Appointed July 2021

Ms Philippa Connolly
Appointed July 2018

Mr Peter Funder
Appointed July 2019

Mr Sam Lobley
Appointed July 2021

Professor Mary O'Reilly
Appointed October 2023

Ms Emma Skinner
Appointed July 2021

Mr Felix Walsh
Appointed July 2025

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)

Frequency of meetings:
Bi-monthly

Finance Committee

Board members:

Ms Emma Skinner (Chair)

Ms Kylie Bishop

Mr Peter Funder

Ms Philippa Connolly

Frequency of meetings:
Bi-monthly

People, Culture and Remuneration Committee

Board members:

Ms Kylie Bishop (Chair)

Ms Philippa Connolly

Frequency of meetings:
Quarterly

Quality Committee

Board members:

Professor Mary O'Reilly (Chair)

Mr Sam Lobley

Frequency of meetings:
Bi-monthly

Redevelopment Committee

Board members:

Mr Peter Funder (Chair)

Ms Philippa Connolly

Frequency of meetings:
As required

The RMH Foundation Committee

Board members:

Mr Peter Funder (Chair)

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 Philippa Connolly.

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

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

The Parkville LHSN Primary Care and Population Health Advisory Committee is attended by Ms Nicole Bartholomeusz and Ms Debbie Munro (General Manager – Home First, Ambulatory and Complex Care).

Organisation structure

As of 30 June 2026

EXECUTIVE COMMITTEES

- Financial Sustainability
- Human Research and Ethics
- Private Practice Agreement
- Data Governance
- Capital Investment / Space
- Digital Health
- Redevelopment Executive
- First Nations Governance
- Emergency Management and Business Continuity
- Environment
- Non-Clinical Policy & Procedure
- People Culture and Communications
- Clinical Council
- Nursing Executive
- Medical Credentialling
- Allied Health Credentialling
- Quality

Board

BOARD COMMITTEES

- Quality
- The RMH Foundation
- Redevelopment
- People Culture and Remuneration
- Community Advisory
- Audit
- Finance

Chief Executive
Professor Shelley Dolan

CHIEF OPERATING OFFICER
JACKIE MCLEOD

Allied Health
Emma Beer

Access, Critical Care and Investigative Services
Ed Savill

Home First, Ambulatory and Complex Care Services
Debbie Munro

Medical Services
Fiona Marsic

Mental Health Services
Sophie Barrett

Surgical Services
Lebe Malkoun

Director, Clinical Transformation, Innovation and Reform
Catherine Humphrey

Director, Surgical Strategy and Partnerships
Edward Wallace

Director, Strategic Projects
Sandra Gates

CHIEF MEDICAL OFFICER
DR FERGUS KERR

Deputy CMO
Dr Rob Feiler
Dr David Fenn

Medical Workforce and Education Unit
Mandy Gvozdich

Clinical Governance/ Education and Training
Prof Lou Irving

Infection Prevention and Surveillance Service
A/Prof Caroline Marshall

VICNISS
A/Prof Deb Friedman

Informatics Chief Medical Information Officer
Dr Robyn Gilles

VIDRL
Dr Katherine Bond

Pharmacy
Kerryn Griffett

Library
Duncan Pilcher

Guidance
Prof Karin Thursky

CHIEF NURSING OFFICER
ADJUNCT PROFESSOR KETHLY FALLON

Nursing Workforce
Megan Hoffmann

Nursing Education
Melody Trueman

Aboriginal Health
Candice McKenzie

Residential Aged Care
Wendy Wallace

Community Engagement and Patient Experience
Liz Cashill

Centre for Nursing Enquiry
Katrina Lenzie-Smith

Security
Liz Virtue

CHIEF PEOPLE AND COMMUNICATIONS OFFICER
AMANDA ARMSTRONG

People Capability and Culture
Fleur Behrens

Safety Culture
Rachel Baker

People Systems and Technology
John Mizzi

Talent and Experience
Eliza Hawley

Communications
Olly Tripodi

CHIEF QUALITY OFFICER
SAMANTHA PLUMB

Emergency Management and Business Continuity
Emma Gardiner

EMR
Benita Butler

Health Intelligence
Liz Singleton

Information and Performance
Whitney Blake

Quality and Improvement
Melissa Bowkett-Hall

Risk
Mindy Vu

Pathology Connect
Adam Boulton

Digital Coordination Centre CARE+ Project
Joseph Cobbledick

CHIEF CORPORATE OFFICER
PAUL URQUHART

Director, Group Reporting Analysis and Corporate Services
Sean Bryant

Corporate Controller
Anna Jenek

Finance Director
Andrew Whittingham

Payroll Services
Mason Clarke-Jones

Property, Procurement and Supply Chain
Marcus Kim

Facilities Management
Michael McCambridge

Deputy Director, the RMH Foundation
Brooke Daly

CHIEF DIGITAL INFORMATION OFFICER
GEORGE COZARIS

Digital Architecture and Emergency Management
Denis Clare

Digital Strategy and Transformation
Suzy McDonald

Digital Consumer Success
Kostas Mimilidis

Digital Information
Ross Buchanan

Digital Platforms
Paul Girdler

Collaboration and Initiatives
Daniel Weales

CHIEF REDEVELOPMENT OFFICER
ROBERT ROTHNIE

Project Director, Parkville Precinct Redevelopment
Sarah Hose

Director, Capital Works and Project Director
Leanne Chappell

CHIEF LEGAL OFFICER AND CORPORATE SECRETARY
FLEUR KATSMARTIN

Director, Medicolegal Services
Andrew Mariadason

Director, Legal Services
Jennifer Roberts

Paralegal
Marlei Hillas

CHIEF TRANSFORMATION OFFICER
PROFESSOR PETER STEEL

Clinical Informatics Centre
Tim Fazio

EXECUTIVE DIRECTOR, PARKVILLE LHSN
SUYIN NG

CHIEF STRATEGY OFFICER
ROSS BROAD

Our care at a glance

135,134
Inpatient admissions (non-mental health)

1292
Mental health inpatient admissions

99,559
Emergency Department presentations

444
Arrivals by air

2430
Trauma patients treated

11,315
Emergency surgeries

18,777
Planned surgeries performed at the RMH (including surgeries and procedures in the endoscopy and cardiology departments)

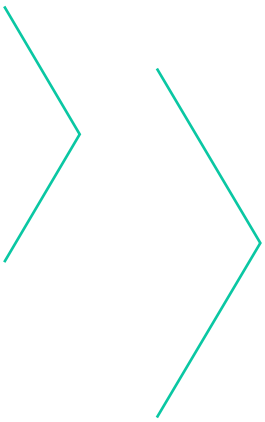
692
Patients supported through the Virtual Hospital (in partnership with Austin Health)

121
Organ transplants

249,644
Specialist clinic (outpatient) appointments (including 89,307 telehealth appointments)

4377
Hospital-in-the-home care episodes

202,720
Mental health service contacts in the community



All data published in annual reports is accurate at the time of publishing. Data may change following audit and data verification, which may not be finalised at the time of publishing.

Year in review

A great place to work and receive care

- In 2025, 752 staff were recognised for their long-time service to the organisation through the Length of Commitment Awards, which included one staff member recognised for 50 years of service and another three for 45 years.
- There were more than 60 finalists in the RMH's Celebrating Excellence Awards in 2025, recognising the contributions and achievements of individuals, teams, consumers and volunteers across the organisation.
- In November 2025, the RMH Mental Health Services launched a new information hub for carers to support them through their loved ones' care journey with the organisation. The information hub, available on the RMH website, brings together information and resources to support families, carers, loved ones, supporters and kin of those who are receiving mental health care at the RMH. The RMH Carer Lived Experience team developed the resources in consultation with consumers and carers.
- The RMH demonstrates a strong commitment to consumer partnership by engaging consumer and carer representatives across more than 70 committees and working groups, spanning Board sub-committees, governance, quality, and improvement initiatives. These partnerships support us to be responsive to our community's needs, build a collaborative approach to all our service designs and improvements, and invite an alternative, but equally important, perspective in discussions and decision-making.
- The RMH Department of Allergy and Immunology was recognised as a Centre of Excellence by the World Allergy Organisation (WAO). The RMH department is the only adult department in Australia to have been recognised by the WAO, and it is testament to the department's commitment to scientific and clinical innovation, education and advocacy, in the field of allergy, asthma, and clinical immunology.
- On National Sorry Day in May 2026, the RMH launched its inaugural First Nations Anti-Racism and Cultural Safety Framework. The framework sets out how the RMH will create a workplace and care environment that is safe, respectful and free from racism for First Nations staff, patients and communities. It recognises that cultural safety cannot be defined or determined by non-Indigenous people or institutions. Our role is to listen, learn and act, dismantling racism, shifting power, and embedding First Nations voices, knowledges and leadership across every level of our organisation.
- Across 2025-26, implementation of the RMH Disability Action Plan 2023-2026 has progressed with action across all five priority areas. Guided by a Disability Working Group composed of consumers and staff, highlights included further embedding the Disability Identifier Tool and raising the profile of Disability Liaison Officers at the RMH. Other initiatives included delivery of disability awareness training to build workforce capability and confidence, strong uptake of the Hidden Disabilities Sunflower Program, and capital works to improve disability access at our Elizabeth St and Grattan St sites.
- The RMH made significant improvements in access to emergency care in 2025-26, supported by participation in the Timely Emergency Care (TEC) Collaborative. Changes to ambulance offload escalation processes resulted in a reduction in the number of ambulance transfer delays of more than two hours by 92 per cent from 2024-25 (from 2,281 patients experiencing an ambulance transfer delay of more than two hours in 2024-25 to just 186 patients in 2025-26). The RMH also achieved an almost 10-minute reduction in average ambulance offload time (from 43.15 minutes in 2024-25 to 33.77 minutes in 2025-26).

- In January 2026, the RMH launched an Action Framework as a structured guide to implementing *In this together: The RMH Community Engagement Strategy 2025–2030*. Co-designed with patients, carers and consumers, the Action Framework outlines actions and outputs across four key focus areas: Communication and Information Sharing, Access and Navigation, Partnerships, and Attitudes and Awareness. It aims to foster an environment where every interaction reflects the preferences, needs and values of each individual.

Grow our Home First approach

- In early 2026, the RMH launched the Older Persons Care Hub and expanded the Residential In-Reach (RiR) program with a new Post-Hospital service. The RiR Post-Hospital Service is supporting RMH patients who need to transition into aged care for the first time or returning with complex or changed needs, while patients referred to the Older Persons Care Hub are visited at home by their care team for assessment and care planning for a short period. These services support patients to get the care they need closer to home, and at the same time avoid unnecessary trips to the hospital or avoidable re-admissions.

Realise the potential of the Melbourne Biomedical precinct

- The RMH continues to work collaboratively with other healthcare organisations and the wider health system to deliver improvements in care for our community. The RMH is a proud member of the Parkville LHSN, which officially came into operation on 1 July 2025. The RMH hosts the LHSN central team and is proudly involved in all aspects of the work, which will support the delivery of equitable and high-quality care for all Victorians. The RMH also continues to support efforts to establish the Public Pathology Victoria network.
- The RMH also supported the transition of the Orygen Specialist Program (OSP) team to PYMHWS from 1 July 2025. This new service is part of the vision set out by the Royal Commission into Victoria's Mental Health System, to create a dedicated youth mental health service for the northwest region of Victoria. After the transition, the RMH continued to provide corporate and enabling services support to PYMHWS.
- As part of International Women's Day celebrations in March 2026, the RMH and the Women's announced a new partnership aimed at closing gaps in diagnosis, treatment and outcomes between men and women. The initiative will place contemporary research into sex- and gender-based differences at the centre of clinical decision making, with the goal of delivering more equitable care for all patients. The new gender-informed clinical care initiative will use data to identify conditions where disparities are most pronounced and, over time, develop tailored pathways for diagnosis and treatment that better reflect patients' needs. The announcement was made at the RMH's International Women's Day Symposium on gender impacts and how to improve diagnosis and clinical care, which involved collaboration with hospitals within the Parkville LHSN, including the Women's and the Peter MacCallum Cancer Centre.
- The Parkville precinct in September transitioned to HealthLink for the secure electronic delivery of discharge summaries and clinical correspondence to GPs and specialist providers. This transition enhances the ability of the precinct's hospitals, including the RMH, to communicate effectively and securely with our network of GPs, supporting timely follow-up care and improving continuity across the healthcare system.

> "These services support patients to get the care they need closer to home and at the same time avoid unnecessary trips to the hospital or avoidable re-admissions."

Become a digital health service

- In late 2025, the RMH joined forces with Austin Health to launch the Victorian Virtual Hospital, an innovative program that uses digital technology such as video, phone and remote monitoring devices to deliver hospital-level specialist care to patients in their homes or in their local and regional hospitals.
- The Victorian Virtual Hospital also involved expanded use of the RMH's Digital Coordination Centre (DCC), with real-time data used to manage ambulance demand and hospital capacity. This helped paramedics to better identify hospitals with available capacity, reducing delays and getting paramedics back on the road sooner.
- In August 2025, staff from the RMH DCC launched a partnership with regional hospitals to help patients living outside Melbourne receive the best possible care and get back home sooner. Weekly online huddles were established to discuss improvements to patient access and flow, with representatives from hospitals in the Hume region visiting the RMH to discuss pathways for patients who require specialist care in Melbourne before returning to their local communities.
- In 2025-26, the RMH launched a new electronic Health Assessment Questionnaire (eHAQ) for all planned surgical patients on Health Hub, supporting safe, timely and person-centred care. The Health Hub patient portal is a secure mobile and web application that lets patients view and manage information about their care at the RMH and other Parkville health services. The eHAQ replaces paper intake forms, enabling clinical teams at the RMH to have access to relevant information to plan for high-quality patient care.
- The RMH Health Intelligence and Finance teams have strongly leveraged PowerBI to undertake a significant automation of reporting, enhancing business insights around activity, and strengthening data security.

Strive for sustainability

- RMH projects received awards in the University of Melbourne's Health Service Environmental Sustainability Competition for 2025-26 for the Best Emissions Reduction and Best Non-Clinical projects, while the 'Gloves Off!' campaign to reduce non-sterile glove use was named the best RMH project
- With increasing demand for services, the RMH continues to deliver needs-led improvements to ensure the continued advancement of health for everyone in the community. The RMH partnered with Ambulance Victoria on the RMH Ambulance Victoria Offload Standard initiative, to meet the rising demand from ED presentations and the new Standards for Safe and Timely Ambulance and Emergency Care. The aim was clear: ensure no patient waits longer than two hours to be offloaded from an ambulance at the RMH.

Build for the future

- The RMH's gas-fired power turbines – also known as cogeneration system – was decommissioned in September 2025. The RMH was one of five major Victorian hospitals to decommission these systems as part of the upgrades through the Guaranteeing Future Energy Supplies project. All five major hospitals reduced annual gas use by around 470,000 gigajoules and associated carbon emissions by around 24,000 tonnes.
- The RMH transitioned to the statewide 100 per cent renewable electricity contract with the State Electricity Commission, further reducing our energy-related carbon emissions. The environmental benefits of this transition include lower gas consumption, and also alignment with HealthShare Victoria's (HSV) green power procurement strategy for all healthcare facilities starting in 2025.
- To replace the back-up power supply that cogeneration system supplied, three new generators were installed at the RMH, and a new third CitiPower feed that is separate to the RMH mains feed and will sit idle as a back-up unless needed.
- In partnership with the Victorian Infrastructure Delivery Authority (VIDA) Health, work has continued on decommissioning our Materials Handling Building in support of our broader redevelopment.

2025-26 SPOTLIGHT

The RMH and Austin Health join forces to launch Victoria's Virtual Hospital

The RMH and Austin Health have joined forces to launch Victoria's first Virtual Hospital – providing greater access to specialist care for all Victorians

The Virtual Hospital has supported expert care for patients from the comfort of their own homes or local hospitals - including from regional settings where specialist treatment may not be available - using innovative digital technology. It has also helped patients return home sooner after a hospital admission by providing check-ups and monitoring remotely, where safe to do so.

One of the patients who has received care through the Virtual Hospital was Linda, who was able to return home just days after complex coronary bypass surgery, supported by the RMH's virtual ward and remote monitoring technology. Instead of remaining in hospital for extended observation, she continued her recovery safely at home alongside family while clinicians monitored her vital signs in real-time.

"At home they would call me every morning [to check in], I was still an inpatient - the doctor, nurse, the physio," Linda said.

"They were wonderful and answered any questions I had. I was happy to be in my own home with my husband and my daughters visiting.

"I just can't speak highly of them [the RMH team]. They're just wonderful. I'm just so grateful for all of them."

The RMH Chief Executive Professor Shelley Dolan said the innovative program was an important step for the future of digital healthcare.



Virtual Hospital patient Linda (centre) with the RMH Chief Executive Prof Shelley Dolan.

"We are delighted to be working closely with Austin Health, the Local Health Services Networks and regional colleagues to deliver the next phase of virtual care for Victoria," Prof Dolan said.

"This will reduce length of stay and provide improved access to world-class healthcare for more communities across Victoria."

The scope of the Virtual Hospital has included a virtual ward for patients receiving care for heart failure and post-cardiac surgery; virtual ward rounds for regional neurology and haematology patients, and; a virtual foetal monitoring service, delivered in partnership with the Royal Women's Hospital.

The Virtual Hospital has also drawn upon the success of the RMH's Digital Coordination Centre (DCC), the digital hub that oversees access and flow across the RMH. As part of the Virtual Hospital, a dedicated representative from Ambulance Victoria is based within the DCC to support ambulance and health service capacity and demand coordination within the northwestern metropolitan region to help ambulances get back on the road faster.

The Virtual Hospital has been extended into 2026-27.

2025-26 SPOTLIGHT

Supporting those who give the gift of a kidney

A new kidney care centre dedicated to living donors will provide better support for people who generously choose to donate a kidney



The kidney care team at John Perrett Kidney Centre

Based at the RMH, the Living Donor Centre brings together a multidisciplinary team of nephrologists, surgeons, nurse coordinators and social workers to support living donors who are offering the amazing gift of a kidney transplant.

Associate Professor Peter Hughes, Lead Physician for Transplantation at the RMH, said the centre would **"streamline the assessment process for donors, reducing time and unnecessary appointments, and provide them with more dedicated care and support".**

By consolidating the pre-donation and post-donation process in one location, the centre will capture more data and insights from the lived experience of consumers around kidney donation. The centre will also undertake co-designed research with patients to identify new ways to support donors after transplantation.

Rebecca Beard and her husband Stuart know just how vital this support can be when navigating the donation pathway.

