Northern Health



Annual Report

2025-26



Our values are integral to the culture of care, team work and collaboration at Northern Health.

Our Vision

Creating a healthier future by working together, innovating and delivering great care.

Our Values

Our values are integral to the culture of care, team work and collaboration at Northern Health.

Our Priorities

Collaborate to deliver safe, efficient, effective and sustainable care in all our services

Demonstrate our commitment to the wellbeing of our valued workforce

Renew and strengthen our infrastructure, systems, tools and processes to financial sustainability and growth

Innovate to shape the future of health care in Victoria

Partner to keep people well and deliver the best possible care locally

Drive research and education to deliver excellent care and develop the next generation of clinicians and health care leaders



Safe

We provide safe, trusted care for our patients. We are inclusive and culturally safe, celebrating the diversity of our staff and community.



Kind

We treat everyone with kindness, respect and empathy. We provide patient-centred and compassionate care.



Together

We work together with our staff, patients, consumers and health system partners.

Acknowledgement

Northern Health acknowledges Victoria's Aboriginal communities and their rich culture and pays respect to their Elders past, present and emerging.

We acknowledge Aboriginal people as Australia's first peoples and as the Traditional Owners and custodians of the land (the Wurundjeri and Taungurung people) on which Northern Health's campuses are built.

We recognise and value the ongoing contribution of Aboriginal people and communities to our lives and we embrace the spirit of reconciliation, working towards the equality of outcomes and ensuring an equal voice.



Mandy Nicholson | Traditional Owner of the Wurundjeri, Dja Dja Wurrung and Ngurai Illam Wurrung, performed the smoking ceremony at the opening of the new Inpatient Psychiatric Unit at Northern Hospital.

Northern Health celebrates, values, and includes people of all backgrounds, genders, sexualities, cultures, bodies and abilities.

We acknowledge people with lived experience of mental ill-health and recovery and the experience of people who have been carers, families, or supporters.

Contents

05	Our Services
06	Our Locations
07	Message from the Board Chair and Chief Executive
09	Our care at a glance
11	Collaborate to deliver safe, efficient, effective and sustainable care in all our services
13	Demonstrate our commitment to the wellbeing of our valued workforce
15	Renew and strengthen our infrastructure, systems, tools and processes for financial sustainability and growth
16	Innovate to shape the future of health care in Victoria
17	Partner to keep people well and deliver the best possible care locally
20	Drive research and education to deliver excellent care and develop the next generation of clinicians and health care leaders
21	North Metro and Mitchell Local Health Service Network
23	Research Report
29	Aboriginal Health and Wellbeing Report
33	Environmental Sustainability
34	Environmental Scorecard
41	Northern Health Foundation
44	Volunteer Services
45	Organisational Structure
47	Board Directors
49	Corporate Governance
55	Statement of Priorities
55	Part A
61	Part B
65	Part C
66	Mental Health and Wellbeing Act 2022
67	Corporate Information
75	Attestations
78	Workforce Information
79	Financial Results
81	Disclosure Index
83	Financial Statements

Our Services

Northern Health is the leading health service provider for the large, diverse and dynamic Northern Growth Corridor in Melbourne's north.

Northern Health provides hospital, community, virtual and home-based services from Northern Hospital Epping, Broadmeadows Hospital, Kilmore District Hospital, Bundoora Centre, Craigieburn Community Hospital and Mernda Community Hospital. In addition, Northern Health provides acute and community-based mental health care for adults and older adults across Melbourne's northern and north-west suburbs.

The Northern Health catchment includes three of the state's highest growth areas – Hume, Whittlesea and Mitchell. The swift development of new suburbs in the north will see the region's population grow from 543,000 residents in 2021 to 970,000 by 2041.

The people and communities we serve are diverse in culture, socio-economic status, and health care needs. The community is made up of people from around 185 countries, speaking more than 100 different languages and following at least 90 different religions or beliefs.

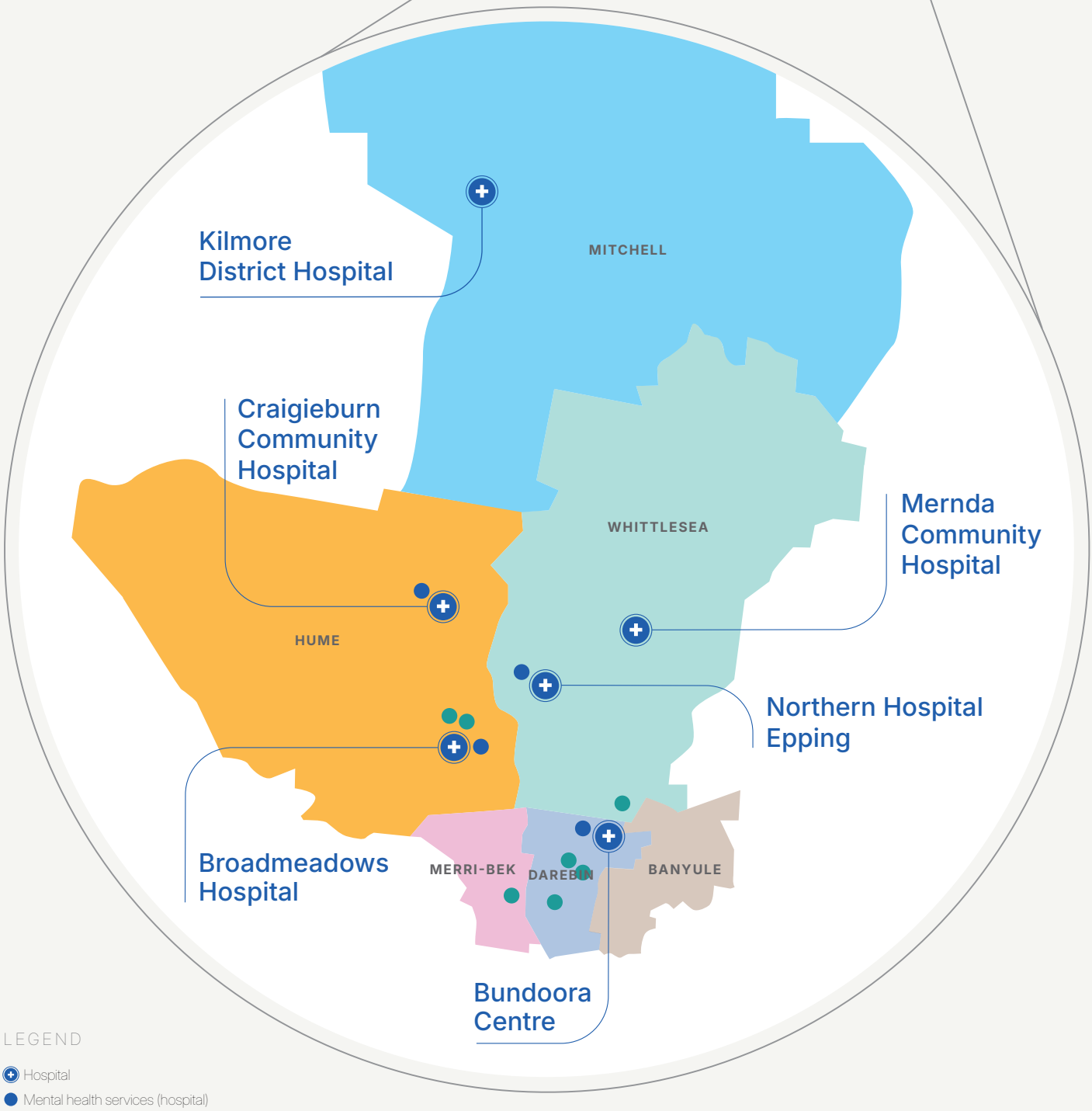


Our Locations

The map below shows the location of Northern Health's hospitals serving the three local government areas — Hume, Mitchell and Whittlesea — that make up the Northern Growth Corridor.

In addition, Northern Health provides acute and community based mental health care for adults and older adults at services across Melbourne's northern and north west suburbs.





LEGEND

- Hospital
- Mental health services (hospital)
- Mental health services (community)

Message from the Board Chair and Chief Executive

As we reflect on the 2025-26 year, we do so with an immense sense of pride in what Northern Health has achieved. This year has been one of growth, innovation and a continued commitment to delivering outstanding care for our rapidly growing community.

Northern Health continues to expand its services across Melbourne's north, with the openings of Craigieburn Community Hospital and Mernda Community Hospital. These significant milestones reflect the health service's commitment to improving access to high-quality care and delivering more services closer to home for the community we serve. As the major provider of health services in Melbourne's northern region, these hospitals are a vital part of meeting the demand of our rapidly growing community. Every service we provide reflects our values - safe care for every patient, kindness in every interaction, and working together with our community and partners.

Northern Health continued to perform strongly throughout the year, caring for more patients than ever before. Our Emergency Department remained the busiest in Victoria, with 121,506 emergency presentations, and over 35,000 arrivals by ambulance. The statewide Virtual Emergency Department (VED), established and operated by Northern Health, saw 320,129 presentations. This enabled 80 per cent of patients, who may have otherwise presented to a physical emergency department, to receive the care they need in the comfort of their own environment.

During the year, 133,745 patients were admitted to Northern Health, 25,337 non-emergency surgeries were performed, 323,679 specialist appointments were conducted, and 3,774 babies were born. The mental health division provided 278,150 hours of community care interactions with 3,366 admissions.

We also made significant progress in building for the future of healthcare. Construction of the Ambulatory Care Centre reached practical completion in June 2026, and was opened in August 2026. This important milestone marks the next phase of the Northern Hospital redevelopment program, with construction of the new Emergency Department expected to commence soon after, with anticipated completion by 2029. These developments will transform the way we deliver care for generations to come and improve capacity and accessibility of the state's busiest Emergency Department.

This year brought many achievements that reflect our commitment to excellence. Northern Health was recognised as an Employer of Choice in the Australian Business Awards 2025. This national recognition showcases Northern Health's dedication to creating a workplace where staff can thrive and feel truly supported and empowered to do their best work.

A key achievement was successfully completing our Australian Council on Healthcare Standards accreditation survey, meeting all accreditation requirements. The surveyors spoke very highly of the culture they experienced across Northern Health, recognising the kindness, professionalism and collaboration demonstrated by our people.

This recognition reflects the dedication of our staff in delivering consistently safe, high-quality care every day and is something every member of our organisation should feel incredibly proud of.

Another important milestone was the establishment of the Local Health Service Network, bringing together Northern Health, Austin Health, Mercy Hospital for Women, and Seymour Health. By working more closely together, we are creating stronger connections across Melbourne's north and the south Mitchell region to improve access, strengthen partnerships, and deliver more coordinated care for our communities. We look forward to what we can achieve together in the years ahead.

Northern Health also continued to lead the way in delivering innovative healthcare. From pioneering groundbreaking TransCarotid

Artery Revascularisation (TCAR) procedures, to introducing the da Vinci Xi robotic surgical system, one of the most advanced surgical technologies available today, our clinicians continue to embrace innovation that improves outcomes, enhances patient care, and bring cutting-edge technology to patients in Melbourne's north.

Northern Health delivers care and services to a richly diverse community, and this is something we pride ourselves on. We have a strong commitment to providing a culturally safe environment to a region made up of people from around 185 countries.

Notwithstanding sector-wide challenges, Northern Health maintained a clear focus on its priorities and delivered an operating surplus of $2.5m.

These achievements would not be possible without our dedicated workforce of more than 9,000 staff. Every day, our people demonstrate extraordinary skill and compassion while living our values of Safe, Kind, Together. Our staff, without question, are Northern Health's greatest asset, and we extend our sincere thanks for the outstanding care they provide to our patients, consumers and community.

Our sincere thanks also goes to the Northern Health Foundation for another successful year of fundraising. Through the generosity of our donors and supporters, the Foundation continues to make an important contribution towards enhancing patient care, advancing research and supporting innovation across Northern Health, including contributing to the purchase of the da Vinci Xi robotic surgical system.

We also acknowledge our volunteers, whose generosity, kindness and commitment enrich the experiences of patients, families and staff across our health service. Their contribution is invaluable, and we are deeply grateful for the time and care they so willingly give.

On behalf of the organisation, we thank the Executive team, and Northern Health Board for their exceptional leadership, guidance and unwavering commitment throughout the year. We also acknowledge the significant contributions of outgoing Board Directors Peter McDonald and John Watson. Across almost a decade of service, Peter and John have helped guide Northern Health through a period of remarkable growth and transformation. Their expertise, wisdom and commitment have helped shape the organisation we are today, and we sincerely thank them for their service.

Looking back on our first year working together as Board Chair and Chief Executive of Northern Health, we can honestly say we continue to be inspired by the people of Northern Health. Every day we see our staff, volunteers and leaders living our values of Safe, Kind, Together, and delivering exceptional care with compassion and professionalism. It is a privilege to serve alongside such dedicated people.

We have been continually impressed by the remarkable people who make Northern Health what it is. Ours is a humble health service delivering extraordinary care to one of Australia's fastest-growing communities. The dedication of our staff, volunteers, Board and partners gives us great confidence for the future.

Together, we have achieved a great deal this year, but our work continues. As we look ahead, we remain committed to delivering exceptional care, embracing innovation, strengthening partnerships, and ensuring Northern Health continues to meet the evolving needs of our community.

Thank you to everyone who has contributed to another successful year. It is an honour to be part of Northern Health, and we look forward to the opportunities the year ahead will undoubtedly bring.

In accordance with the Financial Management Act 1994, we are pleased to present the Report of Operations for Northern Health for the year ending 30 June 2026.



Adjunct Professor Alan Lilly
Board Chair
Northern Health
1 October 2026



Adjunct Professor Debra Bourne
Chief Executive
Northern Health
1 October 2026

Our care at a glance



Emergency presentations

121,506

▲ 2.3%

VED presentations*

320,129

▲ 25.9%

Paediatric emergency presentations

25,593

▲ 1%

Ambulance arrivals

35,049

▲ 4.5%

Elective surgical procedures

25,337

▲ 5%

Babies born

3,774

▲ 11.4%

Hospital admissions

133,745

▲ 3.1%

Figures accurate as of 23 July 2026

*Virtual Emergency Department

**Follow-up interactions with Mental Health patients, post-discharge

Percentages are based on a comparison from the 2024-25 financial year



Mental Health Community Care Contacts**

139,612

101% of funded activity delivered

Specialist Clinic appointments

323,679

▲ 6.1%

Mental Health Adult / Aged Admissions

3,366

▲ 19.3%

Urgent Care Centre Presentations

12,998

Comparative data for 2024-25 is not available, as Northern Health's Urgent Care Centres commenced operations in 2025-26.

Our Achievements

Collaborate to deliver safe, efficient, effective and sustainable care in all our services

Working together across services, disciplines and teams has remained central to Northern Health's commitment to delivering safe, timely and patient-centred care. Throughout the year, collaborative partnerships, innovative models of care and continuous improvement initiatives strengthened the way patients access services while supporting better health outcomes for our growing community.

A significant milestone was the establishment of the North Metro and Mitchell Local Health Service Network, bringing Northern Health together with Austin Health, Mercy Health (Mercy Hospital for Women) and Seymour Health. The Network creates new opportunities to improve access, equity and patient flow, strengthen workforce capability, enhance safety and quality, and streamline shared services while allowing each organisation to retain its own identity and connection with the communities it serves. By working together across the Network, Northern Health is helping build a more connected healthcare system that delivers care closer to home and improves the patient journey.

Collaboration also underpinned Northern Health's successful accreditation against the National Safety and Quality Health Service Standards. Achieving accreditation across all sites and services reflected the dedication of staff to delivering consistently safe, high-quality care, and demonstrated a shared commitment to continuous improvement. The survey highlighted the strength of Northern Health's culture of quality, teamwork and patient-centred care, recognising the organisation's ongoing focus on meeting the highest national standards.

Improving patient flow and ensuring people receive the right care in the right place at the right time remained a major focus throughout the year. The successful completion of the Timely Emergency Care 2 (TEC2) – Excellence in Flow program marked the culmination of several years of collaborative improvement work across emergency, inpatient and community services.

Through initiatives including the Geriatric Emergency Department Intervention (GEDI) model, Ready Steady Home, enhanced care coordination and Progression of Care, TEC2 delivered sustained improvements in patient flow, reduced hospital length of stay and supported more patients, particularly older people, to safely remain at home whenever possible. The program also strengthened collaboration across teams and reinforced Northern Health's values of Safe. Kind. Together, ensuring its legacy continues to inform future improvement initiatives.

Supporting these improvements, Northern Health introduced new Ambulance Victoria transition cubicles within the emergency department to help patients receive care sooner while reducing ambulance handover delays. Located adjacent to the ambulance entrance, the dedicated clinical spaces allow assessment and treatment to begin immediately following arrival. Additional senior medical and nursing staff enable earlier assessment and faster clinical decision-making, improving patient flow while helping Ambulance Victoria crews return to the community more quickly. The initiative reflects Northern Health's continued investment in delivering timely emergency care for Victoria's busiest emergency department.

Innovation also continued to reshape the way emergency care is delivered. The introduction of the Virtual Liaison Nurse pilot, delivered in partnership with the Virtual Emergency Department, has improved access to safe and timely care by identifying suitable patients who can be assessed virtually rather than waiting in the emergency department. Since commencing, the model has successfully diverted the majority of referred patients away from the emergency department while maintaining high levels of patient satisfaction and confidence in the care provided. The initiative demonstrates the benefits of strong collaboration between emergency department clinicians, virtual health, radiology, specialist services and clinical operations, creating a more connected and efficient model of care while preserving emergency capacity for patients requiring in-person treatment.



Northern Health's commitment to excellence was also recognised internationally, becoming the first health service in Australia to be named an International Anticoagulation Centre of Excellence. The recognition acknowledged Northern Health's leadership in delivering evidence-based anticoagulation care, advancing education and research, and maintaining high standards of patient safety. It reflects the expertise and dedication of multidisciplinary teams who continue to improve outcomes for patients through innovation, collaboration and clinical excellence.

Together, these achievements demonstrate Northern Health's commitment to working across services, disciplines and organisations to improve access, strengthen quality and deliver sustainable models of care. By embracing innovation, fostering collaboration and maintaining a strong focus on continuous improvement, Northern Health continues to provide safe, effective and patient-centred care for the communities of Melbourne's north.

Demonstrate our commitment to the wellbeing of our valued workforce

Northern Health staff are at the heart of the organisation. Throughout the year, Northern Health continued to invest in initiatives that support the wellbeing, development, and recognition of its workforce, ensuring employees are equipped to provide exceptional care while feeling valued, connected, and supported in their roles.

This commitment was recognised nationally when Northern Health was named an Employer of Choice in the Australian Business Awards 2025. The award acknowledged the organisation's dedication to creating a workplace where people can thrive through strong leadership, professional development, employee wellbeing and an inclusive culture. It reflects the collective efforts of teams across the organisation to foster an environment where staff feel supported to deliver their best for patients and each other.

Listening to our people remains fundamental to strengthening our workplace culture. In this year's People Matter Survey, Northern Health recorded its highest participation rate achieved to date. This encouraging result reflects the willingness of staff across the organisation to share their experiences and perspectives. Hearing directly from our staff provides valuable insight into what Northern Health is doing well while identifying opportunities to further enhance the workplace, ensuring staff voices continue to shape organisational improvement and future priorities.

Supporting staff wellbeing remained a key focus throughout the year. The expansion of Northern Health's Staff Peer Support Program has strengthened the support available to employees. Delivered by trained peer supporters from across the organisation, the program provides confidential, compassionate support from colleagues who understand the unique challenges of working in healthcare. The continued growth of the program demonstrates Northern Health's commitment to fostering psychological safety, resilience and a culture where staff feel comfortable seeking support when they need it.

Wellbeing initiatives also extended beyond formal support services. The Morning Movement program continued to encourage staff to prioritise their physical and mental wellbeing through regular group exercise sessions before work. By creating opportunities for staff to connect, improve their health and begin the day positively, the initiative supports a healthy workplace culture while reinforcing the importance of self-care in demanding healthcare environments.

Investing in the future workforce remained a priority, with the welcoming of the 2026 Graduate Nurses and Midwives. The new graduates joined Northern Health across a broad range of clinical areas, supported by comprehensive education, structured learning opportunities and experienced educators and preceptors. The graduate program provides a strong foundation for early career clinicians, helping them build confidence, develop clinical capability and establish rewarding careers within Northern Health.

Professional growth was further supported through the launch of Northern Doctors Education's Peer-to-Peer Mentoring Program, providing junior doctors with valuable guidance, encouragement and practical support from more experienced colleagues. The program promotes professional development, strengthens connections across the medical workforce and fosters a culture of learning, collaboration and shared experience. By creating opportunities for mentorship and peer support, Northern Health continues to invest in developing confident and capable clinicians.

Recognising the contributions of all members of the workforce is equally important. During the year, Northern Health celebrated Administrative Professionals Day, acknowledging the dedication and expertise of administrative staff who play a vital role in the delivery of safe, efficient and compassionate healthcare. Often working behind the scenes, these teams provide essential support that enables clinical services to operate effectively and ensures patients, families and staff receive a positive experience across the organisation.

Together, these initiatives reflect Northern Health's ongoing commitment to creating a workplace where staff feel valued, supported and empowered to succeed. Through investment in wellbeing, professional development, recognition and meaningful engagement, Northern Health continues to strengthen its workforce and foster a positive culture that enables staff to deliver exceptional care to the communities we serve.



Supporting staff wellbeing remained a key focus throughout the year.



Renew and strengthen our infrastructure, systems, tools and processes for financial sustainability and growth

Northern Health continues to invest in infrastructure, technology and contemporary models of care to meet the growing healthcare needs of Melbourne's north. Throughout the year, significant milestones were achieved across new facilities, digital transformation and capital projects, strengthening the organisation's capacity to deliver safe, efficient and sustainable healthcare now and into the future.

A major milestone was the official opening of Craigieburn Community Hospital, delivering more healthcare services closer to home for one of Victoria's fastest-growing communities. Operated by Northern Health, the purpose-built facility provides a broad range of outpatient and community-based services, including dialysis, diagnostic imaging, specialist clinics, allied health, chemotherapy and urgent care. By improving access to local care, the hospital is reducing the need for patients to travel to larger metropolitan hospitals while supporting better health outcomes within the community.

The expansion of community-based healthcare continued with the opening of Mernda Community Hospital, another significant investment in improving access to high-quality healthcare across Melbourne's north. The facility offers a range of multidisciplinary services designed to meet increasing demand closer to where people live, providing greater convenience for patients while helping relieve pressure on acute hospital services. Together with Craigieburn Community Hospital, the two community hospitals

represent an important step towards delivering more integrated, accessible and sustainable healthcare for the region's rapidly growing population.

Significant progress was also made on the Ambulatory Care Centre at Northern Hospital Epping, which reached practical completion in June 2026. The new facility provides modern, purpose-built spaces to support outpatient services, clinical care and administrative functions, creating contemporary environments designed to meet the needs of patients, staff and the growing community. The Ambulatory Care Centre opened in August 2026, and represents a key enabling step for the future construction of the new Emergency Department at Northern Hospital Epping. Relocating outpatient and administrative services into the new building will create the capacity required for this major redevelopment, supporting Northern Health's long-term vision for expanded emergency care and future service growth.

Digital transformation also progressed, with Kilmore District Hospital successfully launching its Electronic Medical Record (EMR) system. The implementation marked a significant advancement in the delivery of patient care, providing clinicians with real-time access to comprehensive patient information and improving communication, clinical decision-making and continuity of care. The new system also strengthens patient safety, streamlines workflows and aligns Kilmore District Hospital with contemporary digital healthcare practices across the broader Northern Health network.

Building on this work, Northern Health achieved another important digital milestone through the integration of Emergency Mental Health Services into the Electronic Medical Record. The enhancement enables clinicians to access more complete and timelier patient information, improving communication and coordination between emergency, mental health and multidisciplinary teams. By bringing mental health documentation into a single integrated system, the project supports safer, more connected care while reducing duplication and strengthening clinical decision-making for some of the organisation's most vulnerable patients.

Together, these achievements demonstrate Northern Health's commitment to investing in modern infrastructure, innovative technology and future-focused planning. By expanding community-based services, strengthening digital capability and delivering major capital projects, Northern Health is creating a more connected, efficient and sustainable health service that is well positioned to meet the needs of one of Australia's fastest-growing regions for many years to come.

Innovate to shape the future of health care in Victoria

Innovation continues to drive Northern Health's commitment to delivering world-class healthcare, with the organisation leading new models of care, pioneering research and introducing advanced technologies that are shaping the future of healthcare in Victoria and beyond. Throughout the year, clinicians, researchers and partners worked together to translate innovation into improved patient outcomes, ensuring the community benefits from the latest advances in medicine, digital health and clinical practice.

Northern Health reached a significant milestone in stroke prevention by becoming the first health service in Victoria to perform a groundbreaking transcarotid artery revascularisation (TCAR) procedure. The minimally invasive technique offers a safer treatment option for selected patients with carotid artery disease by reducing the risk of stroke during surgery. Introducing this advanced procedure demonstrates Northern Health's commitment to providing patients with access to leading-edge treatments while continuing to expand the range of highly specialised services available closer to home.

The introduction of the da Vinci Xi robotic surgical system, one of the most advanced surgical technologies available today, marked another significant advancement in patient care. The addition of this leading technology expands treatment options for more than an estimated 200 patients each year undergoing treatment for prostate, kidney, bladder, lung, and bowel cancers. The robot will support greater precision, smaller incisions, and provide fewer complications and shorter hospital stays for patients. The program also strengthens Northern Health's ability to attract and retain highly skilled clinicians while ensuring patients can access advanced surgical care closer to home.

The organisation also strengthened its position as a leader in clinical research by becoming the first site in the world to enrol a patient in an innovative first-in-human vascular clinical trial. The landmark

study explores a next-generation treatment designed to improve outcomes for patients with complex vascular disease. Participation in global research of this scale highlights Northern Health's growing reputation for research excellence and reinforces its commitment to providing patients with early access to emerging therapies while contributing to advances in international medical knowledge.

Innovation extended to the bedside through an Australian-first study exploring the use of artificial intelligence to support Point-of-Care Ultrasound (POCUS) in clinical practice. Led by Northern Health clinicians and researchers, the study is evaluating how artificial intelligence can assist clinicians to acquire and interpret ultrasound images, improving confidence, efficiency and diagnostic capability. By combining advanced technology with clinical expertise, the project has the potential to enhance patient care while supporting workforce capability and expanding access to timely bedside imaging across a range of clinical settings.

Recognising the growing role of virtual care in the future of healthcare, Northern Health also launched the Victorian Centre for Virtual Health Research. The Centre brings together clinicians, researchers, consumers, universities and industry partners to build the evidence base for virtual healthcare and evaluate innovative models of care. By driving research into digital health, virtual care and emerging technologies, the Centre aims to improve patient outcomes, inform future healthcare delivery and position Victoria as a leader in virtual health innovation.

Together, these achievements demonstrate Northern Health's commitment to innovation across research, technology and clinical care. By embracing new ideas, pioneering advanced treatments and collaborating with research and industry partners, Northern Health is helping shape the future of healthcare in Victoria while ensuring patients across Melbourne's north have access to safe, high-quality and innovative care.

Partner to keep people well and deliver the best possible care locally

Northern Health continued to strengthen partnerships with consumers, healthcare providers, universities and statewide services to improve access to care and deliver better health outcomes for the communities of Melbourne's north. Throughout the year, new services, innovative models of care and collaborative approaches expanded opportunities for patients to receive timely, specialist care closer to home while ensuring services remain responsive to the changing needs of the community.

A significant milestone was the launch of the National Lung Cancer Screening Program at Northern Health, supporting the early detection of lung cancer for people at high risk of the disease. As one of the health services delivering the national program, Northern Health is working closely with primary care providers and community partners to improve access to screening, promote early diagnosis and ultimately improve patient outcomes. The program represents an important step in reducing the burden of lung cancer through prevention, early intervention and coordinated care.