Stuart, who lives with polycystic kidney disease, experienced a decline in kidney function and needed a transplant, so Rebecca donated her kidney.

Rebecca reflected the support they received during the testing, surgery and post-donation care phases made their experience easier.

"I felt that I had very good support because I had a transplant coordinator, nurse and doctor looking after me," she said, adding she felt well-supported by the multidisciplinary care, including seeing a priest from the RMH Spiritual Care Services which helped both her body and mind feel best prepared for kidney donation.

The RMH Kidney Transplantation Service is the second-largest kidney transplant unit in Australia, performing more than 100 kidney transplants a year and having conducted the most living donor kidney transplants in Australia.

Professor Karen Dwyer, Director of Nephrology at the RMH, hopes the centre will provide greater awareness about donation, as well as support for those who choose to take part.

"The Living Donor Centre at RMH will set the standard for Australia supporting donors from the moment they enquire, through the work-up, donation and the post-donation period," she said.

The Living Donor Centre has been funded through a generous donation to the RMH Foundation by a former patient, who was the beneficiary of a kidney transplant.

2025-26 SPOTLIGHT

Across generations and cultures, RMH volunteers find common purpose

Volunteers are a highly valued part of the RMH team. They play an important role in improving the experiences of patients, consumers, carers, visitors and staff members

The RMH now has over 200 volunteers, aged from 18-90, from over 30 cultural backgrounds, and speaking over 36 languages. Our volunteer team includes university students, working professionals, and people in retirement. Volunteers are engaged in roles including bedside-assistance and social interaction, wayfinding and navigation, live music, and pet therapy.

Despite coming from different backgrounds and life experiences, Nhat and Nazih have found common ground in their commitment to helping others as volunteers.

Nhat, a student from Vietnam, joined the RMH as a volunteer in 2026. Nazih, originally from Egypt and a retired teacher, has been volunteering with the RMH since 2010.

As wayfinding volunteers, Nhat and Nazih are often the first friendly faces people see when arriving at hospital, greeting visitors, helping patients and families find where they need to go, and offering reassurance during stressful moments.

Despite the decades in age and experience between them, both say volunteering is driven by a desire to help others.

“I always felt I had to do something after I retired, to give back,” Nazih said.



The RMH’s Wayfinding Volunteers Nhat (left) and Nazih (right), alongside RMH Volunteer Service Coordinator Allan Campion (centre).

For Nhat, giving his time to help people has been a lifelong experience.

“Before coming to Australia, I would volunteer in areas of hardship across Vietnam, doing things like teaching English to people who hadn’t received a good education,” Nhat said.

Nhat and Nazih say volunteering alongside people from different generations has created an environment of mutual learning and mentorship.

“The more experienced volunteers know what they are doing, they know this place so well and are happy to share that,” Nhat said.

Nazih said the experience works both ways.

“I feel very comfortable sharing my experience with the younger volunteers, but of course, I am also learning a lot from them too,” he said.

“That’s one of the tenets of teaching, that you also learn from your students.”

The RMH’s Chief Executive Professor Shelley Dolan said volunteers like Nhat and Nazih were crucial to the fabric of the hospital.

“Whether they are helping visitors find their loved one, providing assistance on the ward or supporting programs such as music and pet therapy, we could not provide the level of companionship that we do without our volunteers,” Prof Dolan said.

Awards, recognition and accolades

Staff and services that received recognition across 2025-26:

- **Professor Andrew Roberts** was awarded the prestigious Helen M. Ranney Clinical and Translational Science Medal from the American Society of Hematology for his contributions to blood cancer research and patient care over many years. The award recognised his role in leading the first-in-human venetoclax trial at the RMH in 2011, which has since informed over 500 subsequent studies worldwide and contributed to improved survival for many patients
- One former and one current RMH team member were appointed Members of the Order of Australia (AM), during this year's King's Birthday Honours. **Associate Professor Anne Howard**, a consultant dermatologist at the RMH since 1985, received hers for "significant service to dermatology as a clinician, teacher, examiner and mentor". **Bridget Shaw**, an advanced practice physiotherapist in the ED from 2008-2012, was also recognised for her "significant service to physiotherapy, to clinical training, and to advanced practice leadership"
- **The RMH's Injury Management team** received the 'Leading Return to Work Practice Award' in WorkSafe Victoria's 2025 WorkSafe Awards in February. The RMH's win recognised the significant transformation of its return-to-work practices to provide a collaborative approach between injured workers and their managers. The RMH was also a finalist for the 'Workplace health and safety solution of the year' category for the development of the sexual safety guideline
- **Dr Asha Bonney** was awarded the David Bickhart Clinician Research Fellowship in early 2026. The Bickhart is a sought-after three-year fellowship for outstanding clinician scientists, with Dr Bonney recognised for her impactful work in lung cancer screening and lung nodule management
- Six Victorians with ties to the RMH were honoured as part of the annual Australia Day 2026 Honours: **Dr Colin Begley (AM)**, inaugural Director of the Bone Marrow Research Laboratories; **Professor Stephen Jane (AO)**, former Director of the RMH's Bone Marrow Laboratories; **Dr Rondhir Jithoo (OAM)**, visiting medical officer between 2006 and 2010; **Professor Anne Kelso (AC)**, Chair of the Scientific Advisory Board at the Doherty; **Professor John O'Donnell (AM)**, former RMH orthopaedic surgeon; **Dr Brian Tress (AO)**, former Director of Radiology
- **Kelvin Lay and Matt Prowse** from the RMH Finance team were national winners in the Healthcare Financial Management Association's 2025 Finance Awards in December. They were recognised in the category 'Innovation - Championing Creative Solutions' for their work in Power BI, reporting and analysis
- **The RMH** projects and teams were finalists in three categories at the 2025 Victorian Public Health Care Awards. The hospital-in-the-home eligibility identifier was a finalist in the 'Care in the community' category; the active bystander training program was a finalist in the 'Celebrating a strong and sustainable workforce' category, and; the Live Music Volunteers were finalists in the 'Volunteer Awards Health Volunteer Team of the Year' category

- The RMH announced five new inductees into the RMH Research Hall of Fame in November 2025: **Professor Andrew Roberts AM**, Clinical Haematologist; **Professor Jonathan Kalman AO**, Head of the Heart Rhythm department; **Professor Peter Colman AM**, Endocrinologist; **Professor Kate Leslie AO**, Head of Research in the Department of Anaesthesia and Pain Management, and; **Professor Karin Thursky FAHMS FAIDH**, Infectious Diseases Physician
- **Professor Neeraj Bhala** received the 2025 Bisset Hawkins Medal, which is awarded every three years by the Royal College of Physicians of London to acknowledge work done in the preceding 10 years in advancing sanitary science or promoting public health
- Associate **Professor Daniel Capurro**, General Medicine Consultant, was inducted as a Fellow of the American College of Medical Informatics in recognition of his impact in biomedical and health informatics, acknowledging thought leadership, deep expertise, and scholarly achievement. He became one of only four Australians to hold this distinction
- Three RMH staff were recognised in the Victorian Prevocational Medical Training Awards in October: **Dr Karanjeet Chauhan** (Victorian Prevocational Doctor of the Year), **Professor Lou Irving** (Lifetime Achievement Award (Medical Education)) and **Professor Jonathan Knott** (Distinguished Service Award)
- **Professor David Ritchie**, Acting Director of Clinical Haematology and Head of the Bone Marrow Transplant Service, was awarded the Leadership in Haematology Award from the Haematology Society of Australia and New Zealand in October. Professor Ritchie was recognised for his outstanding contributions to clinical practice, translational research, professional bodies and philanthropy within the haematology community
- **The RMH Facilities Management team** was recognised at the TRIRIGAWorld Awards in August for Best Business Transformation Using IBM TRIRIGA. The implementation of the Computer Assisted Facilities Management (CAFM) system in 2020 marked a transformative milestone for Facilities Management, reforming its operations and paving the way for greater efficiency, productivity and sustainability, all while supporting the RMH's clinical teams and contributing to a positive patient experience
- **Professor Bruce Mann** received the 2025 Alan Coates Award in August for his outstanding contribution to Breast Cancer Trial's clinical trials research program.
- **Professor Bruce Campbell** was awarded the Bethlehem Griffiths Research Foundation 2025 Medal in July for his outstanding achievements in stroke research, specifically in brain imaging, clot retrieval and emergency therapeutics.
- **The RMH Flying Squad** received the 'Allied Health - Team Excellence' award at the 2025 HESTA Excellence Awards in July. The team was recognised for their innovative work in supporting patients with complex psychosocial barriers to leave the hospital safely

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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 for all of our staff.

During 2025-26, the Safety Culture team strengthened workplace health and safety across the RMH through a greater focus on prevention, governance, education and early intervention. This work has supported safer systems of work, stronger leadership accountability and a positive safety culture across the organisation.

Health and safety governance continued to mature through strengthened local occupational health and safety (OHS) committees, improved reporting and clearer escalation pathways. Oversight of key organisational risks - including OVA, manual handling, occupational exposure and hazardous building materials - was also enhanced.

Education remained a priority, with managers, Health and Safety Representatives and staff completing practical training in legislative responsibilities, hazard management, incident reporting and psychosocial health and safety. Improved reporting dashboards and safety analytics have also provided leaders with better visibility of incidents, injuries and emerging risks, supporting earlier intervention and targeted prevention.

The Injury Management team continued to improve outcomes for injured employees through early intervention, proactive case management and stronger partnerships with managers, treating practitioners and WorkSafe.

The team was awarded the 2025 WorkSafe Award for Leading Return to Work Practice, recognising their commitment and the RMH’s sustained focus on supporting injured employees throughout their recovery and successful return to work.

Looking ahead, psychological health and wellbeing will remain a key priority for the RMH. Over the coming year, we will continue implementing our Psychological Health and Wellbeing Action Plan alongside targeted prevention initiatives for manual handling and slips, trips and falls.

Through stronger governance, investment in equipment, improved data analytics, and partnerships with operational leaders, the RMH will continue to strengthen its safety culture and reduce harm to our people through practical, evidence-informed prevention strategies.

Workforce wellbeing

During 2025-26, the Workforce Wellbeing team transitioned to the Psychological Health and Wellbeing team within the Safety Culture portfolio. This reflects an expanded focus on preventing work-related psychological harm and supporting compliance with the Occupational Health and Safety Amendment (Psychological Health) Regulations 2025, which commenced on 1 December 2025.

Alongside continuing to support employees and leaders following critical incidents, organisational change and challenging workplace events, the team adopted a stronger prevention focus.

This included developing the RMH’s psychosocial risk management framework, supporting psychosocial hazard identification and risk assessment, strengthening consultation with Health and Safety Representatives and building leader capability to manage psychosocial risks.

Psychological health reporting has also been integrated into the RMH's broader Safety Culture governance framework, providing improved visibility of organisational trends and psychosocial risks to support prevention, early intervention and legislative compliance.

Sexual safety

The RMH continues to lead the sector in advancing sexual safety initiatives. Following the launch of the Responding to Sexual Safety Incidents: Patient-to-Staff Guideline in 2025, the Sexual Safety Nurse Consultant and OVA Education team have focused on embedding the guideline's principles and response framework across the organisation.

During 2025-26, more than 60 education sessions were delivered to nursing, allied health and education staff, including tailored programs developed to meet the specific needs of individual teams. Ongoing incident consultation and follow-up have also supported consistent, guideline-aligned responses across clinical areas.

The impact of this work has been recognised externally. The RMH was a finalist in the 2025 WorkSafe Awards in the Health and Safety Solution of the Year category for the development of the sexual safety guidelines. The initiative was also highlighted by the Victorian Commissioner for Gender Equality, Dr Nikki Vincent, in an article published in the *Australian Journal of Human Rights* in January 2026.

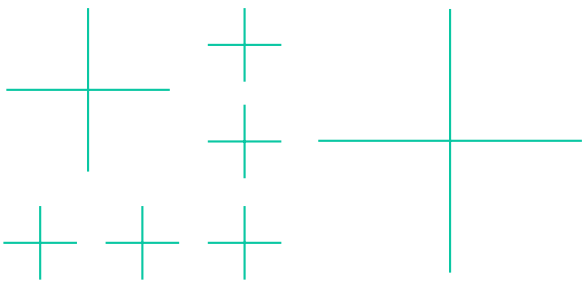
Reporting of sexual safety incidents has continued to improve, reflecting growing staff awareness and confidence in organisational processes. Staff reports relating to sexual safety increased from 211 in 2023 to 440 in 2025, providing valuable data to inform prevention and response strategies. Analysis of sexual harassment reporting has also informed priority actions within the 2026 Gender Equality Action Plan.

Occupational violence and aggression

This year, the RMH has undertaken a comprehensive review of the factors contributing to occupational violence, drawing on detailed analysis of patient cohorts, security data, systems of work, and the physical environment.

Individualised OVA risk assessments have been completed across clinical areas to strengthen our 360-degree approach to prevention and management, with strategies tailored to local risks and operational needs. This work has supported the implementation of targeted improvements and informed practical, sustainable approaches to addressing OVA challenges across our organisation.

Alongside this work, the RMH has continued to invest in measures that ensure a safety-for-all approach remains central to our organisation. In 2025, significant enhancements were made to our security capability, including the establishment and operationalisation of a 24/7 Security Control Room and the introduction of additional roaming security officers in the ED, providing around-the-clock support for staff and patients.



Occupational health and safety statistics[1]

	2023-24	2024-25	**2025-26**
The number of reported hazards / incidents for the year per 100 FTE	47.23	47.67	**48.02**

Commentary:

There were 3573 hazards and incidents reported in 2025-26, compared with 3647 in 2024-25, 3569 in 2023-24 and 3761 in 2022-23. Incident reporting has remained consistent over the past four years, reflecting a mature reporting culture where staff continue to identify and report hazards and incidents. This provides valuable intelligence to target prevention initiatives, strengthen controls and reduce the risk of future harm.

Claim information

	2023-24	2024-25	**2025-26**
The number of 'lost time' standard claims for the year per 100 full-time equivalent staff members	0.82	0.85	**0.93**

Commentary:

Despite the increase in claim volume, return to work outcomes have improved, reflecting the strength of the RMH's injury management capability and sustained focus on early intervention, recovery at work, and supporting employees through their recovery. The success of our early intervention approach was further tested during a temporary increase in psychological injury claims associated with a high-profile workplace matter.

The average cost per claim for the year (including payments to date and an estimate of outstanding claim costs as advised by WorkSafe)	$127,277	$87,613	**$101,550**

Commentary:

The RMH Injury Management team continued to strengthen outcomes for injured employees through early intervention, proactive case management and strong partnerships with managers, treating practitioners and WorkSafe. This approach has supported improved return to work outcomes, with performance continuing to improve across key return to work measures, demonstrating the effectiveness of the RMH's injury management approach.

While the average incurred cost per claim increased compared to the previous year, this does not represent a decline in performance. WorkCover claims continue to develop over several years as payments are made and future claim liabilities are reassessed by WorkSafe. As a result, the 2024-25 claims cohort has matured since the previous reporting period, leading to higher paid costs, subsequent compensation estimates and total incurred costs. This reflects the normal development of claims over time rather than a deterioration in injury management performance.

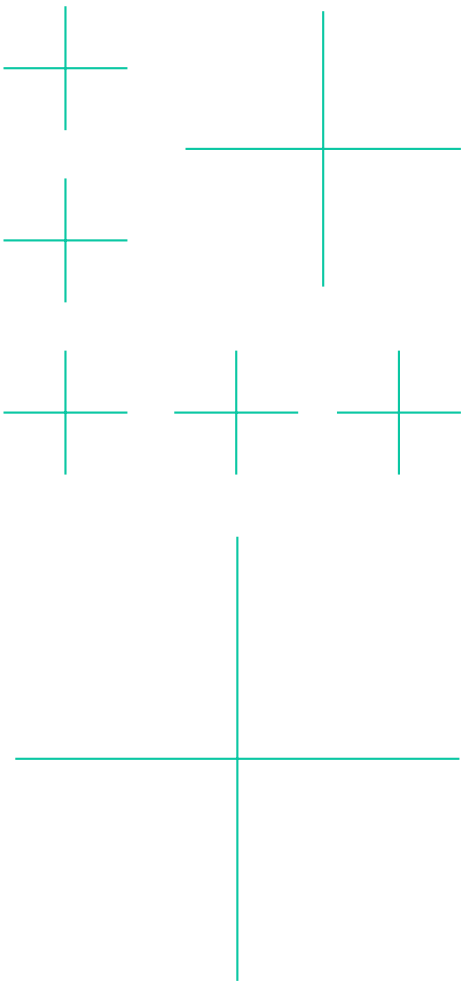
Occupational violence statistics

	2025-26
Workcover accepted claims with an occupational violence cause per 100 FTE	**0.067**
Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked.	**0.426**
Number of occupational violence incidents reported	**1,344**
Number of occupational violence incidents reported per 100 FTE	**18.06**
Percentage of occupational violence incidents resulting in a staff injury, illness, or condition	**8.9%**

1. Occupational health and safety statistics in 2025-26 are affected by the transition of Orygen Specialist Program staff from the RMH to the PYMHWS from 1 July 2025.

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, it must be included.
- **Accepted WorkCover claims** – claims accepted and lodged in 2025-26.
- **Lost time** - defined as greater than one day.
- **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 2026 and the average monthly FTE across 2025-26, with 2024-25 data shown for comparative purposes. Workforce information in 2025-26 is affected by the transition of Orygen Specialist Program staff from the RMH to PYMHWS from 1 July 2025.

	June current month FTE		Average monthly FTE	
Labour category	**2024-2025**	**2025-2026**	**2024-2025**	**2025-2026**
Nursing	3,001	2,948	2,981	2,874
Administration and clerical	1,114	1,109	1,091	1,078
Medical support	987	1,032	983	1,028
Hotel and allied services	589	608	586	592
Medical officers	135	128	137	129
Hospital medical officers	792	781	789	777
Sessional clinicians	290	302	280	288
Ancillary staff (allied health)	821	696	805	674
Total FTE	**7,729**	**7,604**	**7,652**	**7,440**

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 a 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 per cent 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 First Nations Anti-Racism and Cultural Safety Framework.

Our Employee Experience Survey, People Matter, shows improvements in engagement, with the question 'I am proud to tell others I work at the RMH' achieving a 90 per cent response, up four points from 2024. While engagement has improved, inclusion measures of 'I feel culturally safe at work' (84 per cent) and 'I can be myself at work' (82 per cent) have not improved since the 2024 survey. While remaining strong results, this highlights the need for continued focus on inclusion and belonging as we continue to work to ensure equitable outcomes and a workplace where everyone can thrive.

General information

Carers Recognition Act 2012

The RMH recognises the importance of partnering with patients, consumers, carers and families for the best care experience. We continue to progress all practical measures to comply with relevant obligations under the *Carers Recognition Act 2012*.

RMH-wide initiatives that support these obligations include:

- promoting the principles of the *Carers Recognition Act 2012* for people in care relationships who receive our services and to the wider community, for example through posters and patient and carer information (including the support for carers booklet and online portal, readily accessible via QR code).
- co-creation of the Community Engagement Strategy Action Framework 2026-2028, which includes actions related to carers and families. The framework is helping to guide the implementation of the 2024 Community Engagement Strategy 'In This Together'. The strategy was co-designed with patients, consumers, carers and community members, in partnership with the Australian Multicultural Health Collaborative.
- development of an organisational wide Health Equity Roadmap, based on broad stakeholder engagement, including with consumers, carers, community and staff.
- carer representation in various governance structures across the RMH, with evaluation of the impact of consumer and carer engagement. Engagement is supported by processes for reimbursement and remuneration.
- the Family Communications Improvement project, which continues to focus on strengthening family and carer engagement in care and decision-making via timely and responsive communication.
- development of a comprehensive, organisation-wide resource to guide staff in partnering with consumers and carers, including tailored support for engaging with mental health consumers and carers.
- development of the Families Involved in Care resource to support family participation in care, as part of the Improving Delirium Care Project. This resource is now available for use across the RMH, supporting family involvement in care for all patients.
- ongoing collaboration with carer representatives to review and improve information materials, including for carers and decision-makers supporting patients in the ICU, and at end-of-life care.

The RMH Mental Health Services initiatives that support these obligations include the following:

- The Carer and Consumer Lived Experience Director roles are members of the Mental Health Services Executive, ensuring the carer voice is engaged at all levels.
- The Best Care of the Older Person project has continued to embed the carer perspective. Carer representatives play an active role through facilitation of group sessions, development of a lived experience pamphlet, and participation in program, project and clinical meetings. This work ensures carer perspectives are central to project development and engagement with patients, carers and staff.
- A Family, Carers, Kin and Supporters Committee meets regularly and supports clinical and lived experience workforce communication, community engagement and quality improvement.
- The Carer Advisory Group, consisting of community members and carer lived experience staff, meets every six weeks and drives systemic and service quality and improvement.
- Carer lived experience staff and clinical specialists in family work provide colleagues and graduate programs with professional development.
- Development of the 'QRsupport4carers' booklet and online portal, providing access to information and resources for carers, with posters displaying QR codes to access this information visible across the RMH inpatient and community services.

- Regular events are held to offer support and information for families and carers, including coffee catch-ups and welcome sessions.
- Ongoing implementation and development 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.

Growth and development opportunities in 2025-26 included:

- Expansion of the carer lived experience workforce, including a Carer Lived Experience Educator and Carer Peer Support in Neuropsychiatry and Older Adult units, together with a Welcome Navigator role in the inpatient unit. The inner Melbourne community team, which uses the innovative one dialogue team approach, includes two carer lived experience practitioners.
- Recruitment of program management to support the carer peer workforce, in addition to the existing roles of Director and Deputy Directors of Carer and Consumer Lived Experience positions.
- Lived experience staff and clinicians continue to collaborate to ensure that practice guidelines support the principles set out in the *Mental Health and Wellbeing Act 2022*, including those that recognise the vital role of families, carers and supporters.
- Consumer and carer lived experience staff and clinicians provided advice, education, training and support for staff about the *Mental Health and Wellbeing Act 2022*.
- Carer lived experience staff also provided education sessions for carers and families about the *Mental Health and Wellbeing Act 2022*.

Opportunities for improvement being addressed through projects:

- Creation of a working group and subsequent procedure to improve the uptake of advanced statement of preferences and nominated support persons, to ensure that the wishes of consumers of mental health services and their carers are considered.
- Commitment to document and update details of carers in the RMH electronic medical records to improve consumer and carer experiences, facilitate the safe sharing of information via the Health Hub patient portal, and facilitate feedback.
- Seeking feedback from team-based child and family safety champions regarding opportunities for improvement.
- Developing a robust feedback mechanism for carers of consumers accessing the RMH Mental Health Services.

Safe Patient Care Act 2015

The RMH 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 *Freedom of Information Act 1982* (FOI Act) provides a legally enforceable right of public access to information held by government agencies. During 2025-26, all applications made to the RMH were processed in accordance with the FOI 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 FOI 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 2025-26 was $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 RMH FOI. 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.

Most 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.

2025-2026 FOI applications	
Valid applications received	**3,658**
From Members of Parliament	2
From media	0
FOI outcomes	**3,710**
FOI access decisions	3,377
- Granted in full	1,394
- Granted in part	1,980
- Denied in full	3
Withdrawn/not proceeded with	276
No record*	57
In progress at the end of the year	**372**

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

The RMH received 3,658 valid requests during 2025-26. Of the valid requests, 1,753 were non-personal or third-party requests and 1,905 were from, or on behalf of, patients. Two valid requests (of the non-personal and third-party requests) were from a Member of Parliament.

The RMH generated a total of 3,710 FOI outcomes during the 12 months ended 30 June 2026. This number included outcomes from applications that commenced in previous years.

These outcomes included 3,377 FOI decisions. There were 1,373 decisions made within the statutory time periods. Of the decisions made outside statutory time periods, 1,971 were made within a further 45 days and 32 decisions were made in a period greater than this.

Of the total decisions made, 33 decisions were made after mandatory extensions had been applied or extensions were agreed upon by the applicant.

Of the total decisions made, 1,394 granted access to documents in full, 1,980 granted access in part and three denied access in full.

Of requests finalised, the average number of days (including extended timeframes) to decide a request was 32.98 days.

During 2025-26, seven requests were subject to a complaint/internal review by OVIC. 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* 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 Prompt and to the public at thermh.org.au.

Gender Equality Act 2020

The RMH is committed to being a great place to work and a great place to receive care for people of all genders, abilities, backgrounds and identities. While the *Gender Equality Act 2020* provides an important framework for action, the RMH seeks to advance equity, safety and belonging beyond compliance.

Significant progress has been achieved through the 2021-2025 Gender Equality Action Plan, with all but one action completed or progressing as ongoing business. This work has contributed to measurable improvements across a range of gender equality indicators, including a reduction in the gender pay gap at the RMH (median total remuneration) from 18.6 per cent in 2021 to 7.6 per cent in 2025.

Efforts to increase awareness of family violence leave have also had a positive impact. Uptake of family violence leave doubled from 14 employees in 2021 to 28 employees in 2025, while staff perceptions that the RMH would support employees experiencing family violence have continued to improve across all genders.

While progress has been strong, some actions will continue into the next Gender Equality Action Plan. Consultation activities and promoting the benefits of parental leave for men will be progressed through the next Action Plan.

Additional initiatives to strengthen equitable recruitment and promotion practices will also continue. Resources and tools for hiring managers were developed under the previous plan, with the next phase focused on delivering training and embedding consistent practice across the organisation.

Building on the foundations established through our first Action Plan, the RMH will adopt a maturity-based approach to gender equality. Strong engagement from staff and stakeholders across diverse professional and social identities has increased the visibility and impact of this work. Future efforts will focus on strengthening systems, structures and accountability mechanisms to deliver sustainable change.

Our approach will continue to be guided by the following principles:

- Visible and accountable leadership
- Alignment of top-down and grassroots drivers of change
- Evidence-informed decision-making
- Valuing and amplifying lived experience
- Building awareness, capability and confidence
- Embedding an equity lens into organisational systems and processes

We recognise some workforce groups require targeted approaches and will continue to build on successful initiatives, including the work of the Gender Equity in Medicine Committee.

The RMH will also strengthen its capacity for intersectional analysis through improved workforce data collection, reporting and evaluation. We remain committed to supporting leaders across the organisation to understand the value of workforce equity and inclusion, and their role in creating positive outcomes for people of all genders and identities.

Building Act 1993

As required under the *Building Act 1993*, the RMH capital work projects have obtained building permits for new projects and Certificates of Occupancy or Certificates of Final Inspection, where applicable, for all completed projects.

In addition to compliance with the *Building Act 1993*, the RMH capital works also seek 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 Infrastructure Delivery Authority.

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
- Multiplex
- Intrec management
- DNA construction
- Ascot Group

National Competition Policy

In accordance with the requirements of the *Financial Management Act 1994* and the directive of the Department of Treasury and Finance, the RMH confirms its ongoing commitment to the National Competition Policy (NCP) and the revitalised National Competition Principles.

Across 2025-26, the RMH has continued to ensure that all business practices, service delivery models, and regulatory reviews align with the principles of competitive neutrality and has received zero competitive neutrality complaints.

Local Jobs First Act 2003

The *Local Jobs First Act 2003* requires the RMH to prioritise opportunities for local businesses and workers when procuring goods, services, and construction. This framework includes the Victorian Industry Participation Policy (VIPP) and the Major Projects Skills Guarantee (MPSG), which together promote local industry engagement and workforce development.

During 2025–26, the RMH awarded eight Local Jobs First standard projects in metropolitan Melbourne, with a total value of $57.4 million.

These projects achieved an average local content commitment of 73 per cent under approved Local Industry Development Plans and generated 128,416 total labour hours, including 7904 hours performed by apprentices, trainees, and cadets.

Supporting a skilled future: Major Projects Skills Guarantee

During the reporting period, the RMH commenced delivery of the material handling building decant project, awarded to Kane Constructions Pty Ltd. The project commenced in January 2025 and is scheduled for completion by December 2026.

Workforce commitments include the creation and retention of significant employment opportunities, with more than 33,500 labour hours forecast across the life of the project. The project also places a strong emphasis on skills development, with over 7,900 apprenticeship, traineeship and cadetship hours committed, which represents 24 per cent of total labour hours for this project, supporting the growth of the future construction workforce.

Through this project the RMH demonstrated its commitment to sustainable workforce development by achieving a notable 24 per cent MPSG outcome. This performance more than doubles the Victorian Government's mandatory 10 per cent minimum requirement for publicly funded construction contracts valued over $20 million.

Strengthening local industry: small and medium enterprises (SME) engagement

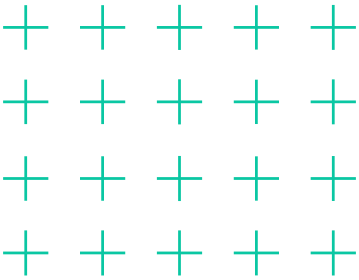
In alignment with the Victorian Government's Local Jobs First Policy, during 2025-26 the RMH actively prioritised local suppliers to drive regional economic growth and build supply chain resilience. We successfully engaged 19 small and medium enterprises within our project supply chains.

Securing these 19 businesses ensured public investments directly stimulated the local economy, preserved competitive market diversity, and sustained local employment. This achievement reflects the RMH's commitment to breaking down barriers for smaller operators.

We continue to provide fair, transparent access to government procurement contracts while fostering a robust network of local industry partners.

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 2025-26 is $70.6m (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)
56,963	13,592	-	13,592

Details of consultancies(under $10,000)

In 2025-26, there was no consultancy where the total fees payable to the consultant was less than $10,000.

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

In 2025-26, there were six consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2025-26 in relation to these consultancies is $0.19m (excluding GST). Details are provided in the below table:

Consultant	Purpose of consultancy	Start date	End date	Total approved project fee $'000 (excluding GST)	Expenditure 2025-26 $'000 (excluding GST)	Future expenditure $'000 (excluding GST)
Caraniche Pty Ltd	Development of program to activate early intervention support for workers experiencing work-related psychological injury	02/04/2026	13/03/2028	46	23	23
Consilium Strategy Pty Ltd	Development of the RMH Strategic Plan	01/08/2025	01/12/2025	50	50	-
Enable Workplace Consulting	Development of program to activate early intervention support for workers experiencing work-related psychological injury	13/03/2026	13/03/2028	216	65	151
FLX Consulting Pty Ltd	Development of Nephrology Strategic Plan	04/03/2025	31/03/2026	16	16	-
Jennifer Cheung Consulting	Food waste audit and AI-enabled opportunity analysis	01/10/2025	31/05/2026	19	19	-
The Leadership Sphere	Design and administration of Surgical Services Culture Survey	01/10/2025	30/06/2027	232	18	214

Disclosure of government advertising expenditure

The RMH did not undertake any government advertising campaigns with total media expenditure of $100,000 or greater in 2025-26.

Reviews and studies expenditure

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

Social procurement framework

Consistent with the Victorian Government's Social Procurement Framework, the RMH continued to implement its Social Procurement Strategy during 2025–26 and prioritised supporting safe and fair workplaces, increasing opportunities for social benefit suppliers, promoting Aboriginal economic participation, and embedding sustainable procurement practices across its operations.

Through direct procurement spend, the RMH contributes to positive social, economic and community outcomes while meeting organisational and operational requirements.

During 2025-26, the RMH recorded $82,467 in direct expenditure with recognised social benefit suppliers, including:

13 Number of social benefit suppliers	**$82,466.51** Spend (excl. GST) with social benefit suppliers
8 Number of Victorian Aboriginal businesses	**$59,333.15** Spend (excl. GST) with Victorian Aboriginal businesses
4 Number of Victorian Social Enterprises (SE)	**$22,033.36** Spend (excl. GST) with Victorian SE
1 Number of Victorian SE (led by a mission for people with disability) and ADE	**$1,100** Spend (excl. GST) with Victorian SE (led by a mission for people with disability) and ADE
0 Number of Victorian SE (led by a mission for job readiness and employment of Victorian priority job seekers)	**–** Spend (excl. GST) with Victorian SE (led by a mission for job readiness and employment of Victorian priority job seekers)

In addition to direct spend, the RMH generated indirect social procurement outcomes through contractual requirements applied to major suppliers. During the reporting period, contracted suppliers achieved 100 per cent compliance with RMH's Supplier Code of Conduct, Gender Equality Policy and Family Violence Leave Policy.

Supplier commitments also delivered $59,333 in expenditure with certified Victorian Aboriginal businesses and prioritised employers recognised for supporting Aboriginal employment, contributing to First Nations peoples' economic participation and workforce inclusion.

By combining targeted procurement spend with supplier contractual obligations, the RMH continues to leverage its purchasing power to create lasting social value and support more inclusive and equitable outcomes for Victorian communities.

The RMH remains committed to strengthening social procurement capability and using its procurement expenditure to create sustainable social, economic and community benefits across Victoria.

Emergency procurement

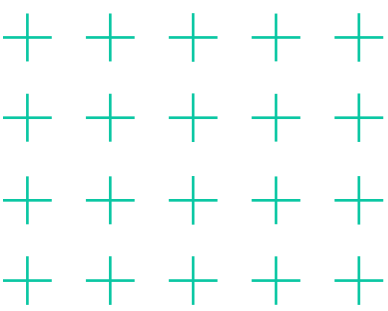
The RMH did not activate any emergency procurement in 2025-26.

Procurement complaints

The RMH received no procurement specific complaints in 2025-26.

Grants and Transfer payments

The RMH did not administer any grants, transfer payments or Commercial-in-Confidence grants in 2025-26.



Environmental performance

Strive for sustainability is one of the 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, continually pushes 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.

This strategic goal is supported in detail by the RMH's *Environmental Sustainability Strategy 2025-30*. The strategy focuses on reducing greenhouse gas (GHG) emissions and waste generation, all while increasing the level and quality of our healthcare services. The environmental performance report justifies how we are making improvements towards these goals.

The 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 dictated by the Department of Treasury and Finance. 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. As in 2024-25, the EDMS emissions calculation for electricity-related activities uses the market-based method in 2025-26, as opposed to the location-based method used in FRD report versions in earlier years.

Reporting boundary for environmental data

Where practicable to obtain, all operations and activities of the RMH are included within the organisational boundary for the 2023-24, 2024-25 and 2025-26[1] reporting periods. Data is included for the four areas represented in the RMH's financial statements. The following areas account for 10 locations[2] throughout Victoria.

The RMH's reporting boundary includes data for the following facilities:

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

Changes to the reporting boundary between 2024-25 and 2025-26 reports:

- All Orygen Youth sites were disaggregated from RMH on 1 July 2025.

1. Where final 2025-26 data is not yet available, estimated positions have been applied. Where estimates were used in the 2024-25 report, these have been updated to final positions.
2. The locations covered in this report can vary year-on-year due to machinery of government changes and movements between health services.

Normalisation factors

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

The VIDA designates normalisation factors for health services as follows:

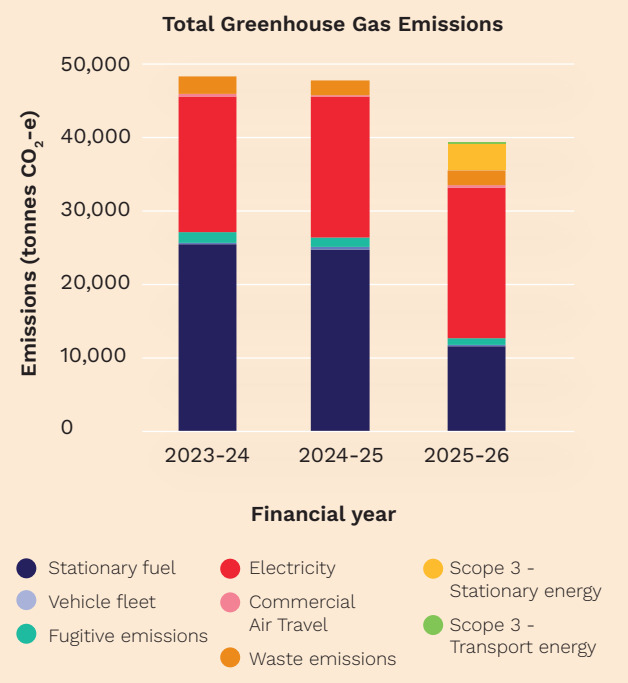
- For energy consumption, emissions from energy use and production, and water consumption by floor area and occupied bed days, are deemed suitable normalisation factors.
- Per patient treated is the appropriate normalisation factor for waste generation.

For this report normalisation data was obtained via:

- Floor area: Obtained from the Department of Health's EDMS and calculated using a gross floor area approach reported in metres squared.
- Patients treated: Obtained internally from the RMH information systems and calculated by the sum of inpatient bed days, residential aged care bed days, separations, and the number of emergency presentations for the reporting period.

Greenhouse gas emissions

The graph below displays the RMH's total GHG emissions from 1 July 2023 to 30 June 2026.