Northern Health also expanded access to respiratory care through the introduction of Virtual Pulmonary Rehabilitation, making specialist rehabilitation services available to patients across Victoria, regardless of where they live. Delivered through virtual technology, the program enables people living with chronic respiratory conditions to participate in supervised exercise, education and self-management support from their own homes. By removing barriers associated with travel and distance, the service improves equity of access while providing patients with greater flexibility to manage their health within their local communities.

Access to specialised diagnostic services also increased with the introduction of Adrenal Venous Sampling (AVS) at Northern Hospital Epping. The new procedure allows patients with primary aldosteronism to undergo important diagnostic testing closer to home, reducing the need to travel to other metropolitan hospitals. The service strengthens Northern Health's endocrine and interventional radiology capabilities while improving convenience, continuity of care and access to highly specialised treatment pathways for patients across the region.

Partnership with consumers remained central to service improvement throughout the year. Northern Health's Allied Health Consumer Partnership Program continued to bring together clinicians, students and consumers to ensure lived experience informs education, service design and quality improvement initiatives. By embedding consumer voices into teaching and learning,


Radiology
Bay 6
Urgent Care



the program is strengthening future healthcare professionals' understanding of person-centred care while fostering meaningful collaboration that enhances both education and clinical practice.

Northern Health also expanded specialist services with the launch of its first dedicated public sleep service, improving access to assessment, diagnosis and treatment for patients experiencing sleep disorders. Bringing together multidisciplinary expertise, the service provides comprehensive care for a range of complex sleep conditions while reducing the need for patients to seek care outside the region. The new service reflects Northern Health's commitment to delivering specialist care locally and improving health outcomes through integrated, patient-centred models of care.

Together, these initiatives demonstrate Northern Health's commitment to partnering with patients, consumers, healthcare providers and the broader community to improve access to high-quality care. By expanding specialist services, embracing innovative models of care and strengthening collaboration across the health system, Northern Health continues to deliver care closer to home while supporting healthier communities across Melbourne's north.

Drive research and education to deliver excellent care and develop the next generation of clinicians and health care leaders

Research, education and knowledge sharing continues to play a vital role in advancing patient care at Northern Health. Throughout the year, the organisation strengthened its commitment to developing future healthcare leaders, supporting clinician-led research and creating opportunities to translate new knowledge into better outcomes for patients, both locally and internationally.

Northern Health's expertise extended beyond Australia's borders when our very own vascular surgeons supported Fiji's first-ever Endovascular Aneurysm Repair (EVAR) procedure. Working alongside local clinicians, the Northern Health team shared specialist knowledge and technical expertise to help establish the procedure within Fiji's healthcare system. The milestone highlights the organisation's commitment to education, global collaboration and building clinical capability, demonstrating how partnerships can improve access to advanced healthcare for communities beyond Melbourne's north.

Supporting the development of emerging healthcare leaders also remained a priority. Dr Karen Kiang was awarded a prestigious fellowship through the Melbourne Academic Centre for Health, recognising her leadership and commitment to improving healthcare through research, innovation and collaboration. The fellowship provides opportunities to further develop leadership capability while strengthening connections across the academic and health sectors, reinforcing Northern Health's commitment to nurturing clinicians who will shape the future of healthcare.

Investment in leadership development was further strengthened through the launch of the CARE Fellowship at Northern Health. The program provides clinicians with dedicated opportunities to undertake quality improvement, education and research projects while developing leadership skills that support both professional growth and organisational improvement. By fostering innovation and empowering staff to lead change, the fellowship contributes to a culture of continuous learning and excellence across the health service.

Northern Health also secured national recognition for its research leadership through a $1.4 million national research trial focused on falls prevention. Led by Northern Health researchers, the study aims to evaluate innovative approaches to reducing falls in hospital settings, addressing one of the most common risks to patient safety. The collaborative project brings together health services and research partners from across Australia, reflecting Northern Health's growing reputation for leading large-scale research that has the potential to improve care well beyond the organisation.

Research excellence was further recognised through Professor Lisa Hui's successful Medical Research Future Fund (MRFF) grant to advance research in perinatal genomics. The nationally competitive funding will support research aimed at improving prenatal diagnosis and expanding understanding of genetic conditions during pregnancy. The project demonstrates Northern Health's ongoing commitment to translational research that informs clinical practice, enhances patient care and contributes to the future of precision medicine.

Together, these achievements demonstrate Northern Health's commitment to advancing healthcare through research, education and leadership. By investing in clinicians, fostering innovation and collaborating with academic, clinical and international partners, Northern Health continues to build the knowledge, capability and leadership required to deliver outstanding care today, while preparing the next generation of healthcare professionals for the future.

North Metro and Mitchell Local Health Service Network

On 1 July 2025, Victoria's Local Health Service Networks (Networks) were officially established. The Networks group health services within a geographical region and are responsible for supporting collaborative care for their community, as close to home as possible.

Northern Health forms part of the North Metro and Mitchell Local Health Service Network, together with Austin Health, Mercy Health (Mercy Hospital for Women) and Seymour District Health.

North Metro and Mitchell Local Health Service Network

Austin Health | Mercy Health Care first | Northern Health | Seymour Health



The map shows the location of hospitals and mental health services managed by each of the four partners - Seymour Health, Northern Health, Mercy Hospital for Women and Austin Health.





LEGEND

- Northern Health (main sites)
- Northern Health (other sites)
- Mercy Hospital for Women (main site)
- Mercy Hospital for Women (other sites)
- Austin Health (main sites)
- Austin Health (other sites)
- Seymour Health

Research Report

The Research Executive Committee, in conjunction with the Research Development and Governance Unit (RDGU), is pleased to report a year of strong growth and transformation in research at Northern Health. Highlights for the 2025-26 financial year include:

Academic Partnerships

RMIT University

The Northern Health – RMIT Clinical Translational Research Partnership (CTRP) was established in May 2024. Since inception, the CTRP has expanded its impact across multiple clinical specialties, advancing diagnostics from laboratory research towards clinical application. Key achievements include published and ongoing work in haematology, thrombosis, metabolic disease, chronic kidney disease, sepsis, gastroenterology, and kidney biomarkers. Key collaborations have delivered novel discoveries in orthopaedics and neonatal medicine, including potential intellectual property opportunities and an international study on neonatal NEC. The program has strengthened its technical personnel, secured research funding, supported clinician-researcher training, expanded PhD and internship pathways, and fostered strong industry, hospital, and university partnerships to accelerate translation into patient care.

La Trobe University

The Equity, Diversity and Inclusion research partnership between Northern Health and La Trobe University, established in January 2025, expanded across several fronts this year. It continued to support four PhD projects focused on virtual and equitable models of care, and for the first time offered two co-funded PhD scholarships (commencing late 2026)



to enable clinicians and emerging researchers to undertake doctoral studies embedded within the health service. The partnership produced key peer-reviewed publications strengthening the evidence base for inclusive care, covering topics such as co-designed peer navigator roles, telehealth access for people experiencing homelessness, digital care pathways, and virtual emergency department models. Workforce research capability was another major focus, with the Stepping into Research program extended into Nursing and the new Clinical Audit for Research and Evaluation Fellowship launched to provide clinicians with protected, mentored research time – including a project on Aboriginal employment and cultural safety led by Andrew Morrison. Finally, the partnership achieved notable grant success, including $398,000 from the Ramsay Foundation for CALD-focused work, a Care Economy grant, and a $10,000 small research grant to Narelle Frazer for culturally adapting a falls prevention program (leveraging a $1.5M MRFF-funded trial), while building a pipeline of further submissions to NHMRC, FightMND and others to sustain growth in externally funded, equity-focused research.

National Clinical Trials Governance Framework

In May 2026, Northern Health successfully completed its second assessment against the National Clinical Trials Governance Framework (NCTGF) as part of accreditation against the National Safety and Quality Health Service (NSQHS) Standards. The assessment reaffirmed Northern Health's commitment to delivering high quality, safe and well governed clinical trials.

At the time of the assessment, Northern Health was conducting 99 clinical trials across 18 departments and two sites, involving more than 2,500 participants. The external assessor reviewed 29 clinical trials spanning a broad range of clinical specialties, trial phases and participant cohorts, reflecting the scale and diversity of the organisation's research portfolio.

The assessment recognised Northern Health's commitment to expanding equitable access to clinical trials, including initiatives to improve participation by culturally and linguistically diverse communities and First Nations peoples. Assessors also acknowledged the organisation's ongoing focus on strengthening consumer involvement in research.

Fully mature systems were identified across almost all of the Framework's actions, confirming that Northern Health has the governance, foundations and quality systems to support continued growth and improvement. With initiatives already underway to further strengthen consumer engagement and participant feedback, Northern Health is well positioned to continue building on these achievements and delivering high-quality clinical research for the communities it serves.

MACH fellowship recipients

Belinda Baines, Podiatry Research and Quality Lead and Renal Podiatrist at Northern Health and Project Lead in Digital Health at La Trobe University, was awarded a Melbourne Academic Centre for Health 2026 MACH Track Fellowship. The fellowship will enable Ms Baines to combine postgraduate research training with clinical work as she works towards completing her PhD.

Dr Sing Tan, Intensive Care Specialist and Director of Digital Clinical Innovation at Northern Health was awarded a 2026 MacHSR Future Leaders Fellowship. His project, 'Development and Implementation of an AI-enabled Real-Time Early Warning System for Critical Care Resource Optimisation' aims to support translation of a high-performing AI prediction model into a validated, clinical AI system.

Research Projects

During the 2025–26 financial year, Northern Health commenced 151 new quality improvement and research projects across 61 departments, reflecting the breadth and diversity of research activity across the organisation. These included issuing governance authorisation for 48 ethically approved projects, including 20 new clinical trials (11 Phase III, seven Phase II and two Phase I studies). In addition, 38 lower risk (Non-HREC)projects and 65 quality assurance projects were approved to commence.

Research continued to be strongly investigator-led, with 98 projects initiated by Northern Health researchers. Across the year, more than 1,700 patients participated in research, reinforcing Northern Health's commitment to advancing evidence-based care and improving health outcomes through high-quality research and innovation.

Research Funding

In collaboration with our research partners, Northern Health research was boosted by continued and growing success in obtaining competitive research funding. Highlights include:

Project Title: Musculoskeletal Wellness Program: A virtual pre-operative program to support older adults through joint replacement surgery.

Chief Investigator:
Professor Adam Semciw

Northern Health Investigators:
Professor Adam Semciw, Dr Juliette Gentle, Soheil Ghan Asle, A/Prof Rebecca Jessup, Rebecca Galea-O'Neil, Dr Hazel Heng, Dr Mani Suleiman, Dr Stephen Quick

Grant Type: Ramsay Health Research Foundation

Funding total: $398,498

Project Title: Transforming healthcare at the Melbourne Academic Centre for Health

Chief Investigator:
Professor John Savill (University of Melbourne)

Northern Health Investigators:
A/Prof Sanjeevan Muruganandan

Grant Type: NHMRC-accredited Research Translation Centres, MACH

Funding total: $1M

Project Title: Transforming the delivery of acute cardiac care: Getting the right patient, the right care, at the right time and place

Chief Investigator: Professor Dion Stubb (Monash University)

Northern Health Investigators:
Dr Loren Sher

Grant Type: NHMRC Partnership Project

Funding total: $1.5M

Project Title: TIM TAMS: Placental Health Test to Prevent Stillbirths and Adverse Pregnancy

Chief Investigator: Professor Stephen Tong (University of Melbourne)

Northern Health Investigators:
Professor Lisa Hui

Grant Type: MRFF Targeted Competitive - Emerging Priorities and Consumer Driven Research 2024

Funding total: $2M

Project Title: Defining and overcoming disease drivers in pregnancy to ensure pregnancies are safe and protected

Chief Investigator: Professor Katherine Kedzierska (Doherty Institute)

Northern Health Investigators:
Professor Lisa Hui

Grant Type: NHMRC Synergy Grants

Funding total: $5M

Internal Research Grant Scheme

To support the growth of Northern Health-led research, a variety of research grants were made available under the Northern Health Research Grants Program.

These grants benefit the Northern Health community through new knowledge generation, support the development of research ideas towards external funding success, enhance research culture and support staff development.

To address craft group under-representation, and to support the strategic research priorities of Northern Health, a targeted call for nursing and mental health research projects was made.

The successful grant recipients included:

Northern Health Foundation Grant

Hui Yin Lim, Northern Pathology Victoria, Northern Clinical Diagnostic and Thrombovascular Research (NECTAR)

Project Title: Integrated Cohort Study Evaluating Novel Coagulation Assays and Digital Technology in Chronic Kidney Disease (ICONIC)

Research @ Northern Grants

Russell Hodgson, Surgery

Project Title: Sustainable Management and Audit of Refuse in Theatres: Bin Innovation for Northern Sustainability (SMART BINS)

Odette Taylor, Health Information Services

Project Title: Artificial intelligence in clinical coding: A performance analysis of accuracy, speed and efficiency

Victor Duong, Respiratory and Sleep Medicine

Project Title: Home nocturnal respiratory rate monitoring to identify recurrence of malignant pleural effusion

Grants in Aid – General

Narelle Frazer, Allied Health

Project Title: Enhancing Falls Prevention for CALD Patients: Adaptation of Safe Recovery Program Resources,

Gemma Monaghan, Dietetics & Orthopaedics

Project Title: Are improvements in diet quality and weight associated with enhanced function, perceived health status and pain in individuals with Osteoarthritis?

Georgios Zisis, Cardiology

Project Title: Patient journey post myocardial infraction of otherwise low-risk profile for Myocardial Infarction recurrence. An observational single site prospective cohort study- AURORA-MI

Grants in Aid – Targeted Call – Nursing

Elise Sutton, Simulation and Safety / Quality & Safety

Project Title: Evaluating the effect of colour-coded scrubs on communication and role clarity in rapid response teams

Grants in Aid – Targeted Call – Mental Health

Trudy Brown, Mental Health

Project Title: Nurse practitioner led sexual and reproductive health care in mental health inpatient units, Mental Health

Research Week

Northern Health Research Week 2025 took place in October, delivering another successful program that highlighted the continued growth of research across Northern Health and its partners. The event attracted 96 abstract submissions, a 23 per cent increase on 2024, demonstrating the expanding breadth and diversity of research activity.