Gross GHG emissions decreased by 18 per cent between 2024-25 to 2025-26.

Due to offsets provided by the SEC for most of the electricity consumed by the RMH in 2025-26, total net greenhouse gas emissions decreased by 63 per cent.

Per patient treated, net emissions decreased by 67 per cent between 2024-25 and 2025-26, reflecting the increase in activity, the impact of the cogeneration plant decommissioning and the electricity offsets provided by the SEC.

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

Between 2024-25 and 2025-26 Scope 1 emissions decreased by 52 per cent. This decrease is attributable to several factors. The most significant impact has been the decommissioning of the RMH Parkville cogeneration plant which resulted in a reduction of 53 per cent in natural gas consumption.

In addition, in July 2025 the nitrous oxide pipeline was deactivated at the RMH Parkville and all key clinical areas transitioned to cylinder based nitrous oxide supply resulting in a reduction of 93 per cent in emissions. The RMH's vehicle fleet has reduced by 20 per cent across 2025-26 and continues to preference electric and hybrid vehicles over petrol vehicles with emissions from transport fuels decreasing a further 33 per cent between 2024-25 and 2025-26.

Scope 2

While the RMH's scope 2 GHG emissions have increased by 8 per cent between 2024-25 and 2025-26, overall these emissions have been reduced to net zero for the first time as a result of Large Scale Generation Certificates (LGCs) being available to the RMH. This outcome is a result of the RMH now receiving all electricity from the grid which is subject to a new SEC contract that includes LGC offsets for all electricity used.

Scope 3

The RMH currently reports scope 3 emissions from corporate air travel, waste disposal and indirect emissions from stationary and transport energy. Total scope 3 emissions have decreased by 10 per cent between 2024-25 and 2025-26. The decrease is primarily due to the reduction of indirect emissions from stationary energy.

Indicator - GHG emissions	2023-24	2024-25	2025-26
Total Scope 1 GHG emissions (Tonnes CO_2-e)	**27,079.55**	**26,374.59**	**12,586.34**
Type of gas			
Carbon Dioxide	25,605.33	24,954.79	11,688.02
Methane	49.32	48.14	22.45
Nitrous Oxide	15.88	15.31	7.43
Fugitive emissions[1]	1,409.05	1,356.35	868.43
Activity source			
Stationary fuel	25,380.16	24,804.80	11,553.90
Vehicle fleet	290.34	244.75	164.01
Fugitive emissions[1]	1,409.05	1,356.35	868.43
Total Scope 2 GHG emissions (Tonnes CO_2-e)	**18,471.42**	**19,140.61**	**20,604.12**
Electricity purchased[2]	18,471.42	19,140.61	20,604.12
Total Scope 3 GHG emissions from commercial air travel and waste disposal (Tonnes CO_2-e)	**7,080.92**	**6,846.80**	**6,141.51**
Commercial air travel	523.47	203.30	244.22
Waste emissions	2,224.36	2,089.13	2,151.82
Indirect emissions from stationary energy	4,257.69	4,489.50	3,701.36
Indirect emissions from transport energy	75.40	64.87	44.11
Total GHG emissions (Tonnes CO_2-e)	**48,224.89**	**47,755.37**	**39,331.97**
Purchased LGCs[3]	0	0	-21,647.25
Total Net GHG emissions (Tonnes CO_2 e)	**48,224.89**	**47,755.37**	**17,684.72**

1. Fugitive emissions include medical gases and emissions from air conditioning and electrical equipment. Air conditioning and electrical equipment emissions data is only partially captured at this point.
2. As in 2024-25, the EDMS emissions calculation for electricity-related activities uses the market-based method in 2025-26, as opposed to the location-based method used in FRD report versions in earlier years.
3. Since July 2025 most RMH sites' electricity is supplied by the SEC under a statewide HSV contract whereby the SEC provides purchased LGCs as an emission offset.

Fugitive emissions

Medical gases

Nitrous oxide is a potent GHG, with global warming potential approximately 300 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, Theatres, ED and Catheter Lab and other key clinical areas, the RMH Parkville nitrous oxide pipeline was decommissioned in July 2025 and all areas have transitioned to cylinder-based nitrous oxide supply. This has resulted in a 93 per cent reduction of nitrous oxide use and emissions in 2025-26.

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

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 is available to report emissions from refrigerants and electrical equipment in this report.

Indicator - Fugitive emissions	2023-24	Tonnes CO_2-e	2024-25	Tonnes CO_2-e	2025-26	Tonnes CO_2-e
Desflurane (l)	0	0	0	0	0	0
Sevoflurane (l)	314.25	93.76	307.75	91.82	347.25	114.21
Nitrous oxide (volume m^3)	913.2	451.59	1,154.2	586.49	76.48	38.89
Medical Gas (Scope 1 emission) (Tonnes CO_2-e)		**545.35**		**678.76**		**153.1**
Refrigerant R22 (kg)			9.5	18.62	6.2	12.15
Refrigerant R32 (kg)			12.6	9.71	24.6	18.97
Refrigerant R134A (kg)	156	203	2	3.06		
Refrigerant R404A (kg)	4.5	18	1.8	3.5		
Refrigerant R410A (kg)					18.4	41.51
Electrical equipment SF6 (kg)	27.4	642.7	27.4	642.7	27.4	642.7
Refrigerants and electrical equipment (Scope 1 emission) (Tonnes CO_2-e)[1]		**863.7**		**677.59**		**715.33**
Total Fugitive emissions (Scope 1 emission) (Tonnes CO_2-e)		**1,409.05**		**1,356.35**		**868.43**

1. Global Warming Potential (GWP) used to calculate tonnes of CO2-e emissions: desflurane (893); sevoflurane (49); nitrous oxide (265). Fugitive emissions data from refrigerants, air-conditioning and electrical equipment 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 by 46 per cent between 2024-25 and 2025-26, due to the reduction of natural gas consumption post decommissioning of the RMH cogeneration plant.

Indicator - Energy use	2023-24	2024-25	2025-26
Total energy use (MJ)	**635,132,004**	**627,224,830**	**339,691,236**
Renewable[1]	19,235,703	20,459,140	106,396,096
Non-renewable	615,896,301	606,765,690	233,295,140
Total units of energy used normalised by patient treated	1,145	1,115	537
Total units of energy used normalised by floor area	3,958	3,897	2,111
Total energy usage from fuels (MJ)	490,269,071	484,358,556	226,540,344
Total energy used from electricity (MJ)	138,489,122	142,866,274	113,257,406

1. This includes electricity consumption attributable to the LRET, as reflected by the Renewable Power Percentage and E10 Fuels.

Electricity production and consumption

Electricity consumption decreased by 21 per cent in 2025-26. Prior to the cogeneration plant decommissioning, additional back-up generators and a third high-voltage feed were installed at the RMH to ensure continued electricity supply to the Parkville precinct. As a result, diesel generator capacity has increased by 63 per cent to 14.42 MW.

Indicator - Electricity production and consumption	2023-24	2024-25	2025-26
Total electricity consumption (MWh)	**38,471.70**	**39,685.08**	**31,460.39**
Purchased[1]	28,084.02	28,938.15	30,986.95
Self-generated	10,387.68	10,746.92	473.44
On-site electricity generated (MWh)	**12,293.45**	**12,574.56**	**480.87**
– Consumption behind-the-meter	10,387.68	10,746.92	473.44
– Exports	1,905.77	1,827.63	7.43
On-site installed generation capacity (MW)			
– Cogeneration	12	12	0
– Solar PV[2]	0.31	0.31	0.31
– Diesel backup generators	8.84	8.84	14.42
Total electricity offsets (MWh)			
– Large-scale Generation Certificates (LGCs)[3]	0	0	21,647.25
– Renewable Power Percentage (MWh)[4]	5,268.37	5,295.78	5,549.76

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 considered to be immaterial and therefore has not been separately reported. The RMH owns part of the transmission and distribution (T&D) network used to distribute electricity throughout the RMH Parkville campus. Energy losses occur as electricity is distributed along the network and T&D 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 Russell House, Cyril Jewell House and the RMH Royal Park.
3. Wind and solar farms create LGCs for each MWh of renewable energy generated. LGCs are then sold to electricity retailers, like the SEC, to offset emissions for customers.
4. Climate Active Market Based methodology dictates that the percentage of electricity consumption attributable to the LRET, as reflected by the Renewable Power Percentage, for a given reporting year, is assigned an emission factor of zero in the carbon account.

Stationary fuel

Natural gas use decreased by 53 per cent in 2025-26. This reduction can be attributed to the decommissioning of the cogeneration plant. Previously natural gas was burnt to produce electricity and steam through cogeneration; now natural gas is only used to power two boilers to produce steam and hot water.

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 per cent increase. No diesel was purchased in 2024-25 as diesel purchased in 2023-24 was being consumed.

In 2025-26, additional generators and diesel tanks were installed and additional diesel fuel purchased to provide back-up power to the RMH Parkville Precinct, compensating for the decommissioning of the cogeneration plant. A third high-voltage feed was also installed to secure electricity supply.

Indicator - stationary fuel	2023-24	2024-25	2025-26
Total fuels used in buildings and machinery (MJ)[1]	**492,564,339.20**	**481,366,161.90**	**224,021,005.60**
Buildings	492,564,339.20	481,366,161.90	224,021,005.60
Natural gas	492,091,481.80	481,366,161.90	223,480,605.40
Diesel (generator)[2]	472,857.40	0	540,400.20
Machinery	-	-	-
Greenhouse gas emissions from stationary fuel consumption (Tonnes CO_2-e)	**25,390.67**	**24,804.80**	**11,553.90**
Natural gas	25,357.47	24,804.80	11,515.96
Diesel (generator)	33.19	0	37.94

1. Building energy consumption includes fuel used in heating, cooling and steam generation. 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 Department of Treasury and Finance grant at the RHM Parkville and the RMH Royal Park in 2023. Electric and hybrid vehicle numbers are continuing to increase and by June 2026 comprised 82 per cent of the RMH fleet.

The total number of vehicles owned has continued to decrease during the reporting period, due to the disaggregation of Orygen Youth sites in July 2025.

Indicator - vehicles	2023-24	%	2024-25	%	2025-26	%
Number and proportion of vehicles	**194**	**100%**	**187**	**100%**	**149**	**100%**
Road vehicles	193	99.48%	186	99.47%	148	99.33%
Passenger vehicles (other than omnibuses)	192	98.97%	184	98.40%	147	98.66%
Internal combustion engine	163	65.98%	151	80.75%	109	73.15%
– Petrol	105	54.12%	56	29.95%	15	10.07%
– Diesel	23	11.86%	10	5.35%	10	6.71%
– Hybrid	35	18.04%	85	45.45%	84	56.38%
Range extended electric vehicle	29	14.95%	33	17.65%	37	24.83%
Buses (omnibuses) (petrol internal combustion engine)	1	0.52%	1	0.53%	1	0.67%
Goods vehicles (internal combustion engine)	1	0.52%	1	0.53%	1	0.67%
– Petrol	0	0.00%	0	0.00%	0	0.00%
– Diesel	1	0.52%	1	0.53%	1	0.67%
Non-road vehicles	**1**	**0.52%**	**1**	**0.53%**	**1**	**0.67%**
– Electric forklift	0	0%	0	0%	0	0%
– Cart (no fuel)	1	0.52%	1	0.53%	1	0.67%

Total transport energy used has decreased by 33 per cent in 2025-26. Energy from all fuel types has dropped as more electric vehicles have joined the fleet. Electricity consumption for charging EVs has decreased by 10 per cent.

Total emissions from the vehicle fleet decreased by 33 per cent in 2025-26.

Corporate air travel increased by 54 per cent in 2025-26, due to improved capture of air travel data this financial year.



Indicator - Transport energy	2023-24	2024-25	2025-26
Total energy used in transportation (MJ)	**4,273,159**	**3,599,899**	**2,412,824**
Road Vehicles (MJ)	4,273,159	3,599,899	2,412,824
– Petrol	3,665,546	3,027,637	1,905,518
– Petrol E10	31,133	29,063	59,361
– Diesel	575,769	543,199	447,945
Electricity (MWh)[1]	23.30	32.84	29.59
Charged at Victorian Government facilities	23.30	32.84	29.59
Not charged at Victorian Government facilities	-	0	0
Non-Road Vehicles	0	0	0
– Electricity (MWh)	0	0	0
Greenhouse gas emissions from vehicle fleet (Tonnes CO_2-e)	**290.34**	**244.75**	**164.01**
Road Vehicles	**290.34**	**244.75**	**164.01**
– Petrol	247.87	204.73	128.85
– Petrol E10	1.95	1.77	3.62
– Diesel	40.53	38.25	31.54
Electricity[1]	**15.33**	**21.73**	**19.67**
Total distance travelled by commercial air travel (passenger km)	**2,093,710**	**881,629**	**1,354,179**

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

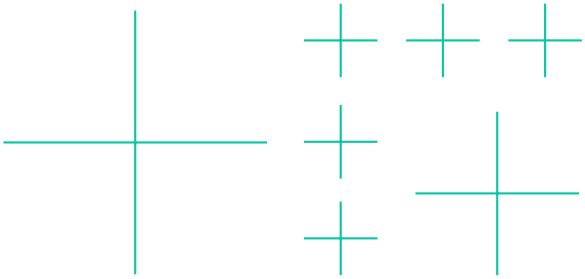
Australia's harsh climate and scarce water resources mean the development of sustainable buildings is an economic and environmental necessity. Recent extreme weather events demonstrate the importance of addressing climate change risk across the RMH's operations, including when it comes to the design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

Water consumption

Since the decommissioning of the RMH cogeneration plant, the boilers generating steam and hot water can reuse the condensate return water to produce steam, reducing the water required for steam generation by 86 per cent. This has had a significant impact on overall water consumption across the RMH which decreased by 15 per cent in 2025-26.

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	2023-24	2024-25	2025-26
Total water consumption (potable water) (kilolitres)	236,642	285,990	242,188
Kilolitres of metered water consumed normalised by per patient treated	0.40	0.47	0.42
Kilolitres of metered water consumed normalised by floor area	1.47	1.78	1.50



Waste and recycling

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

The focus on correct segregation of clinical waste continued this financial year. The Sustainability team in conjunction with Infection Prevention and Surveillance Services continued promoting several initiatives including staff training on clinical waste definitions and the 'Gloves off!' campaign to reduce unnecessary glove use. Clinical waste generation decreased by an additional 12 per cent in 2025-26 over the previous financial year.

Total waste disposed has increased by 3 per cent in 2025-26 over 2024-25, general waste to landfill increased by 6 per cent and recycling increased by 3 per cent.

Indicator - Waste weights	2023-24	% of total	2024-25	% of total	2025-26	% of total
Total units of waste disposed (kg and %)[1]	**2,627,335**	**100**	**2,408,738**	**100**	**2,470,530**	**100**
Landfill						
General waste[2]	**1,350,557**	**51.42**	**1,261,946**	**52.39**	**1,340,686**	**54.27**
Offsite treatment	**369,157**	**14.05**	**317,655**	**13.19**	**278,430**	**11.27**
Clinical waste - incinerated	26,783	1.02	28,891	1.30	35,748	1.45
Clinical waste - sharps	26,803	1.02	25,146	0.98	25,336	1.03
Clinical waste - treated	315,571	12.01	267,843	10.45	217,346	8.80
Recycling/recovery (disposal)	**907,621**	**34.53**	**829,137**	**34.42**	**851,415**	**34.46**
Batteries	2,012	0.08	3,616	0.15	3,208	0.13
Cardboard	474,653	18.07	435,306	18.04	436,175	17.66
Commingled	147,983	5.63	100,195	4.15	80,473	3.26
E-waste	745	0.03	3,238	0.13	4,219	0.17
Fluorescent tubes	966	0.04	784	0.03	717	0.03
Grease traps	109,980	4.19	107,700	4.46	147,273	5.96
Mattresses	3,050	0.12	662	0.03	3,025	0.12
Metals	29,195	1.11	28,943	1.20	39,350	1.59
Organics (food)	34,442	1.31	15,850	0.66	-	0.00
Other recycling[3]	-	-	970	0.04	520	0.02
Paper (confidential)	100,231	3.82	126,458	5.24	124,397	5.04
PVC	3,935	0.13	3,636	0.15	3,142	0.13
Sterilization wraps	390	0.01	1,652	0.07	8,729	0.35
Toner and print cartridges	39	0.00	127	0.01	187	0.01

1. The RMH facilities include a mixture of office 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

Percentage of sites which are covered by dedicated collection services for	2023-24	% of total	2024-25	% of total	2025-26	% of total
Streams	**Sites**	**%**	**Sites**	**%**	**Sites**	**%**
Printer cartridges	13	100%	12	100%	10	100%
Batteries	2	15%	2	17%	7	70%
E-waste	13	100%	12	100%	10	100%

The RMH has maintained a recycling rate of above 34 per cent during the reporting period and GHG emissions from waste continue to decrease. Total waste per patient treated has been further reduced in 2025-26.

Indicator - Waste trends	2023-24	2024-25	2025-26
Total units of waste disposed normalised by patient treated (kg/PT)	**4.39**	**3.94**	**3.90**
Total waste to landfill per patient treated	2.26	2.07	2.12
Total waste to offsite treatment per patient treated	0.62	0.52	0.44
Total waste recycled per patient treated	1.52	1.36	1.35
Total units of waste disposed normalised by floor area (kg/M²)	**16.31**	**14.97**	**15.35**
Total waste to landfill per M²	8.39	7.84	8.33
Total waste to offsite treatment per M²	2.29	1.97	1.73
Total waste recycled and reused per M²	5.64	5.15	5.29
Recycling Rate (%)	**34.55%**	**34.42%**	**34.46%**
Greenhouse gas emissions associated with waste disposal (Tonnes CO_2-e)	**2,224.36**	**2,089.13**	**2,151.82**

Additional information available on request

In compliance with the requirements of the Standing Directions 2018 under the *Financial Management Act 1994*, details in respect of the items listed below have been retained by the RMH and are available on request to the relevant Ministers, Members of Parliament and the public, subject to the provisions of the *Freedom of Information Act 1982*:

- 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 organisation's compliance with statutory disclosure requirements.

Legislation	Requirement	Page Reference
Standing Directions and Financial Reporting Directions	**Report of Operations**	
Charter and Purpose		
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FRD 22	Compliance with building and maintenance provisions of *Building Act 1993*	33-34

Legislation	Requirement	Page Reference
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Notes: (a) References to FRDs have been removed from the Disclosure Index if the specific FRDs do not contain requirements that are in the nature of disclosure.