The week-long program featured oral presentations, poster sessions and a digital poster gallery, alongside daily keynote presentations and themed sessions exploring areas such as digital health, translational research and innovation in care delivery. A Surgical Research Forum and rapid fire presentations further showcased the range of research being undertaken across the organisation.

Keynote speakers included Professor Vassilis Kostakos (University of Melbourne), who presented on the role of big data and human-computer interaction in healthcare; Professor James Boyd (La Trobe University), who discussed opportunities in digital health; and Professor Vasso Apostolopoulos (RMIT University), who highlighted advances in translational research. Additional presentations from Associate Professor Sam Forster (Hudson Institute) and internal leaders such as Dr Katharine See further emphasised innovations in microbiome research and digital care pathways.

The week concluded with a Northern Health Foundation Research Breakfast, collaborative presentations with RMIT University, and a light hearted Great Debate, before culminating in the announcement of award winners across poster and oral presentation categories. The annual Peter Brooks Research Award for the best abstract oral presentation was awarded to Ella Francis for her project entitled “Pre-operative fasting times and the incidence of regurgitation and aspiration -a single-network retrospective data analysis.”

Overall, Research Week 2025 celebrated the continued growth, collaboration, and impact of research at Northern Health, reinforcing its role in improving care and outcomes for the community.

Research Publications

In the 2025-26 financial year, Northern Health researchers led, or contributed to, 286 articles in scientific journals, and 122 published conference abstracts. Some examples include:

- Dominic Chow and colleagues published the results of a randomised controlled trial showing that in people with heart rhythm problems, a newer pacing method called conduction system pacing (CSP) led to fewer heart complications and fewer patients needing additional heart devices than standard pacing (Chow CLD, et al. Clinical Outcomes of Conduction System Pacing vs Right Ventricular Septal Pacing in Atrioventricular Block: The CSPACE Randomized Controlled Trial. J Am Coll Cardiol. 2025 Aug 26;86(8):563-573).
- Rami Subhi and colleagues published a review that found that hospital emergency care for children improves outcomes through three linked mechanisms: legitimacy (permission and expectations), capability (skills and confidence), and connectedness (team coordination). Understanding these helps leaders adapt and prioritise interventions in low-resource settings (Subhi R, et al. From permission to pride: a realist synthesis of how to improve emergency care for children in low-income and lower-middle-income countries. Lancet Glob Health. 2026 Jun 12:103972).
- Vinay Lakra and colleagues examined whether socioeconomic disadvantage influences mental health treatment outcomes. Among community mental health clients, improvements were greater for those with stronger financial resources and household support, while neighbourhood disadvantage, Indigenous status, and language background were not associated with outcomes (Lakra V et al. Individual Socioeconomic Measures and Change in HoNOS Scores among Persons Attending Adult Community Mental Health Services. Community Ment Health J. 2026 Feb 11).
- Emily Farrugia and colleagues investigated whether people with motor neurone disease (MND) have more feeding tube problems than others. While people with MND were more likely to develop excess tissue around the tube site, they were no more likely to need unexpected tube replacements than patients with other conditions (Farrugia E et al. Incidence of unplanned gastrostomy tube replacements and associated complications in people with motor neurone disease and other conditions: A retrospective audit of an Australian dietitian-led clinic. Nutr Clin Pract. 2026 Jun 21).

Over the next 12 months, the Research Executive Committee and Research Development and Governance Unit look forward to continued growth and development of research at Northern Health, and to driving continuous improvement in clinical care and better health outcomes for the people of Melbourne's north and beyond.





Aboriginal Health and Wellbeing Report

The Narrun Wilip-giin Aboriginal Support Unit continues to lead and support Northern Health's work to improve the health, wellbeing and healthcare experiences of Aboriginal and Torres Strait Islander people.

As Northern Health's Aboriginal Support Unit, we work across the organisation to ensure Aboriginal culture, community voice, cultural safety and self-determination are reflected in the way services are planned, delivered and evaluated.

Our work is guided by Northern Health's Aboriginal Cultural Safety Plan and Aboriginal Employment Plan. More importantly, it is informed by Aboriginal patients, families, Elders, community organisations and staff.

We know that Aboriginal health is about more than the treatment of illness. It is connected to family, culture, community, identity and Country. Our role is to support our people through the health system while also challenging and changing the systems that have not always delivered culturally safe, accessible or equitable care.

We are not here to simply meet targets or tick boxes. We are here to advocate, hold space, build relationships and support Northern Health to become a service where Aboriginal people feel culturally safe, respected and heard.

Supporting Our Community

We know that too many of our mob still walk away. During 2025–26, Aboriginal and Torres Strait Islander people continued to access a broad range of services across Northern Health.

Across the financial year, Northern Health recorded:

- 79 Aboriginal babies born;
- 3,312 Aboriginal presentations to the Emergency Department;
- 2,611 Aboriginal inpatient episodes;
- 7,327 Aboriginal outpatient appointments; and
- 8,803 Aboriginal presentations through the Virtual Emergency Department.

Behind every number is an Aboriginal person, family and community.

These figures demonstrate why cultural safety cannot sit with the Aboriginal Support Unit alone. It must be embedded across every clinical area, department, campus and level of leadership within Northern Health.

Throughout the year, our team provided cultural support, advocacy, system navigation, care coordination and connection to community services for Aboriginal patients and their families.

This support was delivered across emergency care, inpatient wards, mental health, maternity, outpatient services and virtual care.

Improving the Emergency Department Experience

We know that Aboriginal people continue to leave emergency care before being seen or before completing treatment.

This cannot be viewed only as a patient issue. People may leave because of long waiting times, previous experiences of racism or discrimination, family and caring responsibilities, transport difficulties, poor communication or not feeling culturally safe.

During the year, our unit continued to support the Emergency Department SMS initiative for Aboriginal patients who left before receiving care.

The message encouraged patients to return if they remained unwell, provided information

about the Virtual Emergency Department, and offered further pathways to support.

The initial pilot involved 97 messages. Approximately nine per cent of recipients returned for care or accessed virtual emergency care following the message.

While the results were modest, the initiative demonstrated that respectful follow-up can help reconnect Aboriginal patients with care.

We continued to work with Emergency Department, virtual care and health information teams to strengthen the initiative through clearer messaging, improved data collection, Aboriginal Liaison Officer follow-up and stronger referral pathways.

Our Aboriginal Liaison Officers also reviewed the experiences of Aboriginal people leaving the Emergency Department early. This work helped identify opportunities to improve communication, cultural support and the overall patient journey.

A culturally appropriate Emergency Department information resource was developed to help Aboriginal patients and families understand triage, waiting times, available support and alternative care options.

Aboriginal Liaison and Patient Advocacy

Our Aboriginal Liaison Officers remained central to the delivery of culturally safe care across Northern Health.

They supported Aboriginal patients and families during Emergency Department presentations, hospital admissions, mental health care, family meetings, discharge planning and referrals to community services.

The Narrun Wilip-giin workforce included:

- Ward-based Aboriginal Liaison Officers;
- Emergency Department Aboriginal Liaison support;
- Aboriginal Mental Health Liaison Officers;
- An Aboriginal Clinical Nurse Educator;
- Aboriginal nursing support linked with virtual care; and
- An Aboriginal Employment and Cultural Safety Advisor.

Our Aboriginal Clinical Nurse Educator continued to mentor and support Aboriginal nurses and students while also working with clinical areas to improve culturally safe practices.

We also progressed culturally appropriate supervision and support for Aboriginal staff working in liaison, mental health and clinical roles.

Aboriginal staff often carry cultural, emotional and community responsibilities that extend beyond their formal position descriptions. Recognising and supporting this cultural load is essential to staff wellbeing, retention and culturally safe practice.

Our unit continued to advocate for appropriate staffing levels, classification, professional development and career pathways for Aboriginal employees.

Strengthening the Aboriginal Workforce

A strong Aboriginal workforce is essential to building trust with the community and improving the cultural safety of Northern Health.

During 2025–26, our unit continued to support the implementation of Northern Health's Aboriginal Employment Plan.

This work included strengthening recruitment and retention practices, supporting culturally safe onboarding, improving workforce visibility and increasing organisational accountability for Aboriginal employment outcomes.

We also progressed planning for an Aboriginal Staff Network.

The network will provide a culturally safe space for Aboriginal staff to connect, share experiences, provide advice and contribute to organisational decision-making.

The Aboriginal Employment and Cultural Safety Advisor continued to provide guidance across recruitment, employment policy, workforce planning, staff support and cultural safety.

Aboriginal employment is not only about reaching a workforce target. It is about creating a workplace where Aboriginal staff feel respected, culturally safe, supported and able to progress into leadership and decision-making roles.

Cultural Safety Education

Our unit continued to deliver face-to-face Aboriginal cultural safety education across Northern Health.

Since January 2025, more than 700 staff have participated in education delivered through the Narrun Wilip-giin Education Plan.

Education topics included:

- Aboriginal cultural safety;
- respectfully asking the Aboriginal and Torres Strait Islander identification question;
- Aboriginal perspectives on death, dying and end-of-life care;
- Closing the Gap;
- the role of Aboriginal Liaison Officers;
- the role of Aboriginal Mental Health Liaison Officers;
- staff orientation; and
- culturally safe responses to clinical scenarios.

Short education sessions were also delivered to ward clerks and other frontline staff. These sessions focused on respectfully asking the identification question and ensuring Aboriginal patients were correctly identified and offered appropriate support.

Our education is delivered by Aboriginal staff and is grounded in lived experience, community knowledge and practical examples from healthcare.

Cultural safety education is not simply about learning facts about Aboriginal people. It requires staff to reflect on power, racism, bias and how healthcare systems can create barriers for Aboriginal patients and families.

In November 2025, Narrun Wilip-giin delivered Aboriginal cultural safety education to the Northern Health Board and Executive.

This reinforced that cultural safety must be understood, led and governed at the highest levels of the organisation.

We also supported Aboriginal Study Days that brought together Aboriginal staff, clinicians, leaders and community representatives to learn, reflect and yarn about cultural safety, health equity and Aboriginal patient experiences.

Research and Quality Improvement

Narrun Wilip-giin continues to strengthen Aboriginal leadership in research, evaluation and quality improvement.

In May 2026, Northern Health approved the Aboriginal-led Care Fellowship project:

Pathways Back to Hospital: Comparing Emergency Department Presentations Among Aboriginal and Torres Strait Islander Patients Who Attend and Do Not Attend Outpatient Appointments.

The study will examine whether Aboriginal patients who do not attend their final outpatient appointment are more likely to present to the Emergency Department within 30 days.

The project does not frame non-attendance as an individual patient failure. Instead, it considers how transport, communication, appointment systems, fragmented pathways, cultural safety and previous healthcare experiences may contribute to people being unable to attend appointments.

The research will use de-identified Northern Health data and will be guided by Aboriginal research ethics, the AIATSIS Code of Ethics and national guidelines for Aboriginal and Torres Strait Islander health research.

Our unit also partnered with Northern Health's virtual care and social work teams to examine culturally safe virtual healthcare for Aboriginal and Torres Strait Islander people.

This work was presented through the Melbourne Academic Centre for Health under the title:

Building Clinician Capability for Culturally Safe Virtual Healthcare with Aboriginal and Torres Strait Islander Peoples.

These projects are helping Northern Health develop stronger evidence about what works and where change is needed.

Working with Aboriginal Community-Controlled Organisations

Our partnerships with Aboriginal Community Controlled Organisations are central to our work.

Narrun Wilip-giin continued to work with First Peoples' Health and Wellbeing, the Victorian Aboriginal Health Service, VACCHO, DPV Health and other Aboriginal organisations and community networks.

The Koori Maternity Service partnership with First Peoples' Health and Wellbeing continued to support Aboriginal women and families to access antenatal care in a culturally safe, community-controlled environment.

This partnership recognises the importance of providing care closer to community and ensuring Aboriginal mothers and families remain connected to trusted Aboriginal services.

We also continued to strengthen referral and follow-up pathways between Northern Health and Aboriginal Community Controlled Organisations.

Our aim is to support continuity of care and ensure Aboriginal patients are connected with culturally safe services after leaving hospital.

Listening to Community

Community voice must guide how Northern Health plans, delivers and evaluates Aboriginal health services. During the year, we continued to engage with Elders, Aboriginal community members and Aboriginal organisations through meetings, hospital tours, advisory structures and yarning opportunities.

These conversations provided direct feedback about communication, access, cultural safety, hospital environments and the need to involve Aboriginal people before decisions are made.

As an Aboriginal Support Unit, our role is not only to listen but to ensure community feedback is heard by Northern Health leaders and translated into meaningful action.

Listening can sometimes be uncomfortable, particularly when community identifies where the health system has caused harm or failed to respond appropriately.

However, honest listening, accountability and action are essential to rebuilding trust.

Celebrating and Embedding Culture

Our unit continued to support the recognition and celebration of Aboriginal culture across Northern Health.

NAIDOC Week activities were held across Northern Health, providing opportunities for staff to recognise Aboriginal strength, history, culture, leadership and achievement.

Activities included a Grand Round, cultural displays, staff engagement and opportunities for education and reflection.

We also supported activities recognising Aboriginal and Torres Strait Islander Children's Day and initiatives promoting cultural pride, identity and literacy for Aboriginal children and families.

Narrun Wilip-giin uniforms featuring Aboriginal artwork continued to strengthen the visibility of our team and assist Aboriginal patients and families to identify culturally safe support.

Aboriginal and Torres Strait Islander flags, Acknowledgement of Country plaques, artwork and culturally identified badges also contributed to more welcoming environments.

These symbols are important, but they are only meaningful when supported by action.

Cultural safety must be demonstrated through staff behaviour, clinical practice, governance, decision-making and accountability.

Looking Ahead

During 2026–27, Narrun Wilip-giin will continue to work across Northern Health to:

- reduce the number of Aboriginal patients leaving care before being seen or completing treatment;
- strengthen Aboriginal Liaison Officer coverage and models of care;
- improve connections between hospital, virtual care, primary care and Aboriginal Community Controlled Organisations;
- continue implementing the Aboriginal Employment Plan;
- strengthen support, cultural supervision and career pathways for Aboriginal staff;
- complete and share the findings of Aboriginal-led research projects;
- improve Aboriginal data governance and oversight;
- continue face-to-face Aboriginal cultural safety education;
- increase the visibility of Aboriginal culture across Northern Health; and
- ensure Aboriginal voices are involved in decisions affecting Aboriginal patients, families, staff and community.

Our goal is to support Northern Health to become a health service where Aboriginal people do not have to leave their culture, identity or family connections at the door to receive care.

We are not simply asking the existing system to make space for Aboriginal people. We are working to change the system so Aboriginal voices, leadership and ways of knowing, being and doing are respected and centred.

Narrun Wilip-giin will continue to stand with our community, advocate for our people and work across Northern Health to create safer, fairer and more culturally responsive care.

Environmental Sustainability

Northern Health is committed to improving sustainability within health system infrastructure and performance.

Northern Health is committed to providing outstanding health care for the Northern community and to promoting an environmentally sustainable and healthy community. Northern Health's Sustainable Environmental Resources Management Policy demonstrates a commitment to environmental responsibility in accordance with the Victorian Government Climate Change Act 2017.

The Northern Health Environmental Management Plan 2023 – 2028 consolidates Northern Health's previous actions to reduce its environmental impacts in its operations, and sets out planning, policies and procedures to support this commitment in the future.

The Environmental Management Plan contains environmental goals to reduce net carbon emissions to zero by 2040 and within this goal, a commitment to net zero Scope 2 emissions by 2025, net zero Scope 1 emissions by 2030, and net zero Scope 3 emissions by 2040.

The Environmental Management Plan also sets-out major environmental initiatives, including:

- **Reducing reliance on natural gas:** The replacement of gas with renewable energy is occurring progressively in line with Victorian Government targets and funding support for transition.
- **Converting car fleet to hybrid and electric:** The motor vehicle fleet is being progressively converted entirely to hybrid or electric with infrastructure for fleet EV charging continuing to be installed across campuses where feasible.
- **Delivering more sustainable healthcare through expanding virtual services:** Northern Health continues to build on strong virtual health offerings which reduce reliance on the built environment and thereby reduce Scope 3 emissions. In 2025-26, the Virtual Emergency Department saw over 320,000 patients, and over 113,000 outpatient appointments were attended via telehealth.
- **Driving emissions reductions through supply chain:** Work continues with Health Share Victoria and other agencies to more accurately record Scope 3 emissions from the supply chain and gain commitments from major suppliers in relation to reducing carbon footprint.

The environmental sustainability initiatives include events and quality improvement programs designed to promote awareness and encourage participation in the delivery of sustainable healthcare.

Waste audits are conducted to explore waste avoidance and resource recovery education opportunities, with findings used to develop a series of interventions that aim to increase resource recovery, reduce waste to landfill and minimise clinical waste costs.

The Victorian Government encourages the efficient use of water in relation to building standards and government projects, and Northern Health is committed to encouraging builders of new buildings and occupants of existing buildings to use water more efficiently.

Northern Health places a strong focus on energy efficiency in organisation-wide environmental management systems and processes, including the setting of targets for improving energy efficiency, and using the energy procurement option that delivers the most competitive price.



Environmental Scorecard

Electricity use	Jul 25 - Jun 26	Jul 24 - Jun 25	Jul 23 - Jun 24	
EL1 Total electricity consumption segmented by source [MWh]				
Purchased	20,776.64	21,449.00	20,342.26	-3.13%
Self-generated	76.30	165.32	165.62	-53.84%
EL1 Total electricity consumption [MWh]	**20,852.94**	**21,614.32**	**20,507.88**	**-3.52%**
EL2 On site-electricity generated [MWh] segmented by:				
Consumption behind-the-meter				
Solar Electricity	76.30	165.32	165.62	-53.84%
Total Consumption behind-the-meter [MWh]	**76.30**	**165.32**	**165.62**	**-53.84%**
Exports				
Solar Electricity	97.98	8.97	9.00	992.85%
Total Electricity exported [MWh]	**97.98**	**8.97**	**9.00**	**992.85%**
EL2 Total On site-electricity generated [MWh]	**174.28**	**174.28**	**174.62**	**0.00%**
EL3 On-site installed generation capacity [kW converted to MW] segmented by:				
Cogeneration Plant	1.00	1.00	1.00	0.00%
Diesel Generator	5.46	5.46	5.46	0.00%
Solar System	1.34	1.34	1.34	0.00%
EL3 Total On-site installed generation capacity [MW]	**7.79**	**7.79**	**7.79**	**0.00%**
EL4 Total electricity offsets segmented by offset type [MWh]				
LGCs voluntarily retired on the entity's behalf	17,994.30			
RPP (Renewable Power Percentage in the grid)	3,721.10	3,926.22	3,815.89	-5.22%
EL4 Total electricity offsets [MWh]	**20,776.64**	**3,926.22**	**3,815.89**	**429.18%**
F1 Total fuels used in buildings and machinery segmented by fuel type [MJ]				
Natural gas	94,108,527.40	99,651,433.20	82,275,764.90	-5.56%
F1 Total fuels used in buildings [MJ]	**94,108,527.40**	**99,651,433.20**	**82,275,764.90**	**-5.56%**
F2 Greenhouse gas emissions from stationary fuel consumption segmented by fuel type [Tonnes CO2-e]				
Natural gas	4,849.41	5,135.04	4,239.67	-5.56%
F2 Greenhouse gas emissions from stationary fuel consumption [Tonnes CO2-e]	**4,849.41**	**5,135.04**	**4,239.67**	**-5.56%**

Electricity use	Jul 25 - Jun 26	Jul 24 - Jun 25	Jul 23 - Jun 24	
T1 Total energy used in transportation (vehicle fleet) within the Entity, segmented by fuel type [MJ]				
Non-executive fleet - Gasoline		**254,728.30**	**127,757.50**	
Petrol		**254,728.30**	**127,757.50**	
Non-executive fleet - E10		**8,041.70**	**8,064.90**	
Petrol (E10)		**8,041.70**	**8,064.90**	
Non-executive fleet - Diesel		**112,650.10**	**56,649.60**	
Diesel		**112,650.10**	**56,649.60**	
Total energy used in transportation (vehicle fleet) [MJ]		**375,420.10**	**192,472.00**	
T2 Number and proportion of vehicles in the organisational boundary segmented by engine/fuel type and vehicle category				
T3 Greenhouse gas emissions from transportation (vehicle fleet) segmented by fuel type [tonnes CO2-e]				
Non-executive fleet - Gasoline		**17.22**	**8.64**	
Petrol		**17.22**	**8.64**	
Non-executive fleet - E10		0.49	0.49	
Petrol (E10)		**0.49**	**0.49**	
Non-executive fleet - Diesel		7.93	3.99	
Diesel		**7.93**	**3.99**	
Total Greenhouse gas emissions from transportation (vehicle fleet) (t CO2-e)		25.65	13.12	
E1 Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) [MJ]				
Total energy usage from stationary fuels (F1) (MJ)	94,108,527.40	99,651,433.20	82,275,764.90	-5.56%
Total energy usage from transport (T1) (MJ)		375,420.10	192,472.00	
Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)	**94,108,527.40**	**100,026,853.30**	**82,468,236.90**	**-5.92%**
E2 Total energy usage from electricity [MJ]				
Total energy usage from electricity (MJ)	75,070,584.92	77,811,562.03	73,828,356.42	-3.52%
E3 Total energy usage segmented by renewable and non-renewable sources [MJ]				
Renewable	75,070,585.60	14,730,339.21	14,334,255.53	409.63%
Non-renewable (E1 + E2 - E3 Renewable)	94,108,526.72	163,108,076.12	141,962,337.79	-42.30%

Electricity use	Jul 25 - Jun 26	Jul 24 - Jun 25	Jul 23 - Jun 24	
E4 Units of Stationary Energy used normalised: (F1+E2)/normaliser				
Energy per unit of Aged Care OBD (MJ/Aged Care OBD)	3,745.30	3,886.70	3,368.67	-3.64%
Energy per unit of LOS (MJ/LOS)	442.37	473.62	430.76	-6.60%
Energy per unit of bed-day (LOS+Aged Care OBD) (MJ/OBD)	395.64	422.18	381.92	-6.29%
Energy per unit of Separations (MJ/Separations)	1,215.66	1,307.74	1,186.10	-7.04%
Energy per unit of floor space (MJ/m2)	1,684.45	1,766.93	1,554.26	-4.67%
W1 Total units of metered water consumed by water source (kl)				
Potable water [kL]	186,506.46	185,335.17	178,644.57	0.63%
Total units of water consumed [kl]	**186,506.46**	**185,335.17**	**178,644.57**	**0.63%**
W2 Units of metered water consumed normalised by FTE, headcount, floor area, or other entity or sector specific quantity				
Water per unit of Aged Care OBD (kL/Aged Care OBD)	4.13	4.06	3.86	1.72%
Water per unit of LOS (kL/LOS)	0.49	0.49	0.49	-1.41%
Water per unit of bed-day (LOS+Aged Care OBD) (kL/OBD)	0.44	0.44	0.44	-1.08%
Water per unit of Separations (kL/Separations)	1.34	1.37	1.36	-1.87%
Water per unit of floor space (kL/m2)	1.86	1.85	1.78	0.63%

Waste and recycling	Jul 25 - Jun 26	Jul 24 - Jun 25	Jul 23 - Jun 24	
WR1 Total units of waste disposed of by waste stream and disposal method [kg]				
Landfill (total)				
General waste - bins	47,991.45	47,991.45	48,145.32	0.00%
General waste - compactors	841,208.97	873,888.97	931,140.00	-3.74%
General waste - skips	420,676.40	441,034.40	448,010.00	-4.62%
Offsite treatment				
Clinical waste - incinerated	19,601.02	19,601.02	20,033.47	0.00%
Clinical waste - sharps	25,130.93	25,130.93	25,409.93	0.00%
Clinical waste - treated	333,480.77	333,480.77	336,939.06	0.00%
Recycling/recovery (disposal)				
Cardboard	173,191	149,890.48	171,823.82	
Commingled	38,093	29,301.58	29,378.24	
Paper (confidential)	197,544	7,225.30	135,754.85	
PVC	882.00	1,362.00	1,562.00	-35.24%
Total units of waste disposed [kg]	**1,688,971.54**	**1,928,906.91**	**2,148,196.68**	**-12.44%**
WR1 Total units of waste disposed of by waste stream and disposal method [%]				
Landfill (total)				
General waste	77.55%	70.66%	66.44%	9.76%
Offsite treatment				
Clinical waste - incinerated	1.16%	1.02%	0.93%	14.21%
Clinical waste - sharps	1.49%	1.30%	1.18%	14.21%
Clinical waste - treated	19.74%	17.29%	15.68%	14.21%
Recycling/recovery (disposal)				
Cardboard	8.00%	7.77%	8.00%	
Commingled	7.30%	1.52%	1.37%	
Paper (confidential)	9.00%	0.37%	6.32%	
PVC	0.05%	0.07%	0.07%	-26.04%

Waste and recycling	Jul 25 - Jun 26	Jul 24 - Jun 25	Jul 23 - Jun 24	
WR2 Percentage of office sites covered by dedicated collection services for each waste stream				
Printer cartridges	0.02%	0.30		
Batteries	0.1%	0.10		
e-waste	0.9%	0.63		
Soft plastics				
WR3 Total units of waste disposed normalised by FTE, headcount, floor area, or other entity or sector specific quantity, by disposal method				
Total waste to landfill per patient treated ((kg general waste)/PPT)	1.30	1.47	1.68	-11.45%
Total waste to offsite treatment per patient treated ((kg offsite treatment)/PPT)	0.38	0.41	0.45	-7.87%
Total waste recycled and reused per patient treated ((kg recycled and reused)/PPT)	0.00	0.20	0.40	-99.57%
WR4 Recycling rate [%]				
Total waste to landfill per patient treated ((kg general waste)/PPT)	1.30	1.47	1.68	-11.45%
Total waste to offsite treatment per patient treated ((kg offsite treatment)/PPT)	**0.38**	0.41	0.45	-7.87%
Total waste recycled and reused per patient treated ((kg recycled and reused)/PPT)	**0.00**	**0.20**	**0.40**	**-99.57%**
WR5 Greenhouse gas emissions associated with waste disposal [tonnes CO2-e]				
tonnes CO2-e	2,186.26	2,255.21	2,344.15	-3.06%

Greenhouse gas emissions	Jul 25 - Jun 26	Jul 24 - Jun 25	Jul 23 - Jun 24	
G1 Total scope one (direct) greenhouse gas emissions [tonnes CO2e]				
Carbon Dioxide	4,837.18	5,147.61	4,242.03	-6.03%
Methane	9.41	9.97	8.23	-5.62%
Nitrous Oxide	2.82	3.10	2.52	-8.87%
Total	**4,849.41**	**5,160.68**	**4,252.79**	**-6.03%**
Scope 1 GHG emissions from stationary fuel (F2 Scope 1) (t CO2-e)	**4,849.41**	**5,135.04**	**4,239.67**	**-5.56%**
Scope 1 GHG emissions from vehicle fleet (T3 Scope 1) (t CO2-e)		**25.65**	**13.12**	
Medical/Refrigerant gases				
Total scope one (direct) greenhouse gas emissions [tonnes CO2e]	**4,849.41**	**5,160.68**	**4,252.79**	**-6.03%**
G2 Total scope two (indirect electricity) greenhouse gas emissions [tonnes CO2e]				
Electricity	13,814.99	14,147.52	13,379.51	-2.35%
Total scope two (indirect electricity) greenhouse gas emissions [tonnes CO2e]	**13,814.99**	**14,147.52**	**13,379.51**	**-2.35%**
G3 Total scope three (other indirect) greenhouse gas emissions associated with commercial air travel and waste disposal (tonnes CO2e)				
Commercial air travel				
Waste emissions (WR5)	2,186.26	2,255.21	2,344.15	-3.06%
Indirect emissions from Stationary Energy	2,252.54	2,319.87	1,980.90	-2.90%
Indirect emissions from Transport Energy		6.45	3.30	
Paper emissions				
Water emissions	261.63	303.16	299.78	-13.70%
Any other Scope 3 emissions	0.00	0.00	0.00	
Total Scope 3 greenhouse gas emissions (t CO2-e)	**4,700.44**	**4,884.70**	**4,628.13**	**-3.77%**
G(Opt) Net greenhouse gas emissions (tonnes CO2e)				
Gross greenhouse gas emissions (G1 + G2 + G3) (t CO2-e)	**23,364.84**	**24,192.91**	**22,260.43**	**-3.42%**
Total gross reported greenhouse gas emissions per bed-day (t CO2-e/OBD)	0.05	0.06	0.05	-5.06%
Purchased LGCs	**-16,554.76**	**0.00**	**0.00**	
Any Reduction Measures Offsets purchased (EL4-related)	**-16,554.76**	**0.00**	**0.00**	
Any Offsets purchased	**-16,554.76**			
Net greenhouse gas emissions (t CO2-e)	**6,810.08**	**24,192.91**	**22,260.43**	**-71.85%**