(b) Refer to the Model financial statements section (Part two) for further details.

Financial summary

The key financial performance measure monitored by the Department of Health and the RMH Board and Management is the Operating Result.

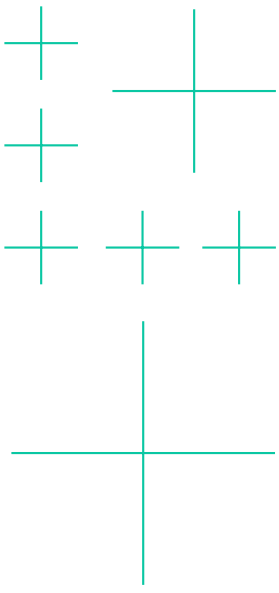
The RMH achieved its break-even Statement of Priorities financial target in 2025-26 by recording a minor surplus of $0.1m. This result was achieved despite ongoing increases in patient activity. This result was supported by the RMH achieving its cumulative $38m financial management improvement target for 2025-26. The Net Result of a $53.3m deficit is primarily due to the incremental impacts of depreciation.

	2026	2025	2024	2023	2022
	$m	$m	$m	$m	$m
Operating Result*	0.1	**0.2**	**(27.5)**	**0.4**	**0.4**
Total Revenue	1,792.0	1,820.7	1,723.6	1,757.0	1,652.1
Total Expenses	1,843.7	1,809.5	1,747.1	1,706.7	1,681.9
Net Result from Transactions	**(51.7)**	**11.2**	**(23.5)**	**50.3**	**(29.8)**
Other Economic Flows	(1.6)	(2.7)	(3.5)	(13.4)	2.3
Net Result	**(53.3)**	**8.5**	**(27.0)**	**37.0**	**(27.5)**
Total Assets	1,543.5	1,703.0	1,651.4	1,514.7	1,490.8
Total Liabilities	650.1	648.7	605.6	644.0	686.0
Net Assets/Total Equity	**893.4**	**1,054.3**	**1,045.8**	**870.6**	**804.8**

*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

	2025-26
	$m
Operating Result	**0.1**
Capital purpose income	64.4
State Supply Arrangements	
– Assets received free of charge or for nil consideration under the State Supply Arrangements	2.3
– State supply items consumed up to 30 June 2026	(1.7)
Expenditure for capital purposes	(20.8)
Investment Income	2.0
Depreciation and amortisation	(96.5)
Finance costs	(1.6)
Net Gain/(Loss) on Non-Financial Assets	0.3
Net Gain/(Loss) on Financial Instruments	(8.2)
Other Gains/(Losses) from Other Economic Flows	6.4
Net Result	**(53.3)**



Modern Slavery Statement for 2025–26

Melbourne Health
ABN 73 802 706 972

Trading as The Royal Melbourne Hospital

Financial Year 1 July 2025 – 30 June 2026

Overview

This Modern Slavery Statement (Statement) is made pursuant to the *Modern Slavery Act 2018 (the Act)* by Melbourne Health ABN 73 802 706 972, trading as the Royal Melbourne Hospital (RMH).

The RMH recognises that modern slavery practices are serious violations of human rights, involving coercion, threats, or deception to exploit individuals and deprive them of their freedom. These practices must be identified and eliminated in all forms.

The RMH is committed to identifying, assessing and addressing modern slavery risks within its operations and supply chains and to maintaining transparent and responsible procurement practices.

The RMH also recognises emerging evidence that modern slavery is not only a human rights issue, but also a health issue, with healthcare systems playing an important role in identifying and responding to individuals experiencing exploitation.

This Statement relates to the reporting period from 1 July 2025 to 30 June 2026.

About modern slavery

Modern slavery encompasses serious exploitation, including:

- trafficking in persons
- slavery and slavery-like practices (including forced labour and forced marriage)
- the worst forms of child labour

Modern slavery can occur in any country, industry, or supply chain tier.

According to the Global Slavery Index 2023, an estimated 50 million people were living in modern slavery globally on any given day in 2021, the most recent comprehensive global estimate available.

Structure, operations and supply chain

The RMH is established as a metropolitan public health service under the *Health Services Act 1988 (Victoria)*.

The RMH:

- does not own or control any other entities;
- provides acute, subacute and community healthcare services;
- operates across three primary hospital campuses in inner Melbourne, alongside a network of further community-based sites, please visit our website for locations (www.thermh.org.au/locations)

The RMH procures a wide range of goods and services, including medical equipment and consumables, pharmaceuticals, ICT hardware and services, and construction and facility management services.

As a Victorian public health service, the RMH is required to purchase a proportion of goods and services through HealthShare Victoria (HSV) collective purchasing agreements.

The RMH's supply chain comprises 10 per cent of spend accessed through HSV collective purchasing agreements. The balance of our spend is procured through state government contracts or government panels and other direct engagements.

The RMH aligns with HSV's Modern Slavery Risk Mitigation Program, including implementation of the HSV Mandatory Minimum Standards, which

provide a consistent, sector-wide approach to identifying and addressing modern slavery risks through increased transparency, accountability, and supplier capability development over time.

Further information is available on the HSV website: healthsharevic.org.au/procurement-guidance/modern-slavery/modern-slavery-resources-for-suppliers/

For construction projects, the RMH complies with Standing Directions 2018 issued under the *Financial Management Act 1994 (Vic)* and the Ministerial Directions and Instructions for Public Construction Procurement issued by the Victorian Department of Treasury and Finance (DTF).

The directions mandate that any supplier working with the Victorian Government must adhere to Victoria's Supplier Code of Conduct. This code explicitly requires suppliers to "actively support the elimination of modern slavery" and provide an ethical workplace. When the RMH selects a builder from the DTF register, it verifies modern slavery statements during the selection process and uses contract templates that embed specific modern slavery risk management clauses into the project.

Modern Slavery Risks

Modern slavery risks may arise across both global supply chains and local operations.

Global supply chain risks

Higher-risk categories relevant to the RMH include:

- manufacturing of medical devices and surgical instruments
- production of textiles (e.g. uniforms, PPE)
- electronics and ICT equipment
- pharmaceutical supply chains.

Risk factors include:

- sourcing from high-risk geographies
- complex, multi-tier supply chains
- use of vulnerable or migrant labour
- weak or poorly enforced labour protections.

Local Operational Risks

In Australia, heightened risk areas include:

- cleaning services
- security services
- catering and hospitality
- labour hire arrangements

These sectors may involve low-paid, migrant, or temporary workers who may be more vulnerable to exploitation.

Actions taken during 2025-26

Supplier risk assessment

During 2025–26, on behalf of the RMH, HSV undertook risk assessments of 100 per cent of suppliers that the RMH accesses through HSV collective agreements and introduced the risk assessment of directly engaged suppliers. 50 per cent of suppliers that the RMH engages with directly were also risk assessed during the period.

Collaboration and engagement

- Continued collaboration with HSV and key suppliers
- Engaged directly with high-risk suppliers to improve transparency and mitigation strategies
- Participated in sector-wide initiatives and forums relating to ethical procurement

The RMH adopts a progressive realisation approach, recognising that suppliers are at different stages of maturity and supporting them to build capability over time through staged implementation of modern slavery controls.

Procurement controls

- Maintained mandatory minimum standards in procurement processes
- Required suppliers with annual revenue ≥ $100 million to provide a Modern Slavery Statement
- Embedded modern slavery considerations in tender evaluation processes
- Incorporated contractual clauses and risk-based controls

Alignment with HSV Mandatory Minimum Standards

The RMH has aligned its approach with the HSV Mandatory Minimum Standards, which set minimum expectations across five key areas:

- Implementation of a modern slavery policy
- Risk-based due diligence processes
- Accessible grievance and remediation mechanisms
- Training and awareness programs
- Monitoring and evaluation of effectiveness

These standards are progressively implemented across procurement activities and form a key component of the RMH's approach to managing modern slavery risks.

People and training

During 2025-26:

- Five RMH staff participated in modern slavery training
- Training was delivered across procurement and contract management, finance and operational leads
- The RMH participated in five out of the six organised industry or community-of-practice sessions.

The RMH continues to strengthen its training approach by:

- expanding awareness across the organisation
- considering role-specific training.

Training is recognised as a critical control to improve identification and prevention of modern slavery risks.

Policies, tools and governance

The RMH maintains a Modern Slavery Framework supported by:

- Modern Slavery Policy
- ESG risk assessment tool
- Procurement policies aligned with the HSV Purchasing Policies and the Victorian Government Supplier Code of Conduct.

Supplier Policy Adoption

Of suppliers assessed:

- 91 per cent have a modern slavery policy
- 83 per cent have mechanisms to ensure compliance.

Remediation and due diligence

Due diligence

The RMH applies a risk-based due diligence approach, focusing on risks to people rather than solely on business or financial risk. This includes:

- supplier risk assessments
- contractual controls
- pre-engagement screening
- audits where required

Remediation

- 87 per cent of assessed suppliers reported having remediation processes in place

The RMH supports the use of accessible and transparent grievance mechanisms for identifying modern slavery risks. These mechanisms are available to both internal and external stakeholders and allow for anonymous reporting where appropriate.

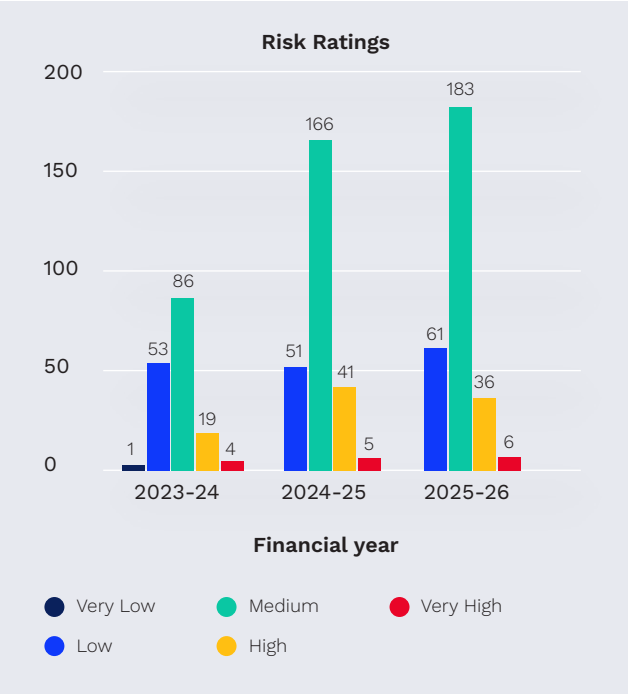
Where risks or incidents are identified, the RMH prioritises engagement and remediation through corrective action plans. Contract termination is considered a last resort where remediation cannot be achieved.

In addition, 79 per cent of suppliers reported having a dedicated resource responsible for modern slavery risk oversight.

Effectiveness of actions

The RMH continues to strengthen its approach to measuring effectiveness through both qualitative and quantitative indicators.

Scaling Supplier Visibility & Risk Profiles



The increase in the number of low and medium risk ratings may be reflective of the increased response rate and improved understanding of supplier modern slavery risks in the supply chain with suppliers taking actions to respond to these risks. The number of suppliers with a high risk rating has decreased from last year, which could indicate some suppliers are progressing in their plans to action Modern Slavery policies and due diligence processes. The number of suppliers rated as very high risk has increased by one over the previous year.

Metrics and continuous improvement

The RMH monitors effectiveness through measures such as:

- supplier risk assessment outcomes
- training participation rates
- supplier engagement and remediation progress
- monitoring of grievance and reporting mechanisms

Key improvements

- Expanded scope of supplier risk assessments to include the engagement of HSV to risk assess suppliers that are directly engaged by the RMH
- Increased supplier engagement and transparency
- Enhanced feedback to suppliers on risk ratings and expectations

Future commitments (2026-27 focus areas)

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 expand direct supplier risk assessments to cover at least 80% of direct spend
- Deepening engagement with high-risk and very high-risk suppliers through the provision of risk rating letters and links to resources and free online training
- Delivering targeted supplier education sessions aligned with HSV standards
- Strengthening integration of modern slavery risk into contract management
- Enhancing internal reporting, governance, and effectiveness metrics.

Consultation and approval

As the RMH does not own or control any other entities, no consultation with other entities is required under the Act.

Closing statement

The RMH acknowledges that modern slavery risks exist within its healthcare supply chains and remains committed to identifying, assessing and addressing these risks.

Through continuous improvement, alignment with sector frameworks, and collaboration with suppliers and partners, the RMH will continue to strengthen its approach to preventing, mitigating and responding to modern slavery risks and contribute to the elimination of modern slavery in all its forms.

This Statement was approved by the Board of Melbourne Health on 26 August 2026.



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
Melbourne
26 August 2026

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
26 August 2026

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
26 August 2026

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
26 August 2026

Compliance with Health Share Victoria (HSV) Purchasing Policies

I, Shelley Dolan, on behalf of Melbourne Health, certify that Melbourne Health is fully compliant with respect to the HSV Purchasing Policies as required by the Health Services Act 1988 (Vic). Melbourne Health has implemented appropriate internal controls, which have been critically reviewed throughout the year.



Professor Shelley Dolan
Chief Executive
Melbourne
26 August 2026

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 sets out how each health service is expected to contribute to the Department of Health Strategic Plan by working towards defined strategic priorities.For 2025-26 the Minister for Health requested the RMH focus on 18 immediate and ongoing deliverables across five strategic priorities:

Strategic priority / goal	Health service deliverable	RMH response
Innovate and improve access and care		
Align with the Victorian Clinical Governance Framework to strengthen clinical governance systems, ensuring safe, high-quality care.	Demonstrate high-quality care in which consumer engagement and input is actively sought, facilitated and used to drive system change to improve consumer experience and outcomes.	**Status: Ongoing** **Commentary:** The RMH demonstrates a strong commitment to delivering high-quality, person-centred, value-based healthcare by actively partnering with consumers to design, deliver and improve services. Consumer engagement is embedded across the organisation, ensuring that the voices, experiences and priorities of patients, carers and the community directly inform service planning, evaluation and continuous improvement. This work is underpinned by a comprehensive Consumer Engagement Strategy, which establishes a structured framework for partnering with consumers across the continuum of care. Key examples of this commitment are the Patient Centred Value-Based Healthcare project and the strengthening of patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) across the organisation. These initiatives systematically capture consumers' perspectives on their health outcomes and care experiences, providing meaningful data that is used to identify opportunities for improvement, monitor the impact of changes, and support more responsive, person-centred care.

Strategic priority / goal	Health service deliverable	RMH response
	Ensure that health service reporting, reviews and decision-making are underpinned by a safety culture and systems that are transparent, accurate and fair for staff and consumers.	**Status: Achieved** **Commentary:** Health service reporting, reviews and decision-making are underpinned by a strong culture of safety, openness, and continuous improvement. An environment is fostered where staff and consumers feel safe to raise concerns, report incidents, and provide feedback aligned with a just culture. Decisions are informed by accurate, timely, and transparent information, and fair and consistent processes promote accountability, learning, and quality improvement. Staff and consumers are actively engaged in these processes, strengthening trust, improving patient outcomes, and supporting a culture of excellence in care.
	Health services are able to show evidence of a comprehensive training program approach that includes performance management, accountability, and continuous improvement.	**Status: Achieved** **Commentary:** The RMH maintains a comprehensive training program that supports staff capability, performance management, accountability, and continuous improvement. Training requirements are monitored, completion is tracked, and managers are responsible for ensuring compliance. Training programs are regularly reviewed using feedback, audits, and organisational outcomes to inform ongoing improvements and ensure training remains current and effective. The development of a new capability framework, to be embedded in recruitment processes, succession planning and learning and development, provides a consistent approach to building workforce capability and supporting continuous improvement.
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 all relevant standards outlined in the Standards for Safe and Timely Ambulance and Emergency Care (STAEC) for Victorians and the accompanying Implementation Guide	**Status: Ongoing** **Commentary:** The RMH has continued to improve access to emergency care through the continued implementation of the STAEC standards and participation in the Timely Emergency Care (TEC) Collaborative. Changes to ambulance offload escalation processes have reduced ambulance transfer delays of more than two hours by 92 per cent from 2024-25 to 2025-26. Other improvements included enhancements to our electronic medical record to support better coordination of care, and the development of new processes to monitor and respond to patients waiting to be seen. This year we expanded our ED Geriatrician (EDGE) program to operate seven days a week and introduced early frailty screening, helping reduce hospital admissions for older patients. The RMH achieved a strong 4.5 out of 5 rating in the TEC Excellence in Flow program. Work has commenced to implement a new 48 hour model of care in the Acute Medical Unit. The RMH has also introduced weekend coordination meetings to support patient flow seven days a week.

Strategic priority / goal	Health service deliverable	RMH response
Maintain a commitment to delivering equitable and timely access to planned care and drive reform in alignment with the Planned Surgery Reform Blueprint.	Implement and scale theatre optimisation initiatives in planned surgery, for example same-day surgery and same-day surgery by default models of care, criteria-led discharge, monitoring of theatre measures, and high-throughput approaches such as high-intensity theatre lists.	**Status: Ongoing** **Commentary:** The RMH completed 10,022 planned surgeries in 2025-26, exceeding our target of 9500 and making this our busiest planned surgery year on record. Weekend high-intensity theatre (HIT) lists continued to increase surgical activity, reduce long waits and support timely access to care. We also expanded same-day procedures across six surgical streams, helping improve patient flow, reduce hospital stays and make better use of inpatient beds. The criteria-led discharge program continued to improve discharge planning and patient flow in Orthopaedics and Emergency General Surgery and is now being expanded to Cardiac Surgery, Trauma and Urology. Approximately 13 per cent of patients in 2025-26 (including 26 per cent of Orthopaedic patients) were supported through the program, providing more proactive coordination and multidisciplinary engagement in patient care. Improving operating theatre efficiency remained a key focus. Through ongoing performance monitoring and daily coordination, full-year theatre utilisation reached 85.2 per cent for 2025-26, ensuring available capacity was used effectively to meet growing demand.
	Proactively manage planned surgery and specialist clinics (or outpatients) waitlists, for example validating and supporting patients into optimal care pathways such as evidence-based alternatives to surgery and optimisation pathways. A particular focus should be applied to long-waiting patients and priority population groups (for example, Aboriginal and Torres Strait Islander patients and under-18 patients).	**Status: Ongoing** **Commentary:** The RMH continued to strengthen waitlist management to ensure patients receive the right care at the right time. Regular reviews and clinical audits helped maintain an accurate and up-to-date waiting list, while patients awaiting surgery were actively monitored and supported. Patients for whom surgery was not the most appropriate option were linked with alternative specialist services, including spine, soft tissue and hand clinics, ensuring timely access to expert assessment and treatment. The Enhanced Recovery After Surgery Plus (ERAS+) program continued to improve outcomes for patients undergoing complex surgical procedures. Implemented across specialties including Hepatobiliary Surgery, Head and Neck Surgery, and Orthopaedics, the program supports faster recovery, earlier mobilisation and shorter hospital stays. During 2025-26, 250 patients participated in an ERAS+ pathway, resulting in 222 bed days saved. Following these strong results, plans are underway to expand the program to additional surgical specialties in 2026-27, further improving recovery outcomes, hospital capacity and patient flow.

Strategic priority / goal	Health service deliverable	RMH response
Support the implementation of the “Next Phase of Reform” to deliver inclusive, personalised, compassionate, integrated mental health and wellbeing care in the community	Progress mental health reform: Implement mental health services per department guidelines, and engage in reform related initiatives to improve access to community mental health services, crisis reforms, headspace integration, youth and adolescent inpatient care, catchment removal as well as infant, child and youth age streaming.	**Status: Ongoing** **Commentary:** A key achievement during 2025-26 was the continued implementation of the Open Dialogue model of care, the first model of its kind in an Australian adult public mental health service. During the year, the RMH established a multidisciplinary community team that includes lived-experience practitioners, delivered extensive staff training, developed an evaluation framework, and strengthened partnerships with academic and sector organisations. These foundations will support future growth of the model and improve access to person-centred mental health care. As part of the reform directions, the RMH successfully completed the separation of the PYMHWS to create Victoria’s first dedicated youth mental health service. This work included relocation of the inpatient unit and implementing the first stage of community care transition arrangements. Work is underway with PYMHWS and The Royal Children’s Hospital to develop future youth electroconvulsive therapy (ECT) pathways. The RMH continued to support major mental health reforms, including changes to community service catchments and planning for future adult, older adult and youth service arrangements. Our teams also contributed to statewide service redesign initiatives, helping shape contemporary community-based models of care and improving access to services.
	Partner with Safer Care Victoria in one or more mental health improvement programs: elimination of restrictive intervention, improving sexual safety, implementation of the zero suicide framework and reducing compulsory treatment	**Status: Achieved** **Commentary:** The RMH continued to improve safety and quality across its mental health services through participation in the Safer Care Victoria Restrictive Interventions Collaborative, achieving reductions in the use of seclusion and restraint and embedding sustainable approaches to support further improvement. The service strengthened governance and patient safety through enhanced ward-level performance and safety monitoring, implementation of agreed improvement actions following significant events, workforce redesign and targeted safety initiatives to address aggression, violence and interpersonal risk. The RMH also expanded its research and quality improvement capabilities to support innovative models of care, including Open Dialogue, Wellness on Wheels and Safe Haven. These programs place lived experience at the centre of service design and delivery, helping improve access to care, patient outcomes, safety and overall service quality.

Strategic priority / goal	Health service deliverable	RMH response
	Progress partnerships, whether through a formal partnership, MoU or exchange of letters, with local community-based mental health services (including Mental Health and Wellbeing Locals, Headspace and other local NGO providers) and deliver initiatives that align with the objectives of the *Mental Health and Wellbeing Act 2022*, and in accordance with the priorities outlined in Victoria's next phase of reform for Mental Health and Wellbeing.	**Status: Achieved** **Commentary:** In 2025-26, the RMH strengthened partnerships across the mental health, primary care and community sectors to improve support for people with complex needs. Updated agreements with the City of Melbourne and VincentCare enhanced housing pathways for people experiencing homelessness and supported the ongoing delivery of the Wellness on Wheels service. Partnerships with cohealth, North Western Melbourne Primary Health Network, Wellways, Forensicare and housing providers also strengthened integrated care pathways and support for vulnerable consumers. Across 2025-26, the RMH continued to play a leading role in mental health reform through our partnership with the Victorian Collaborative Centre for Mental Health and Wellbeing. Key achievements included establishing the Lived Experience Knowledge Group, leading consortium activities and developing evaluation and translational research programs. These efforts have strengthened lived experience participation, enhanced research capability and supported knowledge sharing across the sector to improve mental health outcomes and drive ongoing system reform.
Prudent, sustainable and effective use of resources		
Develop and implement initiatives to strengthen financial sustainability. By delivering sustainable, responsible budgets, we can ensure a well-managed, viable, and sustainable health system for the future.	Deliver the key initiatives outlined in the Budget Action Plan within Government parameters.	**Status: Achieved** **Commentary:** The RMH successfully delivered its cumulative 2025-26 Financial Management Improvement Program, with the RMH's internal Financial Sustainability Committee providing oversight. These financial improvements supported the RMH to achieve a break-even 2025-26 financial outcome, while navigating ongoing increases in patient activity. Initiatives centred around workforce management, generating third-party revenues, digitisation, and procurement efficiencies.
	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:** A significant focus has been on driving business innovation and insights through Power BI report development across many aspects of the RMH's financial performance and operations, including surgery, mental health, subacute, allowances, workforce and daily activity performance. The RMH also continues to participate in a sector-wide benchmarking working group which has created several financial performance metrics allowing comparison across all Victorian public hospitals.

Strategic priority / goal	Health service deliverable	RMH response
	Use funding efficiently and effectively to optimise patient-facing services. Undertake programs to reduce the cost of service delivery, improve safety, capacity and reduce unnecessary waiting.	**Status: Achieved** **Commentary:** The RMH successfully delivered its target efficiency/savings program during a year of sustained patient demand and growth. Cost reductions have been achieved through procurement of clinical supplies, controlling FTE and embracing new models of care. New models of care without infrastructure investment include virtual wards and regional clinics. There is an ongoing focus on length of stay and further models to absorb growing emergency care. Planned surgery and endoscopy activity has increased to address growing community demand.
A stronger workforce		
Position Victoria as a leader in employee experience, capability, and capacity by focusing on future roles and professional development in line with the Victorian Health Workforce Strategy to ensure a regenerative and sustainable workforce.	Implement processes to sustain workforce supply and fulfill obligations, including those under the *Gender Equality Act 2020* by improving employee experience in leadership, health and safety, flexibility, career development, and agility to ensure safe, high-quality care.	**Status: Achieved** **Commentary:** Pleasingly the RMH achieved our highest ever participation (50 per cent) and engagement score (78 per cent) in the 2026 People Matter Survey. Significant focus was placed on building safety culture across the organisation, including a new team being established to specifically focus on psychological health and safety. Further, a thorough codesign and consultation process was undertaken across the organisation to develop the first RMH Capability Framework. The RMH also achieved compliant status with the *Gender Equity Act 2020* for this reporting period.
	Collaborate with the department to improve workforce data analytics, generate actionable insights, and enhance strategic planning.	**Status: Ongoing** **Commentary:** Significant work is being undertaken across the Parkville LHSN to improve data integrity and reporting, including working closely with the department to align our approach with the broader state.
Improving Aboriginal health and wellbeing		
Enhance Delivery and Access to Culturally Safe Services, fostering strong connections to culture. Address racism and provide Aboriginal people with culturally safe healthcare and referral pathways between mainstream and community-controlled health services.	Deliver high-quality cultural safety training to all executives and staff using independent, expert, community-controlled organisations or a registered Aboriginal business.	**Status: Ongoing** **Commentary:** In 2025-26, the RMH implemented a new position within the First Nations Health Unit that is responsible for all staff training at the RMH. A new online form has been introduced to allow all staff to request face-to-face cultural safety training with high engagement from staff across the RMH. Four modules on anti-racism and health equity have been developed and are due for imminent release to staff. The ED has been identified as focus area with tailored training modules, with in-services planned for all emergency staff.

Strategic priority / goal	Health service deliverable	RMH response
	Health service executives and senior leaders establish and maintain strong, ongoing partnerships with Aboriginal community-controlled organisations and/or recognised Aboriginal leaders within their local catchments. These partnerships must be based on regular, proactive engagement that prioritises the voices, self-determined priorities, and cultural knowledge of Aboriginal communities in the design, delivery, and evaluation of health and wellbeing services.	**Status: Ongoing** **Commentary:** A new First Nations breast and lung cancer screening service commenced in 2025-26 in partnership with the Victorian Aboriginal Health Service (VAHS). The RMH also partnered with VAHS to progress collaborative action in cancer. A range of seed funding projects in 2025-26 also involved consultation and partnerships with Aboriginal-led community organisations, such as Djirra. The RMH also partnered with recognised Aboriginal leaders in the scoping and funding for First Nations Mural artworks in ED, Cardiology and ICU (final delivery of the project expected late-2026). The RMH has also been a strong participant in the implementation of *marra ngarrgoo, marra goorri* – the Victorian Aboriginal Health, Medical and Wellbeing Research Accord. RMH Executives have engaged strongly with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to progress the landmark Accord.
	Ensure culturally appropriate systems for identifying Aboriginal and Torres Strait Islander patients and implement responsive discharge plans and referral pathways.	**Status: Ongoing** **Commentary:** The RMH First Nations Anti-Racism and Cultural Safety Framework was launched in mid-2026. A new service has commenced to support Aboriginal and Torres Strait Islander people presenting to the ED, with mandated First Nations Health Liaison Officer referral pathways directly from ED triage. Funding has extended to explore patient-led discharge events for safer discharge and connection to services.
Moving from Competition to Collaboration		
Collaborate within the Local Health Service Network to build a more integrated health system, with better access and experience for patients, strengthened workforce, consistently high quality care, and more sustainable healthcare delivery.	Meet all objectives agreed to in the Local Health Service Network Statement of Expectations across priority areas (access, equity and flow, workforce, safety and quality, and shared services).	**Status: Achieved** **Commentary:** All Parkville LHSN Statement of Expectations milestones were met by the Parkville LHSN (as varied by agreement with the Department of Health). In 2025-26, the Parkville LHSN successfully established its governance and leadership structures, executed its foundational documents (a Memorandum of Understanding and an IP and Data Sharing Agreement), developed its inaugural strategy (Strategy 2025-2028), commenced work on its Network Clinical Services Plan, delivered a workforce plan, established its Safer Together Program, progressed work on several shared services, and delivered all other milestones set out in the Statement of Expectations. The RMH has been an active member of the Parkville LHSN, making significant contributions to all initiatives. In addition, the RMH is the fund holder and employer of Network staff and has provided significant in-kind support to the Network.

Part B – Performance Priorities

High quality and safe care

Key Performance Measure	Target	2025-26 Result
Infection prevention and control		
Percentage of healthcare workers immunised for influenza	94%	93.4%
Continuing care		
Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations	≥ 0.645	0.733
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	100%
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%	92%
Aboriginal Health		
Difference between the percentage of Aboriginal patients and non-Aboriginal patients who left against medical advice	0%	4%
Difference between the percentage of Aboriginal patients and non-Aboriginal patients presenting to ED who did not wait to be treated	0%	10%
Mental Health Patient Experience		
Percentage of consumers who rated their overall experience with a service in the last three months as positive	80%	62%
Percentage of families/carers reporting a ‘very good’ or ‘excellent’ overall experience of the service	80%	47%
Percentage of families/carers who report they ‘always’ or ‘usually’ felt their opinions as a carer were respected	90%	82%
Percentage of mental health consumers reporting they ‘usually’ or ‘always’ felt safe using this service	90%	81%

Key Performance Measure	Target	2025-26 Result
Mental Health follow-ups, readmissions, and seclusions		
Percentage of consumers followed up within 7 days of separation – Inpatient	88%	99.6%
Percentage of consumers re-admitted within 28 days of separation - Inpatient	< 14%	7.8%
Rate of seclusion episodes per 1,000 occupied bed days - Inpatient	≤ 6	12.1

Strong Governance, Leadership and Culture

Key Performance Measure	Target	2025-26 Result
Organisational culture		
People matter survey – Percentage of staff with an overall positive response to safety culture survey questions	80%	83%[1]

1. Changes to the 2025-26 Health Sector People Matter Survey has affected the 'Percentage of staff with an overall positive response to safety culture survey questions' measure. Historical results are not directly comparable and should be interpreted with consideration of a break in the time series.

Timely Access to Care

Key Performance Measure	Target	2025-26 Result
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%	83%
Number of patients admitted from the planned surgery waiting list	9,500	10,022
Percentage of patients on the waiting list who have waited longer than the clinically recommended time for their respective triage category	25% proportional improvement from prior year: ≤ 28.8%	31.6%
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% from prior year: <= 1.82	1.95

Key Performance Measure	Target	2025-26 Result
Emergency Care		
Percentage of patients transferred from ambulance to emergency department within 40 minutes	Royal Melbourne Hospital: 4% improvement from the same time last year: ≥ 72.7%	73%
Number of emergency patients with a length of stay (LOS) in the ED greater than 24 hours	0	29
Average ED length of stay (LOS) for admitted patients, in minutes	Avg LOS <414 minutes or, if not met, a 5% improvement from the same time last year: ≤ 414	456
Average ED length of stay (LOS) for non-admitted patients, in minutes	Avg LOS <240 minutes or, if not met, a 3% improvement from the same time last year: ≤ 218	241
Mental Health		
Percentage of mental health-related emergency department presentations with a length of stay of less than 4 hours	65%	44%
Percentage of departures from emergency departments to a mental health bed within 8 hours	80%	49%
Number of admitted mental health occupied bed days	16,616	16,887
Number of community mental health service hours	88,146	91,180
Specialist Clinics		
Percentage of patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe	95%	87%
Home Based Care		
Percentage of admitted bed days delivered at home	11.3%	10.7%

Effective financial management

Key Performance Measure	Target	2025-26 Result
Operating result ($M)	0.00	0.12
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	0.77
Variance between the forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June 2026	5% movement in forecast revenue and expenditure forecasts	Achieved

Part C – Activity and funding

Funding type	2025-26 activity achievement
Consolidated activity funding	
Acute admitted, subacute admitted, emergency services, non-admitted NWAU	165,284
Community mental health NWAU	8,719
Acute admitted	
Acute admitted DVA	221
Acute admitted TAC	7,139
Subacute/non-acute, Admitted and Non-admitted	
Subacute - DVA	8
Transition care - bed days	7,218
Transition care - home days	13,614
Aged care	
Residential aged care	21,376
Mental Health and Drug Services	
Mental health ambulatory	266
Mental health subacute	9,264
Primary health	
Community health / primary care programs	1

Financial statements

How this report is structured

Melbourne Health presents its audited general purpose financial statements for the financial year ended 30 June 2026 in the following structure to provide users with the information about Melbourne Health's stewardship of the resources entrusted to it.

Declarations

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

Victorian Auditor-General's report

Financial statements

Comprehensive operating statement

Balance sheet

Cash flow statement

Statement of changes in equity

Notes to the financial statements

1 About this report

1.1 Basis of preparation

1.2 Material accounting judgements and estimates

1.3 Accounting standards issued but not yet effective

1.4 Reporting entity

1.5 Economic dependency

1.6 Administrative restructure

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2 Funding delivery of our services

2.1 Revenue and income from transactions

3 The cost of delivering our services

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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 2026 and the financial position of Melbourne Health at 30 June 2026.

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
26 August 2026



Professor Shelley Dolan
Chief Executive

Melbourne
26 August 2026



Paul Urquhart
Chief Corporate Officer

Melbourne
26 August 2026

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 2026 • 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 2026 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 the 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
27 August 2026

Simone Bohan
as delegate for the Auditor-General of Victoria

Melbourne Health
Comprehensive operating statement
For the financial year ended 30 June 2026

	Note	Total 2026 $'000	Total 2025 $'000
Revenue and income from transactions			
Revenue from contracts with customers	2.1(a)	1,349,172	1,243,118
Government grants	2.1(b)	270,318	409,336
Other income	2.1(c)	172,508	168,264
Total revenue and income from transactions		**1,791,998**	**1,820,718**
Expenses from transactions			
Employee expenses	3.1(a)	(1,271,651)	(1,268,065)
Depreciation and amortisation	4.3	(96,484)	(98,087)
Supplies and consumables	3.1(d)	(241,091)	(231,067)
Other operating expenses	3.1(e)	(234,445)	(212,295)
Total expenses from transactions		**(1,843,671)**	**(1,809,514)**
Net result from transactions - net operating balance		**(51,673)**	**11,204**
Other economic flows included in net result			
Net gain/(loss) on sale of non-financial assets		255	427
Net gain/(loss) on financial instruments		(8,230)	(5,385)
Other gains/(losses) from other economic flows		6,375	2,215
Total other economic flows included in net result		**(1,600)**	**(2,743)**
Net result		**(53,273)**	**8,461**

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

Melbourne Health
Balance sheet
As at 30 June 2026

	Note	Total 2026 $'000	Total 2025 $'000
Financial assets			
Cash and cash equivalents	6.2	162,329	179,202
Receivables	5.1	118,001	115,947
Contract assets	5.2	19,318	15,947
Investments	5.3	22,922	21,524
Total financial assets		**322,570**	**332,620**
Non-financial assets			
Prepayments		28,435	29,968
Inventories	5.4	35,540	23,782
Property, plant and equipment	4.1	1,134,170	1,287,727
Intangible assets	4.2	22,832	28,866
Total non-financial assets		**1,220,977**	**1,370,343**
Total assets		**1,543,547**	**1,702,963**
Liabilities			
Payables	5.5	201,085	209,426
Contract liabilities	5.6	27,834	22,467
Borrowings	6.1	51,151	56,820
Employee benefits	3.1(b)	364,846	353,529
Monies held in trust	5.7	5,227	6,505
Total liabilities		**650,143**	**648,747**
Net assets		**893,404**	**1,054,216**
Equity			
Property, plant and equipment revaluation surplus		904,322	904,322
Restricted specific purpose surplus		89	89
Contributed capital		224,721	332,260
Accumulated surplus/(deficit)		(235,728)	(182,455)
Total equity		**893,404**	**1,054,216**

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

Melbourne Health
Cash flow statement
For the financial year ended 30 June 2026

	Note	Total 2026 $'000	Total 2025 $'000
Cash flows from operating activities			
Receipts from government		1,471,847	1,485,947
Patient and hospital fees received		74,497	74,740
Donations and bequests received		6,253	5,511
GST received from/(paid to) ATO[(i)]		47,707	52,545
External recoveries		44,624	41,952
Other receipts		178,744	162,764
Total receipts		***1,823,672***	***1,823,459***
Payments to employees		(1,243,365)	(1,241,322)
Payments for supplies and consumables		(243,080)	(229,150)
Other payments		(310,090)	(269,870)
Total payments		***(1,796,535)***	***(1,740,342)***
Net cash flows from/(used in) operating activities	8.1	**27,137**	**83,117**
Cash flows from investing activities			
Proceeds from sale of non-financial assets		838	843
Purchase of non-financial assets		(35,041)	(58,945)
Purchase of financial assets		(1,508)	(1,146)
Net cash flows from/(used in) investing activities		**(35,711)**	**(59,248)**
Cash flows from financing activities			
Repayment of borrowings		(7,013)	(8,051)
Repayment of accommodation deposits		(2,244)	(1,445)
Receipt of accommodation deposits		958	2,091
Net cash flows from/(used in) financing activities		**(8,299)**	**(7,405)**
Net increase/(decrease) in cash and cash equivalents held		**(16,873)**	**16,464**
Cash and cash equivalents at beginning of year		179,202	162,738
Cash and cash equivalents at end of year	6.2	**162,329**	**179,202**

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 2026

	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 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**
Net result for the year	-	-	-	(53,273)	(53,273)
Capital contribution transfer to another health service[(i)]	-	-	(861)	-	(861)
Transfer to Victorian Government[(i)]	-	-	(106,678)	-	(106,678)
Balance at 30 June 2026	**904,322**	**89**	**224,721**	**(235,728)**	**893,404**

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

[(i)] As per Note 1.6, nets assets were transferred during the year by way of capital contribution to Parkville Youth Mental Health and Wellbeing Service ($0.9m), and The Department of Health ($106.7m).