Normalisation factors	Jul 25 - Jun 26	Jul 24 - Jun 25	Jul 23 - Jun 24	
1000km (Corporate)				
1000km (Non-emergency)				
Aged Care OBD	45,171.00	45,659.00	46,340.00	-1.07%
ED Departures	440,345.00	371,854.00	310,445.00	18.42%
FTE	6,385.00	5,952.00	210.00	7.27%
LOS	382,439.00	374,693.00	362,395.00	2.07%
OBD	427,610.00	420,352.00	408,735.00	1.73%
PPT	1,007,121.00	927,908.00	850,791.00	8.54%
Separations	139,166.00	135,702.00	131,611.00	2.55%
TotalAreaM2	100,436.00	100,436.00	100,436.00	0.00%

NOTE: Indicators are not reported where data is unavailable or an indicator is not relevant to the organisation's operations



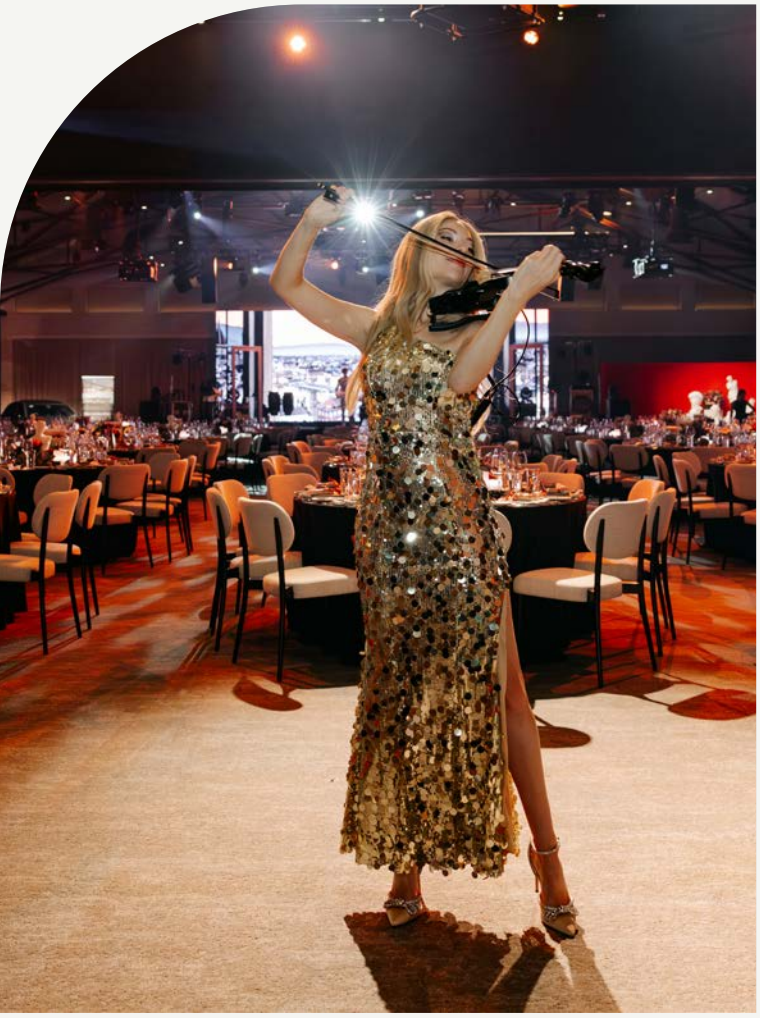
Northern Health Foundation

Northern Health Foundation, with the support of our generous community, continues to work alongside Northern Health to drive innovation, excellence and better health outcomes across our health service.

Our supporters continue to inspire us through their generosity and commitment to improving healthcare for communities across Melbourne's north. Philanthropic support remains critical to advancing Northern Health's values of safe, kind and together, while helping to create a more equitable health service for our community.

During the 2025-26 financial year, Northern Health Foundation provided more than $1M in philanthropic funding to Northern Health, supporting a diverse range of initiatives across equipment, research, education and training. Over the past year, the Foundation raised more than $2.2M, made possible through the generosity of donors, corporate partners, trusts and foundations, community groups and those who have chosen to leave a gift in their Will.

We thank every supporter who has contributed to this important work. Their generosity is helping Northern Health deliver better care today while investing in the healthcare of tomorrow.





Turning generosity into impact

Bringing robotic surgery to Melbourne's north

A major highlight for Northern Health Foundation this year has been our work supporting the introduction of the da Vinci Xi robotic surgical system at Northern Health.

The system will support more than 200 patients each year, including patients undergoing treatment for prostate, kidney, bladder, lung and bowel cancers, as well as people requiring other complex and urgent surgical procedures.

Securing the da Vinci Xi was the result of a year-long philanthropic campaign, supported by the generosity of donors through our tax appeal, corporate partners, community groups and Gifts in Wills.

The campaign culminated in the Foundation's Gala Ball, A Night Where Art Met Healing, held on 9 May at the 1 Hotel Melbourne Ballroom in Docklands. More than 430 guests joined us for the evening, with an extraordinary $140,000 raised to support this important advancement in care.

> *"I'd like to thank our generous donors for supporting this exciting advancement. It's a bold step toward a healthier, more equitable future for Melbourne's northern communities."*
>
> **Debra Bourne, Chief Executive, Northern Health**







Supporting our littlest patients

Philanthropy is also helping Northern Health provide the best possible care to some of our youngest and most vulnerable patients. During the year, Northern Health Foundation was delighted to receive funding from the Muriel and Les Batten Foundation to support the purchase of three vital pieces of equipment: two Panda Warmers, supporting neonatal and paediatric patient care across areas including the Emergency Department and Birthing Suite/Maternity Assessment Centre, and a Sonosite ST Ultrasound System for the Maternity Assessment Centre.

These pieces of equipment will support clinicians to provide timely, effective and compassionate care for babies, children and their families when they need it most.

"The funding of this device represents a vital investment in both the health of our youngest patients and the ability of our healthcare team to deliver rapid, effective, and compassionate care. We are incredibly grateful for the support of the Muriel and Les Batten Foundation."

– Simone Jervis, Midwifery Unit Manager, Birthing Suite and Maternity Assessment Centre

Advancing research in the north

Philanthropy also plays an important role in building Northern Health's research capacity and supporting innovation that can improve patient outcomes.

Through its support of Research Week and the Research Grant Awards, the Foundation continues to help foster a strong and vibrant research culture across Northern Health.

Dr Loren Sher, Program Director of the Virtual Emergency Department and Paediatric Emergency Physician, was awarded a $50,000 research grant for a project examining a new discharge framework designed to improve patient health literacy, reduce hospital readmissions and support patients as they transition from hospital back into the community.

"With Northern Health having the busiest Emergency Department in the state, I'm incredibly grateful to Northern Health Foundation and the local community for this grant."

– Dr Loren Sher, Program Director, Virtual Emergency Department and Paediatric Emergency Physician

Looking ahead

Northern Health Foundation is proud to partner with our community to support Northern Health's vision for a healthier, more equitable future for Melbourne's north.

From investing in world-leading surgical technology and essential equipment, to supporting research and developing the healthcare innovations of tomorrow, every philanthropic contribution makes a difference.

We thank our donors, corporate partners, trusts and foundations, community groups and all those who have supported Northern Health throughout the year. Together, we are helping build a healthier future for our community.

Northern Health Foundation Board Directors

Board Chair

Peter McWilliam

Deputy Chair

Trudi Hay

Professor Don Campbell

Domenic Isola – *Resigned October 2025*

Koby Jones

Dr Santosh Kaur

Associate Professor Cate Kelly

Tricia Lee

John Molnar

Shannon Ryan – *Resigned March 2026*

Christopher Turner

Volunteer Services

Northern Health's Volunteer Services team continued to demonstrate outstanding commitment and community impact across all sites this year. Volunteers contributed thousands of hours to patient support, fundraising, community engagement and operational assistance, strengthening the quality of care delivered across our health service.

National Volunteer Week highlighted this dedication, with 17 volunteers recognised for milestone service, and a total of 1,184 combined years of service, including two volunteers reaching 20 years of service, and one volunteer celebrating 30 years supporting Northern Health.

Volunteer led fundraising and community partnerships delivered significant contributions, enabling the purchase of essential equipment and enhancing patient comfort. Key outcomes included $35,000 from the Kilmore Op Shop, $15,000 from the Northern Hospital Epping Knitting Guild, $5,000 from Broadmeadows Hospital Volunteers and $16,000 from the Busy Fingers Auxiliary at Bundoora.

Volunteers also coordinated the collection and distribution of more than $30,000 of in-kind donations, including handmade comfort items, hygiene packs, children's activity bags and specialised patient care accessories, while continuing to support wards, outpatient areas and community programs across all campuses.

Volunteer Impact Snapshot

180
Active Volunteers

13,475
Hours Contributed

$703K
In-Kind Value of Volunteer Time

$61K
Funds Raised

Combined fundraising through Kilmore Op Shop, Busy Fingers Auxilliary Bundoora, Epping Knitting Guild and Broadmeadows Volunteers

$30K+
In-Kind Donations

Collected and distributed enhancing patient care

1,184
Years of service

Combined years of service

Volunteers enrich the patient journey, support staff and strengthen Northern Health's connection to the community.

Organisational Structure

Northern Health Board



Chief Executive
Debra Bourne

Chief People Officer
Rebecca Hodges

- Payroll & Remuneration
- HR & Talent Acquisition
- OHS & Wellbeing
- Workforce Planning & Projects
- Learning, Org Capability and Experience

Chief Financial Officer
Basil Ireland

- Biomedical Services
- Business Support
- Engineering Capital & Development
- Financial Accounting
- HIS
- Revenue & Reporting
- Supply Services
- Support Services

Executive Director Quality & Safety
Bill Shearer

- Accreditation
- Enterprise Risk Management
- Quality, Safety & Clinical Governance
- Transformation Unit
- Virtual Services

Chief Operating Officer
Linda Romano

- Access
- Community Hospitals
- Emergency Services
- Medicine & Cancer Services
- Womens & Childrens
- Surgical Services
- Hospital Without Walls & Sub Acute
- Specialist Outpatient Clinics

Chief Medical Officer
Prahlad Ho

- Northern Doctors
- Design & Discovery
- Northern Health Research
- Northern Imaging Victoria
- Northern Pathology Victoria
- Pharmacy Services
- Library

Office of the Chief Executive

Director Corporate Governance
Ren Cazar

Senior Executive Advisor
Deidre Cope

Executive Assistant
Ricky Busuttil

Chief Nursing & Midwifery Officer
Lisa Cox

- Divisional Director Nursing – Surgical Services
- Infection Prevention
- Nursing Workforce Unit
- Nursing Education

Chief Allied Health Officer
Jason Cirone

- Allied Health Services
- Transcultural & Language Services
- Pastoral Care
- Narrun Wilip-Giin

Executive Director Mental Health
Belinda Scott

- Mental Health Services
- Patient Experience
- Emergency Management

Chief Digital and Technology Officer
Anthony Gust

- ICT
- Digital Training
- Digital Projects
- CLEO
- Data Analytics
- Decision Support
- Electronic Medical Record
- Development

Executive Director Public Affairs & Foundation
Pina Di Donato

- Public Affairs
- Corporate Fundraising
- Volunteer Services

Chief Legal Officer & Executive Director Strategy & Planning
Carolyn Baker

- Legal Services
- Strategy & Planning
- FOI & Privacy

Board Directors



Adjunct Professor Alan Lilly | BOARD CHAIR

A/Prof Alan Lilly was appointed as Board Chair of Northern Health on 1 July 2025.

Alan is a leading expert and independent consultant in health and aged care with a distinguished career across public, private and not-for-profit organisations. He brings a wealth of experience across the health, aged care, and social care sectors, currently serving as Principal of Acumenity and having held Chief Executive roles at major health and social care services, including Eastern Health, BlueCross, and Jewish Care Victoria.

Alan also brings a strong track record in governance, having served on the Boards of The Royal Women's Hospital, The Royal Victorian Eye and Ear Hospital, and the Mayflower Group, and contributed to state-wide initiatives as a Council Member of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. As a Consultant, he co-conducted independent COVID-19 outbreak reviews for the Commonwealth Department of Health and contributed extensively to the Royal Commission into Aged Care Quality and Safety. He previously served on the Australian Health Protection Principal Committee (AHPPC) Aged Care Advisory Group and he is an Adjunct Professor of Australian Catholic University.

With a clinical background as both a Registered Psychiatric Nurse and Registered General Nurse, and postgraduate qualifications in Health Services Management and Health Administration, Alan brings both frontline insight and strategic leadership expertise spanning operational excellence, clinical governance, care quality & safety and consumer experience. He is a Fellow of the Australian Institute of Company Directors and a Fellow and Certified Health Executive of the Australasian College of Health Service Management.



Associate Professor Cate Kelly

A/Prof Cate Kelly was appointed as a Board Director of Northern Health on 1 July 2025.