Note 1: About this report

Structure

1.1 Basis of preparation
1.2 Material accounting judgements and estimates
1.3 Accounting standards issued but not yet effective
1.4 Reporting entity
1.5 Economic dependency
1.6 Administrative restructure
1.7 Changes in accounting policy

These financial statements represent the audited general purpose financial statements of Melbourne Health for the year ended 30 June 2026.

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 26 August 2026.

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 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 are not expected to have material impact on the financial statements.

- AASB 2022-10 *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities*

- AASB 2024-2 *Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments*

- AASB 18 *Presentation and Disclosure of Financial Statements*

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 2025, pursuant to a Victorian Government Gazette, Melbourne Health effected the transfer of certain properties associated with Orygen Specialist Program (OSP) and their attaching rights and liabilities to Parkville Youth Mental Health and Wellbeing Service.

The transfer of these properties was effected as a restructuring of administrative arrangements per Financial Reporting Direction (FRD) 119 *Transfers through contributed capital* and was accounted for as a capital transfer during 2025-26.

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

	$'000
Cash	13,700
Plant and equipment	861
Employee benefits	(13,700)
Total	861

In addition to the above transfer, land and building for OSP was transferred to the Department of Health under FRD 119 via contributed capital as per below:

	$'000
Land	58,674
Buildings	48,004
Total	106,678

Note 1.7: Changes in accounting policy

In the current year, Melbourne Health changed its accounting policy for the subsequent measurement of right-of-use (ROU) assets arising from market leases from the revaluation model to the cost model, in line with updated FRD 104 *Leases* requirements.

Under the cost model, ROU assets are measured at cost less accumulated depreciation, impairment and lease remeasurements. Previously, these assets were measured at fair value.

The change has been applied using the modified retrospective approach. Comparative information has not been restated, and the carrying amounts at 30 June 2025 have been recognised as opening balances under the new policy from 1 July 2025.

ROU assets arising from significantly below-market (peppercorn) leases continue to be measured at cost, with no change in policy.

Impact of the change in accounting policy

On transition, there was no impact on the financial statements. No impairment was identified for ROU assets as at 30 June 2026.

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 predominantly receives income (grants) 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.

Note 2.1: Revenue and income from transactions

	Note	Total 2026 $'000	Total 2025 $'000
Revenue from contracts with customers*	2.1(a)	1,349,172	1,243,118
Government grants*	2.1(b)	270,318	409,336
Other income	2.1(c)	172,508	168,264
Total revenue and income from transactions		**1,791,998**	**1,820,718**

* Movement between categories is primarily due to Mental Health community grants moving from fixed grants in 2025 to activity based funding in 2026.

Note 2.1 (a): Revenue from contracts with customers

	Total 2026 $'000	Total 2025 $'000
Government grants (State) - Operating	1,143,009	1,051,059
Government grants (Commonwealth) - Operating	71,973	69,637
Patient and resident fees	40,155	37,630
Private practice fees	47,031	43,429
Commercial activities	47,004	41,363
Total revenue from contracts with customers	**1,349,172**	**1,243,118**
Melbourne Health disaggregates revenue by the timing of revenue recognition.		
Goods and services transferred to customers:		
At a point in time	1,232,887	1,137,709
Over time	116,285	105,409
Total revenue from contracts with customers	**1,349,172**	**1,243,118**

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 *Revenue from Contracts with Customers*.

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, research income, 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): Government grants

	Total 2026 $'000	Total 2025 $'000
Government grants (State) - Operating	209,439	313,136
Government grants (State) - Capital	60,639	95,800
Government grants (Commonwealth) - Capital	240	400
Total government grants	**270,318**	**409,336**

How we recognise government grants

Government operating grants

Melbourne Health recognises income of not-for-profit entities under AASB 1058 *Income of Not-for-Profit Entities* 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.

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 Infrastructure Delivery Authority	The Department of Health made payments to the Victorian Infrastructure Delivery Authority to fund capital works projects during the year ended 30 June 2026, 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 2.1 (c): Other income

	Note	Total 2026 $'000	Total 2025 $'000
Operating activities			
Other capital purpose income		14,725	16,894
Assets and services received free of charge or for nominal consideration	2.1(d)	8,524	8,153
Salary and wages recoveries		34,029	28,692
Other income from operating activities		95,311	90,496
Total income from operating activities		**152,589**	**144,235**
Non-operating activities			
Rental income		7,607	8,358
Other interest		10,297	14,525
Dividends		2,015	1,146
Total income from non-operating activities		**19,919**	**24,029**
Total other income		**172,508**	**168,264**

How we recognise other income

Income from operating activities

Income from operating activities includes salary and wages and other recoveries from external organisations and are recognised as income upon receipt.

Income from non-operating activities

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.

Other interest

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 (d): Fair value of assets and services received free of charge or for nominal consideration

	Total 2026 $'000	Total 2025 $'000
Cash donations and gifts	6,253	5,511
Plant and equipment	-	665
Personal protective equipment and other consumables	2,271	1,977
Total fair value of assets and services received free of charge or for nominal consideration	**8,524**	**8,153**

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 in 2025.

Personal protective equipment

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

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 4.15% (as issued by Department of Treasury and Finance), 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 21.03% (representing employees with less than 1 year of service) and 80.03% (representing employees becoming entitled to long service leave within a year). • discounting at the rate of 4.74%, 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 2026 $'000	Total 2025 $'000
Employee expenses	3.1(a)	1,271,651	1,268,065
Supplies and consumables	3.1(d)	241,091	231,067
Other operating expenses	3.1(e)	234,445	212,295
Total expenses incurred in the delivery of services		**1,747,187**	**1,711,427**

Note 3.1 (a): Employee expenses

	Total 2026 $'000	Total 2025 $'000
Salaries and wages	1,119,117	1,107,279
On-costs	117,755	114,006
Agency expenses and external contract staff	14,536	27,108
Fee for service medical officer expenses	4,181	4,221
WorkCover premium	16,062	15,451
Total employee expenses	**1,271,651**	**1,268,065**

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 2026 $'000	Total 2025 $'000
Current employee benefits and related on-costs		
Accrued days off		
Unconditional and expected to be settled wholly within 12 months [(i)]	3,388	3,252
	3,388	**3,252**
Annual leave		
Unconditional and expected to be settled wholly within 12 months [(i)]	99,228	94,699
Unconditional and expected to be settled wholly after 12 months [(ii)]	14,952	14,782
	114,180	**109,481**
Long service leave		
Unconditional and expected to be settled wholly within 12 months [(i)]	25,991	19,662
Unconditional and expected to be settled wholly after 12 months [(ii)]	152,851	155,435
	178,842	**175,097**
Other employee benefits		
Unconditional and expected to be settled wholly within 12 months [(i)]	1,017	985
	1,017	**985**
Provisions related to employee benefit on-costs		
Unconditional and expected to be settled wholly within 12 months [(i)]	18,013	16,081
Unconditional and expected to be settled wholly after 12 months [(ii)]	23,583	23,313
	41,596	**39,394**
Total current employee benefits and related on-costs	**339,023**	**328,209**
Non-current employee benefits and related on-costs		
Conditional long service leave	22,637	22,267
Provisions related to employee benefit on-costs	3,186	3,053
Total non-current employee benefits and related on-costs	**25,823**	**25,320**
Total employee benefits and related on-costs	**364,846**	**353,529**

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

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

Provisions related to employee benefit on-costs movement schedule

	Total 2026 $'000	Total 2025 $'000
Carrying amount at start of year	**42,447**	**39,135**
Additional provisions recognised	21,480	22,209
Amounts incurred during the year	(18,359)	(18,630)
Net gain/(loss) arising from revaluation of long service liability	(786)	(267)
Carrying amount at end of year	**44,782**	**42,447**

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 comprehensive operating statement 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.

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	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000
Defined benefit plans[(i)]:				
Emergency Services and State Super (ESSSuper)	67	112	3	3
Aware Super defined benefit	-	2	8	11
Defined contribution plans:				
HESTA	30,655	31,418	3,873	3,819
Aware Super	47,122	46,919	5,888	6,022
Other	26,565	22,695	3,741	3,051
Total	**104,409**	**101,146**	**13,513**	**12,906**

[(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.

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.

Note 3.1 (d): Supplies and consumables

	Total 2026 $'000	Total 2025 $'000
Pharmaceutical supplies	72,314	68,233
Medical and surgical supplies (including prostheses)	104,532	98,830
Diagnostic and radiology supplies	40,534	38,304
Other supplies and consumables	23,711	25,700
Total supplies and consumables	**241,091**	**231,067**

How we recognise 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.

Note 3.1 (e): Other operating expenses

	Total 2026 $'000	Total 2025 $'000
Finance cost	1,804	1,882
Fuel, light, power and water	12,036	11,235
Repairs and maintenance	7,297	8,077
Maintenance contracts	42,921	40,146
Medical indemnity insurance	19,510	16,423
Other administrative expenses	65,881	71,960
Expenditure for capital purposes	33,331	11,708
Other operating expenses	51,665	50,864
Total other operating expenses	**234,445**	**212,295**

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.

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.

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.
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	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
Land at fair value - Crown	243,361	302,035	-	-	243,361	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	(9,636)	(8,259)	38,049	39,426
Buildings at fair value	760,829	802,493	(140,360)	(80,340)	620,469	722,153
Leasehold improvements	30,194	31,381	(10,275)	(7,986)	19,919	23,395
Works in progress at cost	57,025	66,384	-	-	57,025	66,384
Plant, equipment and vehicles at fair value	341,323	301,379	(214,815)	(195,884)	126,508	105,495
Total property, plant and equipment	**1,509,256**	**1,580,196**	**(375,086)**	**(292,469)**	**1,134,170**	**1,287,727**

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	Leasehold improvements	Works in progress	Plant, equipment and vehicles	Total
		$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2024		**302,035**	**28,830**	**9**	**40,803**	**765,758**	**26,086**	**28,557**	**101,328**	**1,293,406**
Additions		-	-	-	-	592	472	66,634	18,845	86,543
Disposals		-	-	-	-	-	-	-	(415)	(415)
Assets received/(provided) free of charge		-	-	-	-	-	-	(48)	665	617
Net transfers between classes		-	-	-	-	20,865	-	(28,759)	7,894	-
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**	**23,395**	**66,384**	**105,495**	**1,287,727**
Additions		-	-	-	-	614	-	26,224	17,908	44,746
Disposals		-	-	-	-	-	-	-	(1,366)	(1,366)
Assets received/(provided) free of charge		-	-	-	-	-	-	1,326	745	2,071
Net transfers between classes		-	-	-	-	6,697	-	(36,817)	29,471	(649)
Asset transfers via contributed capital		(58,674)	-	-	-	(48,004)	(480)	(92)	(290)	(107,540)
Depreciation	4.3	-	-	-	(1,377)	(60,991)	(2,996)	-	(25,455)	(90,819)
Balance at 30 June 2026	4.1	**243,361**	**28,830**	**9**	**38,049**	**620,469**	**19,919**	**57,025**	**126,508**	**1,134,170**

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 earlier of the interim revaluation or next scheduled independent revaluation 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	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
Concessionary land	9	9	-	-	9	9
Concessionary buildings	47,685	47,685	(9,636)	(8,259)	38,049	39,426
Buildings	58,774	58,576	(26,206)	(20,737)	32,568	37,839
Plant, equipment and vehicles	25,810	23,427	(16,824)	(14,855)	8,986	8,572
Total right-of-use assets	**132,278**	**129,697**	**(52,666)**	**(43,851)**	**79,612**	**85,846**

	Concessionary land	Concessionary buildings	Buildings	PPE, F&F & V*	Total
	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 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 (1)	**9**	**39,426**	**37,839**	**8,572**	**85,846**
Additions	-	-	198	4,232	4,430
Disposals	-	-	-	(1,061)	(1,061)
Depreciation	-	(1,377)	(5,469)	(2,757)	(9,603)
Balance at 30 June 2026	**9**	**38,049**	**32,568**	**8,986**	**79,612**

* Property plant and equipment, furniture and fittings and vehicles

(1) As a result of a change in FRD 104 Leases effective for reporting periods from 30 June 2026, right-of-use assets are measured at cost for reporting period 2026. The comparative information for reporting period 2025 is not restated and is reported at the previously determined fair value. For further information, refer to Note 7.4.

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
- an estimate of costs to dismantle and remove the underlying asset or to restore the underlying asset or the site on which it is located, less any lease incentive received.

Subsequent measurement

Right-of-use assets are subsequently measured at cost less accumulated depreciation, impairment and any adjustments for remeasurement of the lease liability.

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	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
Software	101,159	100,872	(78,413)	(72,777)	22,746	28,095
Software works in progress at cost	16	701	-	-	16	701
Post office license	70	70	-	-	70	70
Total intangible assets	**101,245**	**101,643**	**(78,413)**	**(72,777)**	**22,832**	**28,866**

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 2024		**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**
Additions		166	299	-	465
Reclassified to expenses		-	(834)	-	(834)
Net transfers between classes		150	(150)	-	-
Amortisation	4.3	(5,665)	-	-	(5,665)
Balance at 30 June 2026	4.2	**22,746**	**16**	**70**	**22,832**

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.

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 2026 $'000	Total 2025 $'000
Depreciation		
Concessionary buildings	1,377	1,377
Buildings at fair value	60,991	65,062
Leasehold improvements	2,996	3,163
Plant, equipment and vehicles at fair value	25,455	22,822
Total depreciation	**90,819**	**92,424**
Amortisation		
Software	5,665	5,663
Total amortisation	**5,665**	**5,663**
Total depreciation and amortisation	**96,484**	**98,087**

How we recognise 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.

How we recognise 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.

	2026	2025
Buildings	1 to 55 years	1 to 55 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

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

Note 4.4: Impairment of assets

Impairment of property, plant and equipment

The recoverable amount of primarily non-cash-generating assets of not-for-profit entities, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 *Fair Value Measurement*, with the consequence that AASB 136 *Impairment of Assets* does not apply to such assets that are regularly revalued.

Impairment of intangible assets

Intangible assets with finite useful lives are tested for impairment whenever an indication of impairment is identified.

Melbourne Health did not record any impairment losses for the year ended 30 June 2026 (30 June 2025: 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 Monies held in trust

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	Description
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 2026 $'000	Total 2025 $'000
Current receivables			
Contractual			
Inter hospital debtors		13,900	11,707
Trade receivables		11,417	13,471
Patient fees		14,227	9,132
Allowance for impairment losses	5.1(a)	(5,983)	(4,344)
Other receivables		12,238	25,054
Total contractual receivables		**45,799**	**55,020**
Statutory			
GST receivable		9,056	8,617
Total statutory receivables		**9,056**	**8,617**
Total current receivables		**54,855**	**63,637**
Non-current receivables			
Contractual			
Long service leave - Department of Health		63,146	52,310
Total contractual receivables		**63,146**	**52,310**
Total non-current receivables		**63,146**	**52,310**
Total receivables		**118,001**	**115,947**
Financial assets classified as receivables (Note 7.1)			
Total receivables		118,001	115,947
Provision for impairment		5,983	4,344
GST receivable		(9,056)	(8,617)
Total financial assets classified as receivables	7.1	**114,928**	**111,674**

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 receivables 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 2026 $'000	Total 2025 $'000
Balance at the beginning of the year	**4,344**	**3,332**
Increase in allowance	8,094	6,455
Amounts written off during the year	(6,455)	(5,443)
Balance at the end of the year	**5,983**	**4,344**

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 2026 $'000	Total 2025 $'000
Current			
Contract assets		19,318	15,947
Total current contract assets		19,318	15,947
Total contract assets	5.2(a)	**19,318**	**15,947**

Note 5.2 (a): Movement in contract assets

	Total 2026 $'000	Total 2025 $'000
Balance at the beginning of the year	**15,947**	**12,443**
Add: Additional costs incurred that are recoverable from the customer	19,318	15,947
Less: Transfer to revenue recognition	(15,947)	(12,443)
Total contract assets	**19,318**	**15,947**

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

	Specific purpose fund		Capital fund		Total	
	2026 $'000	2025 $'000	2026 $'000	2025 $'000	2026 $'000	2025 $'000
Non-current						
Financial assets at fair value through net result						
Managed investment fund	-	-	22,791	21,524	22,791	21,524
Equities*	131	-	-	-	131	-
Total non-current financial assets	131	-	22,791	21,524	22,922	21,524
Total investments	**131**	**-**	**22,791**	**21,524**	**22,922**	**21,524**
Represented by:						
Foundation investments	131	-	22,791	21,524	22,922	21,524
Total investments	**131**	**-**	**22,791**	**21,524**	**22,922**	**21,524**

*Equities investment relates to bequest donation received by Melbourne Health Foundation at the end of June 2026. The equities were disposed at the beginning of July 2026.

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 (CBS).

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 2026 $'000	Total 2025 $'000
Aids and appliances at cost	94	95
Medical and surgical consumables at cost	5,685	4,112
Pharmacy supplies at cost	4,844	3,561
Pathology supplies at cost	1,837	1,780
Land and buildings - Home Lottery*	23,080	14,234
Total inventories	**35,540**	**23,782**

* Land and buildings represent seven properties held as at 2026 (2025: four properties), which are used to support the philanthropic activities of the RMH Home Lottery.