She is an experienced medical healthcare executive with a background in leadership roles across the Victorian health sector, most recently as Chief Medical Officer at Royal Melbourne Hospital.

She is currently working as a healthcare consultant in Australia and internationally, advising on health system strengthening, clinical governance and clinical leadership. She serves as Deputy Academic Lead, Transforming Health Domain at University of Melbourne. Cate brings experience as a Board Director at Berry Street Yooralla where she is also Chair of the Quality and Safeguarding Committee.



Ms Nirasha Parsotam

Ms Nirasha Parsotam was appointed as a Board Director of Northern Health on 1 July 2025.

Nirasha is a strategic health leader with over 20 years' experience spanning clinical, corporate, and research sectors. She currently serves as the Chief Strategy Officer with the Digital Health CRC, and brings deep expertise in healthcare strategy, systems thinking, quality and safety, digital transformation, innovation and commercialisation.

Beginning her career as a clinical pharmacist, Nirasha has since held senior leadership roles across both the public and private sectors, including health insurance at Bupa Australia, research innovation and commercialisation at the Murdoch Children's Research Institute, and various health, quality, and safety programs with the New Zealand Health Quality & Safety Commission, Ministry of Health, and the Institute for Healthcare Improvement (IHI). She holds postgraduate qualifications in pharmacy, public health and health administration from the University of NSW, and is a Graduate of the Australian Institute of Company Directors. Nirasha was a member of the inaugural Victorian Voluntary Assisted Dying Review Board and is known for building inclusive cultures and driving measurable improvements in health outcomes, safety, and system integration.



Dr Michael Walsh

Dr Michael Walsh was appointed as a Board Director of Northern Health on 1 July 2025.

He has served as Chief Executive of major healthcare organisations in Australia and internationally for over 20 years, including Johns Hopkins Aramco Healthcare (JHAH), Cabrini Health, and National Health Authority Qatar. In his role as Chief Executive of JHAH in 2020, he has been pivotal in driving significant organisational growth and transformation, focusing on a people-centric approach, clinical excellence, and strategic business insight.

His experience spans three countries, managing health services for diverse populations, with prominent leadership roles including 11 years at Cabrini Australia, where he led growth in teaching, research, and fundraising, and positions at South East London NHS Strategic Health Authority in the U.K. and The Alfred in Melbourne.

He has led major health system reforms, COVID pandemic responses, and organisational transformations across public and private sectors, while serving as Vice President of the Royal Australasian College of Medical Administrators for eight years.

A medical doctor by training and specialist in Medical Administration and Health Service Management with advanced qualifications from Harvard University, his expertise encompasses strategic healthcare leadership, international health systems development, and large-scale organisational change management.



Dr Andrea Kattula

Dr Andrea Kattula was appointed as a Board Director of Northern Health on 1 July 2019.

Andrea originally trained as an anaesthetist, working in hospitals in Australia and the United States. She transitioned to a career in safety & quality in healthcare and brings broad experience in successfully establishing clinical governance systems and processes, leading change, engaging clinicians and supporting clinical leadership development.

Alongside medical and anaesthesia qualifications, Andrea has completed a Bachelor of Psychological Science degree and a Master of Quality Improvement in Healthcare. She is a Graduate of the Australian Institute of Company Directors (GAICD), an Associate Fellow of the Australian College of Health Service Managers (ACHSM) and an Affiliate of the Governance Institute of Australia (GIA).

Committed to delivering safer health care, Andrea has served in a range of safety and quality roles over the past 20 years. Most recently these roles have included Chair of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (2017-2019), Deputy Chair of the Victorian Perioperative Consultative Council (2019-2022), and member of the Victorian Audit of Surgical Mortality Management Committee (ongoing since 2012). She presently teaches as a Lecturer in the Master of Public Health program for Monash University.

Andrea is also a keen Meals on Wheels volunteer in her local community.



Mr Peter McDonald

Mr Peter McDonald was appointed as a Board Director of Northern Health in December 2016.

He is an executive with Australian Red Cross Lifeblood and previously worked as CFO at Austin Health and Alfred Health for 12 years. Prior to that, he had a number of senior management roles in Victorian Government departments.

Peter is a Council Member, Chair of the Finance & Resources Committee and a member of the Corporate Governance & Audit Committee at La Trobe University, as well as a Fellow of CPA Australia.



Mr Domenic Isola

Mr Domenic Isola was appointed as a Board Director of Northern Health on 1 July 2022.

Domenic commenced his career in Local Government in 1996 following a career in institutional banking audit in a leading financial institution. He has expertise in financial management, reporting and audit, extensive management skills, experience in governance and risk and strong leadership and public sector experience.

Domenic commenced with Hume City Council in June 1999 and held the positions of Finance Manager and Director, City Governance and Information before being appointed Chief Executive Officer in August 2007, a role he held for 13 years.

He was previously a co-opted member of the former board of Dianella Community Health and Community Chef. During that time, he served on the Finance and Audit committees and remains a member of DPV Health.

Domenic has led a number of local initiatives and dealt with a broad range of complex matters in the north, working with a range of stakeholders, including Government Ministers, community health organisations, and Government agencies, and maintains strong working relationships with community health organisations.

Domenic is a Board Director of Yarra Valley Water and a member of the Finance and Audit Committee.



Mr John Watson

Mr John Watson was appointed as a Board Director of Northern Health in August 2016.

John has had a long career in State and Local Government for more than four decades. He has held several leadership roles in Local Government, including Chief Executive Officer of the former Shire of Bulla, Moonee Valley City Council and Hume City Council. John's Victorian Government roles include periods as a Director and then as Executive Director of Local Government Victoria.

John has been Chair of the Victoria Grants Commission since 2012 and was Chair of the Panel of Administrators of the Brimbank City Council from 2012 to 2016. He Chairs or sits as an independent member on the Audit and Risk Committees for a number of Victorian local governments, the Municipal Association of Victoria and the Maryborough District Health Service.



Associate Professor Jo-Anne Mazzeo

A/Prof Jo-Anne Mazzeo was appointed as a Board Director of Northern Health in November 2023.

Joanne is an Australian Legal Practitioner who works across the health, education and disability sectors to conduct investigations, provide legal advice and deliver training and alternative dispute resolution methods. Joanne has previously worked as in-house Counsel for the Mental Health Review Board of Victoria and the Disability Services Commissioner of Victoria, has held various positions on State Government Boards and Tribunals, is currently a Legal Member of the Mental Health Tribunal of Victoria and is Deputy Chair of the Independent Office for School Dispute Resolution (within the Department of Education). Joanne is also the Convenor of the Medical Law Program within the Monash University Medical Degree, is a Senior Lecturer at both Monash and La Trobe Universities, where she teaches health law-related content at both undergraduate and postgraduate levels, and is a Senior Legal Advisor for the Victorian Institute of Forensic Medicine. Joanne is admitted to practice in both the High Court of Australia and the Supreme Court of Victoria.

Corporate Governance

Appointment of Directors

As described in the Health Services Act 1988 (S.65S), Northern Health has a Board of Directors consisting of up to nine persons appointed by the Governor in Council on the recommendation of the Health Minister for a term of up to three years. A director of the board must not serve more than nine consecutive years.

Role of the Board

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

Key aspects of this governance role include:

- Setting the organisation's statement of priorities and strategic plans and monitoring compliance with those statements and plans
- Developing financial and business plans, strategies and budgets to ensure the accountable and efficient provision of health services and long-term financial viability of the health service
- Establishing and maintaining effective systems to ensure that the health services provided meet the needs of the communities served and that the views of users and providers of health services are taken into account
- Monitor the performance of the health service to ensure:
  - it operates within its budget
  - auditing and accounting systems accurately reflect the financial position and viability of the health service
  - adherence to its financial and business plans, strategic plans and statements of priorities
  - effective and accountable risk management systems are in place
  - effective and accountable systems are in place to monitor and improve the quality, safety and effectiveness of the health services provided
  - problems identified with the quality, safety or effectiveness of the health services provided are addressed in a timely manner
  - the health service continually strives to improve the quality and safety of the services provided and to foster innovation, and
  - the committees established operate effectively
- Appointing and monitoring the performance of the Chief Executive
- Establishing the organisation structure, including management structure
- Developing arrangements with other relevant agencies and service providers to enable effective and efficient service delivery and continuity of care
- Ensuring the Minister and Secretary are advised about significant board decisions and are informed of issues of public concern or risks to the health service
- Establishing a Finance Committee, an Audit Committee and a Quality and Safety Committee
- Facilitating research and education
- Adopting a code of conduct for staff.

Board meetings and access to management

At Board and committee meetings, the Executive and other senior members of staff regularly present information or decision items relevant to their areas of responsibility in the health service.

Between meetings, individual board members have contact with management related to their involvement in committees and are contacted by the Chief Executive on major issues.

Delegation of functions

The Northern Health By-Laws provide for the delegation of duties by the Board.

The Board has approved and regularly reviews a detailed Delegations of Authority Policy, enabling designated Northern Health Executives to perform their duties through the exercise of specified authorities.

Board Committees

Small groups of directors provide their expertise through participation in committees that support the functioning of the Board. Directors who were not designated committee members were able to attend and participate in meetings.

Directors and attendees of the Northern Health Executive were as follows:

Finance Committee

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

Peter McDonald – Chair

Alan Lilly – Member

John Watson – Member

Domenic Isola – Member

The following executive staff attend this Committee:

Debra Bourne – Chief Executive

Ren Cazar – Director, Corporate Governance

Basil Ireland – Chief Financial Officer (Executive Sponsor)

Rick Garotti – Deputy Chief Financial Officer

Jimmy Jacob – Director, Business Support

Audit & Risk Committee

The Audit and Risk Committee meets quarterly and assists the Board in fulfilling its financial management and related reporting responsibilities for Northern Health, including compliance with laws and regulations, the maintenance of an effective and efficient audit system, and the maintenance of ongoing relationships with Northern Health's auditors.

John Watson – Chair

Alan Lilly – Member

Nirasha Parsotam – Member

Peter McDonald – Member

The following executive staff attend this Committee:

Debra Bourne – Chief Executive

Ren Cazar – Director, Corporate Governance

Basil Ireland – Chief Financial Officer (Executive Sponsor)

Rick Garotti – Deputy Chief Financial Officer

Rebecca Hodges – Chief People Officer

Linda Romano – Chief Operating Officer

Bill Shearer – Executive Director, Quality, Safety and Transformation

Anthony Gust – Chief Digital and Technology Officer

Christine Polmear – Director, Risk and Performance

Quality & Safety Committee

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

Andrea Kattula – Chair

Jo-Anne Mazzeo – Member

Cate Kelly – Member

Michael Walsh – Member

The following executive staff attend this Committee:

Debra Bourne – Chief Executive

Ren Cazar – Director, Corporate Governance

Linda Romano – Chief Operating Officer

Prahlad Ho – Chief Medical Officer

Bill Shearer – Executive Director, Quality Safety and Transformation (Executive Sponsor)

Belinda Scott – Executive Director, Mental Health, Emergency Management and Patient Experience

Lisa Cox – Chief Nursing and Midwifery Officer

Jason Cirone – Chief Allied Health Officer

Maree Glynn – Director, Clinical Practice Improvement

Christine Polmear – Director, Risk and Performance

Susanty Tay – Deputy Chief Medical Officer

Community Advisory Committee

The Community Advisory Committee meets quarterly and advises the Board on strategies to enhance and promote consumer and community participation at all levels within the health service. The Committee seeks to enhance the Board's ability to advocate on behalf of the communities served by Northern Health.

Jo-Anne Mazzeo – Chair

Cate Kelly – Member

Nirasha Parsotam – Member

The following executive staff attend this Committee:

Debra Bourne – Chief Executive

Ren Cazar – Director, Corporate Governance

Linda Romano – Chief Operating Officer

Belinda Scott – Executive Director, Mental Health, Emergency Management and Patient Experience (Executive Sponsor)

Clare McCarthy (resigned) – Director Patient Experience

Pina Di Donato – Executive Director, Public Affairs and Foundation

Karen Bryant – Manager, Narrun Wilip-giin, Aboriginal Support Unit

The following people are consumers:

Mr Nathan Foggie – Consumer (August 2025)

Mr Shane Burke – Consumer

Ms Tania De Carli – Consumer

Ms Maureen Canzano – Consumer

Mr Evan Bichara – Consumer

Ms Careena Newcastle – Consumer

Ms Nurcihan Ozturk – Consumer

Ms Dalal Sleiman – Consumer

Primary Care and Population Health Advisory Committee

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

Domenic Isola – Chair

Andrea Kattula – Member

Michael Walsh – Member

The following executive staff attend this Committee:

Debra Bourne – Chief Executive

Ren Cazar – Director, Corporate Governance

Jason Cirone – Chief Allied Health Officer (Executive Sponsor)

Linda Romano Chief Operating Officer

Belinda Scott – Executive Director, Mental Health, Emergency Management and Patient Experience

Chelsea Simpson – Director of Planning and Strategy

Karen Bryant – Manager, Narrun Wilip-giin Aboriginal Support Unit

Agency Attendees

Ben Norden – Coordinator, Social Planning and Healthy Communities, Hume City Council

Stephen McKay – Manager Community Strengthening, City of Whittlesea

Rebecca Sirianni – Manager Community Planning, Mitchell Shire Council

Gavin Wilson, Mitchell Shire Council

Euna Hwang – Department of Health

Alex Haynes – CEO, Whittlesea Community Connections

Carolyn Gillespie – CEO, Women's Health In the North

Michael Graham – Junior, Victorian Aboriginal Health Service

Sarah O'Leary – Director Integrated Care, NWMPHN

Narelle Quinn – Executive Director, Eastern Melbourne PHN

Jacque Phillips – COO, Murray PHN

Don Tidbury – CEO, DPV Health

Peter McWilliam – Northern Health Foundation

Chris James – NORTH Link

David Wild – CEO, Omnia Community Health

Melanie Chisholm – Senior Manager, NEPHU

Annaliese van Diemen – Medical Director, NEPHU

Bree Grinlinton – Principal Advisor, RMIT University

Matthew Oates – Head of Clinical Education, La Trobe University

Paula Nunez – Executive Director, Action on Disability within Ethnic Communities

Tracey Pearce – Head of Health and Community, Kangan Institute

Remuneration & Appointments Committee

The Remuneration Committee meets once per year to advise and make recommendations to the Board on matters relating to Executive and senior staff remuneration, performance, and recruitment.