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

Note 5.5: Payables

	Note	Total 2026 $'000	Total 2025 $'000
Current payables			
Contractual			
Payables		23,104	16,555
Accrued employee costs		76,145	62,119
Accrued expenses		51,772	54,962
Deferred capital grant income	5.5(a)	38,502	47,845
Inter - hospital creditors		1,268	14,200
Other		8,928	12,618
Total contractual payables		**199,719**	**208,299**
Statutory			
GST payable		1,366	1,127
Total statutory payables		**1,366**	**1,127**
Total current payables		**201,085**	**209,426**
Total payables		**201,085**	**209,426**
Financial liabilities classified as payables (Note 7.1)			
Total payables		201,085	209,426
Deferred capital grant income		(38,502)	(47,845)
GST payable		(1,366)	(1,127)
Total financial liabilities classified as payables	7.1	**161,217**	**160,454**

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 capital grant income

	Total 2026 $'000	Total 2025 $'000
Opening balance of deferred capital grant income	**47,845**	**51,955**
Grant consideration for capital works received during the year	26,513	44,160
Deferred capital grant income recognised as income due to completion of capital works	(35,856)	(48,270)
Closing balance of deferred capital grant income	**38,502**	**47,845**

How we recognise deferred capital grant income

Grant consideration was received from the Department of Health and Victorian Infrastructure Delivery Authority 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.

Note 5.6: Contract liabilities

	Total 2026 $'000	Total 2025 $'000
Opening balance of contract liabilities	**22,467**	**18,175**
Add: payments received for performance obligations yet to be completed during the period	12,072	9,142
Add: grant consideration for sufficiently specific performance obligations received during the year	11,365	9,272
Less: revenue recognised in the reporting period for the completion of a performance obligation	(9,450)	(9,097)
Less: grant revenue for sufficiently specific performance obligations work recognised consistent with the performance obligations met during the year	(8,620)	(5,025)
Total contract liabilities	**27,834**	**22,467**
Represented by		
Current contract liabilities	23,034	22,467
Non-current contract liabilities	4,800	-
Total	**27,834**	**22,467**

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: Monies held in trust

	Note	Total 2026 $'000	Total 2025 $'000
Current monies held in trust			
Patient monies		138	130
Refundable accommodation deposits		5,089	6,375
Total current monies held in trust		**5,227**	**6,505**
Represented by:			
Cash assets	6.2	5,227	6,505
		5,227	**6,505**

How we recognise monies held in trust

Refundable Accommodation Deposits (RAD)/Accommodation Bond liabilities

RAD/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* and *Aged Care Act 2024* effective from 1 November 2025.

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.
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 1.25% and 6.03%.
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. 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 2026 $'000	Total 2025 $'000
Current borrowings			
Lease liabilities [(i)]	6.1(a)	9,578	9,374
Total current borrowings		**9,578**	**9,374**
Non-current borrowings			
Lease liabilities [(i)]	6.1(a)	41,573	47,446
Total non-current borrowings		**41,573**	**47,446**
Total borrowings	7.1	**51,151**	**56,820**

(i) Secured by the assets leased.

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 2026 $'000	Total 2025 $'000
Interest on lease liabilities	1,804	1,882
Total interest expense	**1,804**	**1,882**

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 2026 $'000	Total 2025 $'000
Current lease liabilities		
Lease liability	9,578	9,374
Total current lease liabilities	9,578	9,374
Non-current lease liabilities		
Lease liability	41,573	47,446
Total non-current lease liabilities	41,573	47,446
Total lease liabilities	**51,151**	**56,820**

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

	Total 2026 $'000	Total 2025 $'000
Not longer than one year	11,156	10,729
Longer than one year but not longer than five years	35,853	35,399
Longer than five years	9,830	17,238
Minimum future lease liabilities	**56,839**	**63,366**
Less unexpired finance expenses	(5,688)	(6,546)
Present value of lease liabilities	**51,151**	**56,820**

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 payment.

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	99 years*
Concessionary buildings	25 to 40 years*
Buildings	2 to 20 years
Plant, equipment and vehicles	5 to 9 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 (e)).

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 6.03%.

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.

Description of leased asset	Our dependence on lease	Nature and terms of lease
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 2026 $'000	Total 2025 $'000
Cash on hand (excluding monies held in trust)		22	23
Cash at bank - CBS (excluding monies held in trust)		157,080	172,674
Total cash held for operations		**157,102**	**172,697**
Cash at bank - CBS (monies held in trust)		5,227	6,505
Total cash held as monies held in trust		**5,227**	**6,505**
Total cash and cash equivalents	7.1	**162,329**	**179,202**

Note 6.3: Commitments for expenditure

30 June 2026	Less than 1 year $'000	1-5 Years $'000	Over 5 years $'000	Total $'000
Capital expenditure commitments	26,149	-	-	26,149
Operating expenditure commitments	41,988	59,306	3,629	104,923
Non-cancellable short term and low value lease commitments	2,506	5,159	-	7,665
Total commitments (inclusive of GST)	**70,643**	**64,465**	**3,629**	**138,737**
Less GST recoverable				(12,612)
Total commitments (exclusive of GST)				**126,125**

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**

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 2026 $'000	Total 2025 $'000
Assumption and transfer out of liabilities [(i)]	3,219	4,885
Restructuring of administrative arrangements [(ii)]	(107,539)	-
Total non-cash financing and investing activities	**(104,320)**	**4,885**

[(i)] During the reporting period, Melbourne Health assumed right-of-use lease liabilities of $4.0 million (2025: $4.9 million) and transferred out right-of-use lease liabilities of $0.8 million (2025: Nil). These transactions are not reflected in the cash flow statement.

[(ii)] As part of the administrative restructure of mental health services, properties with a carrying value of $106.7 million were transferred to the Department of Health and $0.9 million to PYMHWS via contributed capital. These transactions are not reflected in the cash flow statement (refer 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. Melbourne Health uses a range of valuation techniques to estimate fair value. The health service selects a valuation technique which is considered most appropriate, and for which there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs. Subsequently, 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 2026	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	162,329	-	-	162,329
Receivables	5.1	114,928	-	-	114,928
Investments	5.3	-	22,922	-	22,922
Total financial assets		**277,257**	**22,922**	**-**	**300,179**
Financial liabilities					
Payables	5.5	-	-	161,217	161,217
Borrowings	6.1	-	-	51,151	51,151
Monies held in trust - refundable accommodation deposits	5.7	-	-	5,089	5,089
Monies held in trust - patient monies	5.7	-	-	138	138
Total financial liabilities		**-**	**-**	**217,595**	**217,595**

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	5.3	-	21,524	-	21,524
Total financial assets		**290,876**	**21,524**	**-**	**312,400**
Financial liabilities					
Payables	5.5	-	-	160,454	160,454
Borrowings	6.1	-	-	56,820	56,820
Monies held in trust - refundable accommodation deposits	5.7	-	-	6,375	6,375
Monies held in trust - patient monies	5.7	-	-	130	130
Total financial liabilities		**-**	**-**	**223,779**	**223,779**

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 and equities 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 capital grant income);
- borrowings; and
- 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 on the following page 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 2025-26.

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 'Expected Credit Loss' approach. Subject to AASB 9, 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 2026	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		1,914	1,650	944	558	2,958	8,024
Loss allowance	5.1	-	**825**	**944**	**558**	**2,958**	**5,285**
Other patient fees receivables:							
Expected loss rate		2%	6%	9%	12%	24%	
Gross carrying amount of contractual receivables		2,078	1,410	583	581	1,552	6,204
Loss allowance	5.1	**42**	**85**	**52**	**70**	**372**	**621**
Trade debtors (sundry debtors only):							
Expected loss rate		0%	0%	0%	0%	11%	
Gross carrying amount of contractual receivables		11,253	3,794	1,571	879	704	18,201
Loss allowance	5.1	-	-	-	-	**77**	**77**
Total loss allowance		**42**	**910**	**996**	**628**	**3,407**	**5,983**

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**

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 2026	**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	161,217	161,217	159,563	1,654	-	-	-
Borrowings	6.1	51,151	51,151	787	1,630	7,181	32,649	8,904
Monies held in trust - refundable accommodation deposits	5.7	5,089	5,089	294	459	1,288	3,048	-
Monies held in trust - patient monies	5.7	138	138	138	-	-	-	-
Total financial liabilities [(i)]		**217,595**	**217,595**	**160,782**	**3,743**	**8,469**	**35,697**	**8,904**

				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	160,454	160,454	158,663	1,549	242	-	-
Borrowings	6.1	56,820	56,820	805	1,431	6,810	31,463	16,311
Monies held in trust - refundable accommodation deposits	5.7	6,375	6,375	350	293	1,831	3,901	-
Monies held in trust - patient monies	5.7	130	130	130	-	-	-	-
Total financial liabilities [(i)]		**223,779**	**223,779**	**159,948**	**3,273**	**8,883**	**35,364**	**16,311**

(i) Ageing analysis of financial liabilities excludes statutory financial liabilities (i.e GST payable), deferred capital 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 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 equities and 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 2026	**Carrying amount $'000**	**Net result $'000**	**Net result $'000**
Contractual financial assets			
Investments	22,922	(4,584)	4,584
Total impact	**22,922**	**(4,584)**	**4,584**

		-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**

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, with the exception of right-of-use assets arising under AASB 16, which are measured using the cost model.

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 2026 $'000	Fair value measurement at end of reporting period using: Level 1 $'000	Level 2 $'000	Level 3 $'000
Managed investments	5.3	22,791	-	22,791	-
Equities		131	131	-	-
Total financial assets held at fair value through net result		**22,922**	**131**	**22,791**	**-**
Total investments at fair value		**22,922**	**131**	**22,791**	**-**

	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**	**-**

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.

Equities

Equities are valued at fair value with reference to a quoted (unadjusted) market price from an active market.

Melbourne Health classifies these instruments as Level 1.

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

	Note	Carrying amount 30 June 2026 $'000	Fair value measurement at end of reporting period using: Level 1 [i] $'000	Level 2 [i] $'000	Level 3 [i] $'000
Non-specialised land at fair value		28,830	-	28,830	-
Specialised land at fair value		243,361	-	-	243,361
Total land at fair value	4.1	**272,191**	**-**	**28,830**	**243,361**
Non-specialised buildings at fair value		10,536	-	10,536	-
Specialised buildings at fair value		577,365	-	3,047	574,318
Total building at fair value	4.1	**587,901**	**-**	**13,583**	**574,318**
Plant, equipment and vehicles at fair value		117,522	-	-	117,522
Total plant, equipment and vehicles at fair value	4.1	**117,522**	**-**	**-**	**117,522**
Total non-financial physical assets at fair value		**977,614**	**-**	**42,413**	**935,201**

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

	Note	Carrying amount 30 June 2025 $'000	Fair value measurement at end of reporting period using: Level 1 [i] $'000	Level 2 [i] $'000	Level 3 [i] $'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.

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 2026 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 2026.

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.

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

	Note	Land	Buildings	Plant, equipment and vehicles
		$'000	$'000	$'000
Balance at 1 July 2024		**302,035**	**748,688**	**101,328**
Additions/(disposals)		-	541	18,845
Assets received/(provided) free of charge		-	-	665
Net transfers between classes		-	20,865	7,894
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**
Additions/(disposals)		-	415	13,676
Assets received/(provided) free of charge		-	-	745
Net transfers between classes		-	6,697	29,471
Transfers in (out) of Level 3		-	(37,839)	(8,572)
Asset transfers via contributed capital		(58,674)	(48,004)	(290)
Gains/(losses) recognised in net result				
- Depreciation		-	(53,752)	(22,698)
- Disposals		-	-	(305)
Balance at 30 June 2026 [(ii)]	7.4(b)	**243,361**	**574,318**	**117,522**

(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

8.1 Reconciliation of net result to net cash flows from operating activities
8.2 Responsible persons disclosures
8.3 Remuneration of executives
8.4 Related parties
8.5 Remuneration of auditors
8.6 Ex-gratia expenses
8.7 Events occurring after the balance sheet date
8.8 Equity

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

	Note	Total 2026 $'000	Total 2025 $'000
Net result		(53,273)	8,461
Non-cash movements:			
(Gain)/loss from disposal of non-financial assets		(255)	(427)
Revaluation of financial assets at fair value through profit or loss		110	(1,085)
Depreciation and amortisation	4.3	96,484	98,087
Allowance for impairment losses of contractual receivables		1,639	1,012
DH non cash grants		(7,304)	(23,930)
Assets provided free of charge		-	175
Assets received free of charge		(1,326)	(734)
Other non cash movements		-	274
Movements in Assets and Liabilities:			
(Increase)/decrease in receivables and contract assets		(7,064)	(38,152)
(Increase)/decrease in inventories		(11,758)	(848)
(Increase)/decrease in prepayments		1,533	(5,533)
Increase/(decrease) in payables and contract liabilities		(2,974)	22,791
Increase/(decrease) in employee benefits		11,317	23,023
Increase/(decrease) in monies in trust		8	3
Net cash inflow/(outflow) from operating activities		**27,137**	**83,117**

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 2025 - 15 Apr 2026
Minister for Ambulance Services	01 Jul 2025 - 15 Apr 2026
The Honourable Harriet Shing MP:	
Minister for Health	15 Apr 2026 - 30 Jun 2026
Minister for Ambulance Services	15 Apr 2026 - 30 Jun 2026
The Honourable Melissa Horne MP:	
Minister for Health Infrastructure	01 Jul 2025 - 30 Jun 2026
The Honourable Ingrid Stitt MP:	
Minister for Mental Health	01 Jul 2025 - 30 Jun 2026
Minister for Ageing	01 Jul 2025 - 30 Jun 2026
The Honourable Lizzie Blandthorn MP:	
Minister for Children	01 Jul 2025 - 30 Jun 2026
Minister for Disability	01 Jul 2025 - 30 Jun 2026
Governing Board	
Ms Linda Bardo Nicholls AO (Chair of the Board)	01 Jul 2025 - 30 Jun 2026
Ms Emma Skinner	01 Jul 2025 - 30 Jun 2026
Mr Felix Walsh	01 Jul 2025 - 30 Jun 2026
Ms Kylie Bishop	01 Jul 2025 - 30 Jun 2026
Professor Mary O'Reilly	01 Jul 2025 - 30 Jun 2026
Ms Nicole Bartholomeusz	01 Jul 2025 - 30 Jun 2026
Mr Peter Funder	01 Jul 2025 - 30 Jun 2026
Ms Philippa Connolly	01 Jul 2025 - 30 Jun 2026
Mr Sam Lobley*	01 Jul 2025 - 30 Jun 2026
Accountable Officer	
Professor Shelley Dolan (Chief Executive Officer)	01 Jul 2025 - 30 Jun 2026

* Non paid board member

Remuneration of responsible persons

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

Income band	Total 2026 No.	Total 2025 No.
$0 - $9,999*	1	2
$50,000 - $59,999	1	1
$60,000 - $69,999	6	6
$110,000 - $119,999	-	1
$120,000 - $129,999	1	-
$630,000 - $639,999	-	1
$650,000 - $659,999	1	-
Total numbers	**10**	**11**

* Non paid board member

	Total 2026 $'000	Total 2025 $'000
Total remuneration received or due and receivable by responsible persons from the reporting entity amounted to:	**1,231**	**1,192**

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 2026 $'000	**Total 2025 $'000**
Short-term employee benefits	4,376	4,036
Post-employment benefits	359	341
Other long-term benefits	171	150
Termination benefits	117	-
Total remuneration [(i)]	**5,023**	**4,527**
Total number of executives	15	14
Total annualised employee equivalent [(ii)]	11.6	11.0

(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 Felix Walsh	Board Member
Ms Kylie Bishop	Board Member
Professor Mary O'Reilly	Board Member
Ms Nicole Bartholomeusz	Board Member
Mr Peter Funder	Board Member
Ms Philippa Connolly	Board Member
Mr Sam Lobley*	Board Member
Professor Shelley Dolan	Chief Executive Officer
Ms Amanda Armstrong	Chief People and Communications Officer
Dr Fergus Kerr	Chief Medical Officer
Ms Fleur Katsmartin	Chief Legal Officer | Corporate Secretary, Legal and Medico-Legal Services
Mr George Cozaris	Chief Digital Information Officer | Executive Director, Digital Innovation
Ms Jackie McLeod	Chief Operating Officer
Adjunct Professor Kethly Fallon	Chief Nursing Officer
Mr Paul Urquhart	Chief Corporate Officer | Chief Financial and Procurement Officer, Infrastructure and Clinical Support Services
Professor Peter Steel	Chief Transformation Officer (Joined 05 Jan 2026)
Mr Robert Rothnie	Chief Redevelopment Officer
Mr Ross Broad PSM	Chief Strategy Officer (Joined 16 Feb 2026)
Ms Samantha Plumb	Chief Quality Officer | Quality, Informatics and Improvement

* Non paid board member

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.

	Total 2026 $'000	Total 2025 $'000
Compensation - KMPs		
Short-term employee benefits	4,645	4,276
Post-employment benefits	357	343
Other long-term benefits	149	140
Total [(i)]	**5,151**	**4,759**

[(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 government related entities of $1,401m (2025: $1,406.4m). The Department of Health also paid $7.3m (2025: $23.9m) of construction costs on behalf of Melbourne Health.

Expenses incurred by Melbourne Health in delivering services 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 2026 (2025: Nil).

There were no related party transactions required to be disclosed for Melbourne Health Board of Directors, Chief Executive Officer and Executive Directors in 2026 (2025: Nil).

Note 8.5: Remuneration of auditors

	Total 2026 $'000	Total 2025 $'000
Victorian Auditor-General's Office		
Audit of the financial statements	233	222
Total remuneration of auditors	**233**	**222**

Note 8.6: Ex-gratia expenses

Melbourne Health has made the following ex-gratia expenses:	Total 2026 $'000	Total 2025 $'000
Compensation payment	10	42
Total ex-gratia expenses	**10**	**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

Public Pathology Victoria

Melbourne Health has been designated as the lead health service for the consolidated Public Pathology Victoria network for the Parkville Precinct under the Victorian Government's Pathology Reform Program. As part of this reform, pathology services from Melbourne Health, Royal Children's Hospital, Royal Women's Hospital and Peter MacCallum Cancer Centre are scheduled to transition to the new Public Pathology Victoria structure managed by Melbourne Health during the first half of 2026-27 financial year.

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 and buildings. The revaluation surplus is not normally transferred to the accumulated surpluses/(deficits) on derecognition of the relevant asset except for right-of-use asset revaluations previously recognised under the revaluation model.

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

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