Alan Lilly – Chair

John Watson – Member

Peter McDonald – Member

Andrea Kattula – Member

The following executive staff attend this Committee:

Debra Bourne – Chief Executive (Executive Sponsor)

Ren Cazar – Director, Corporate Governance

Michelle Fenwick (resigned) – Executive Director, People and Culture



Directors' Attendance for Board and Sub Committee Meetings: 1 July 2025– 30 June 2026

	Board	Finance Committee	Audit and Risk Committee	Quality and Safety Committee	Community Advisory Committee	Primary Care and Population Health Advisory Committee	Remuneration and Appointments Committee	**Total**
Number of Meetings	**12**	**10**	**5**	**5**	**5**	**4**	**1**	**42**
Alan Lilly	12/12	9/10	5/5	3/0	2/0	1/0	1/1	**33**
Jo-Anne Mazzeo	10/12	0/0	0/0	3/5	4/5	0/0	0/0	**17**
John Watson	10/12	9/10	5/5	0/0	0/0	0/0	1/1	**25**
Peter McDonald	10/12	10/10	4/5	0/0	0/0	0/0	1/1	**25**
Andrea Kattula	12/12	1/0	5/0	5/5	2/0	4/4	1/1	**30**
Domenic Isola	11/12	9/10	0/0	0/0	0/0	3/4	0/0	**23**
Cate Kelly	12/12	0/0	0/0	3/5	4/5	0/0	0/0	**19**
Nirasha Parsotam	11/12	1/0	5/5	1/0	5/5	1/0	0/0	**24**
Michael Walsh	12/12	6/0	4/0	5/5	2/0	3/4	0/0	**32**

NOTES

- The first number indicates the number of meetings attended, the second number indicates eligibility or membership of the particular committee
- All board members are welcome to attend other committee meetings with the exception of the Community Advisory Committee as the terms of reference indicate a limited number of Directors attend these meetings
- The December Board meeting is combined Board and Finance Committee meeting
- The total attendance does not include the Corporate Governance Workshop and the Annual General Meeting, which were held on the same day as the Board in November 2026 and the Strategic Planning Workshop in March 2026



Statement of Priorities Part A

Innovate and improve access and care

Goal	Health Service Deliverable	Status	Outcome
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	Achieved	Northern Health has embedded consumer engagement and value-based care across its clinical governance and quality systems. The Clinical Governance Framework aligns with the Safer Care Victoria framework and promotes consumer partnership, patient-centred care and continuous improvement. PROMs and PREMs (Patient-Reported Outcome Measures and Experience Measures) are incorporated into clinical care pathways and embedded in reporting through patient experience surveys, patient satisfaction measures, consumer feedback and outcome monitoring. Consumers are actively involved in governance, service planning, quality improvement and feedback processes, ensuring consumer perspectives are routinely used to drive improvements in patient experience and outcomes, and to inform future priorities.
	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.	Achieved	Northern Health has established a strong safety culture through a Clinical Governance Framework and Quality and Safety Management System that promote transparency, continuous learning and data-driven decision-making. Quality, safety, patient experience and outcome measures are routinely monitored, reported and reviewed through governance structures from frontline teams to Executive and Board level. Robust reporting, review and escalation processes support accurate, transparent and fair decision-making, while ensuring opportunities for learning, improvement and risk reduction are systematically identified and acted upon.
	Health services are able to show evidence of a comprehensive training program approach that includes performance management, accountability, and continuous improvement.	Achieved	Northern Health maintains a comprehensive training and quality and safety program that supports workforce capability, performance management, accountability and continuous improvement. Through routine monitoring, analysis and sharing of quality and safety data at organisational, divisional and unit levels, staff and leaders are equipped to identify unwarranted clinical variation, implement improvement actions and monitor outcomes. Ongoing standardisation of quality and safety reporting across the organisation continues to strengthen accountability, performance oversight and evidence-based decision-making.

Goal	Health Service Deliverable	Status	Outcome
Improve access to timely emergency care by implementing system-wide patient flow strategies that reduce emergency department wait times and improve ambulance-to-hospital transfer 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.	Achieved	Northern Health has delivered sustained improvements in patient flow and timely access to emergency care through implementation of system-wide flow initiatives aligned with the Standards for Safe and Timely Ambulance and Emergency Care (STAEC). The organisation successfully completed the Timely Emergency Care (TEC2) Excellence in Flow program, achieving a final score of 4.5 (1.0-5.0 scale), which reflects significant and sustained improvement with new models of care embedded into routine practice. This was supported by reductions in admissions to acute ward beds and inpatient length of stay. Initiatives improved patient flow, reduced delays, enhanced discharge planning and strengthened access to timely emergency care.
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.	Achieved	Northern Health continued to implement and scale theatre optimisation initiatives to improve planned surgery efficiency, patient flow and same-day surgery outcomes. Key achievements included increased same-day discharge rates for laparoscopic cholecystectomy and hernia repair procedures, expansion of the Acute Pain Service to support same-day surgery, implementation of digital care pathways across multiple surgical specialties, and the successful embedding of Criteria-Led Discharge within the Electronic Medical Record and across surgical specialties. These initiatives have streamlined perioperative care, reduced delays and supported more efficient use of surgical capacity.
	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).	Achieved	Northern Health has strengthened proactive management of planned surgery and specialist clinic waitlists through ongoing auditing, embedded administrative review processes, and implementation of a revised Planned Surgery Access Policy that aligns with current requirements and best practice. Non-surgical treatment pathways continue to be strengthened and expanded to support patients into the most appropriate care pathway, while nurse-led specialist clinics have improved timely assessment, patient flow and access to care. Monitoring of surgical wait times for long-waiting patients and patients under 18 years remains embedded in routine performance oversight to support equitable and timely access to services.

Goal	Health Service Deliverable	Status	Outcome
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.	Achieved	Northern Health continued to progress implementation of the Victorian Government's mental health reform agenda by strengthening access to community and inpatient mental health services, supporting the removal of catchment barriers, and enhancing regional collaboration. Key initiatives included implementing processes to support cross-catchment access to care, establishing an escalation process for infant, child and youth inpatient services through the Local Health Service Network, and strengthening monitoring of demand to support timely access to care.
	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.	Achieved	Northern Health continued its partnership with Safer Care Victoria to implement mental health improvement initiatives aligned with statewide reform priorities. Key achievements included expanding the Safewards model beyond mental health settings to support safer care across the organisation and continuing to reduce restrictive practices within the Mental Health Division, including the permanent closure of two seclusion rooms.
	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.	Achieved	Northern Health continued to strengthen partnerships with community-based mental health services through collaborative service delivery, formal partnerships and Local Health Service Network initiatives, supporting implementation of the Mental Health and Wellbeing Act 2022 and Victoria's mental health reform priorities. Key partnerships have enhanced access to community-based mental health care, improved service integration and patient pathways, and supported system-wide collaboration to improve patient flow.

Prudent, sustainable and effective use of resources

Goal	Health Service Deliverable	Status	Outcome
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 on the key initiatives as outlined in the Budget Action Plan within Government parameters.	Achieved	Northern Health delivered against the Budget Action Plan. The operating budget targets were achieved, resulting in a year-end surplus.
	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.		A Financial Sustainability Plan was developed as part of the budget process; sustainability initiatives were delivered and monitored throughout the year with efficiencies identified and delivered to offset the budget gaps. Targeted financial savings were achieved, with a year-end surplus.
	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.	Achieved	Northern Health continued to demonstrate efficient use of available funding, maintaining a comparatively low cost per National Weighted Activity Unit (NWAU) relative to peer health services, while supporting growth in patient-facing services. Northern Health's ResourceWise Committee delivered a rolling plan of cost saving and productivity enhancing opportunities. Investments in new and expanded services were supported by a rigorous business case and approval process.

A stronger workforce

Goal	Health Service Deliverable	Status	Outcome
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 fulfil 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.	Achieved	Workforce sustainability outcomes were achieved, with the 2025/26 People Matter Survey meeting or exceeding four of five performance targets (Engagement, Workload, Flexible Working and Safety Climate), while Manager Leadership was marginally below target (84% vs 85%). Attrition remained below target (5.73% vs 6.1%). Gender Equality Act obligations were met through endorsement of the Gender Equality Action Plan 2026–2030, and leadership capability and succession planning were strengthened through targeted development initiatives.
	Collaborate with the department to improve workforce data analytics, generate actionable insights, and enhance strategic planning.	Achieved	Northern Health collaborated with the LHSN and Department of Health to strengthen workforce analytics and evidence-based planning with the completion of the LHSN Workforce Profile and Regional Workforce Plan. Workforce insights from the Clinical Services Plan inform strategic planning, workforce capability priorities, and future service delivery models across the Network. Data-driven initiatives underway include shared graduate programs, common credentialling, shared workforce systems, and specialist workforce-sharing arrangements to improve workforce mobility, capability and sustainability.

Improving Aboriginal health and wellbeing

Goal	Health Service Deliverable	Status	Outcome
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.	Achieved	Northern Health delivered high-quality Aboriginal Cultural Safety training to the Executive and Board through an approved, expert-led program, strengthening leadership capability to provide culturally safe care and supporting the organisation's commitment to improving health outcomes for Aboriginal and Torres Strait Islander peoples.
	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.	Achieved	Northern Health continued to strengthen partnerships with Aboriginal community-controlled organisations through ongoing engagement, collaborative planning and shared service delivery. Regular partnerships with Aboriginal organisations have informed service planning, supported culturally safe care, and strengthened Aboriginal community participation in the design and delivery of health services, with continued progress recognised through successful accreditation against the National Safety and Quality Health Service Standards.
	Ensure culturally appropriate systems for identifying Aboriginal and Torres Strait Islander patients and implement responsive discharge plans and referral pathways.	Achieved	Northern Health continued to strengthen culturally appropriate systems for identifying Aboriginal and Torres Strait Islander patients and improving referral and discharge pathways through collaborative initiatives with Aboriginal community-controlled organisations. Ongoing staff education, strengthened partnerships, and demonstrated compliance with the National Safety and Quality Health Service Standards have supported culturally responsive care and improved continuity of care for Aboriginal patients.

Moving from competition to collaboration

Goal	Health Service Deliverable	Status	Outcome
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).	Achieved	The inaugural North Metro and Mitchell Local Health Service Network established strong governance and delivered the majority of Statement of Expectations initiatives, with 11 of 16 completed, three adapted to better meet local needs, one deferred by the Department of Health and one continuing into 2026–27. Significant outcomes included development of the Network Strategy, Clinical Services Plan and Workforce Plan, alongside collaborative improvements to patient access, clinical pathways, workforce capability, shared services, and quality and safety across member health services.



Statement of Priorities Part B

High-quality safe care

Key Performance Measure	Target	Actual
Infection prevention and control		
Percentage of healthcare workers immunised for influenza	94%	97%
Continuing care		
Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations	≥ 0.645	0.897
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	100%
Patient experience		
Percentage of patients who reported positive experiences of their hospital stay	95%	90%
Aboriginal Health		
Difference between the percentage of Aboriginal patients and non Aboriginal patients who left against medical advice	0%	3%
Difference between the percentage of Aboriginal patients and non Aboriginal patients presenting to ED who did not wait to be treated	0%	4%

Key Performance Measure	Target	Result
Mental Health Patient Experience		
Percentage of consumers who rated their overall experience with a service in the last three months as positive	80%	61.5%
Percentage of families/carers reporting a 'very good' or 'excellent' overall experience of the service	80%	40.2%
Percentage of families/carers who report they 'always' or 'usually' felt their opinions as a carer were respected	90%	71.5%
Percentage of mental health consumers reporting they 'usually' or 'always' felt safe using this service	90%	74.4%

Key Performance Measure	Target	Result
Mental Health follow-ups, readmissions, and seclusions		
Percentage of consumers followed up within 7 days of separation – Inpatient.	88%	87%
Percentage of consumers re-admitted within 28 days of separation - inpatient.	< 14%	11%
Rate of seclusion episodes per 1,000 occupied bed days - inpatient	≤ 6	4.71

Strong governance, leadership and culture

Key Performance Measure	Target	Result
Organisational culture		
People matter survey – Percentage of staff with an overall positive response to safety culture survey questions.*	80%	75%

Changes to the 2025-26 Health Sector People Matter Survey has affected the 'Percentage of staff with an overall positive response to safety culture 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	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%	94%
Number of patients admitted from the planned surgery waiting list	11,959	11,923
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	1.5%
Optimisation of surgical inpatient length of stay (LOS), including through the use of virtual and home-based pre- and post-operative models of care	Reduction in average LOS for surgical patients by 2% on 24-25 performance	1.35
Emergency Care		
Percentage of patients transferred from ambulance to emergency department within 40 minutes	4% improvement on 24-25 performance	79%
Number of emergency patients with a length of stay in the ED greater than 24 hours	Zero	0
Average ED length of stay (LOS) for admitted patients, in minutes	Avg LOS < 414 minutes, if not met a 5% improvement from last year	594
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	269
Mental Health		
Percentage of mental health-related emergency department presentations with a length of stay of less than 4 hours	65%	28%
Percentage of departures from emergency departments to a mental health bed within 8 hours	80%	55%
Number of admitted mental health occupied bed days	39,216	44,085
Number of community mental health service hours	218,612	139,612*

*101% of funded activity delivered

Key Performance Measure	Target	Result
Specialist Clinics		
Percentage of patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe	95%	87.8%
Home Based Care		
Percentage of admitted bed days delivered at home	8.7%	8.2%

Effective financial management

Key Performance Measure	Target	Result
Finance		
Operating result ($M)	0.00	2.5
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	0.56
Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June	5% movement in forecast revenue and expenditure forecasts	Achieved

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.



Statement of Priorities Part C

Funding Type	2025-26 Activity Achievement
Consolidated Activity Funding	
Acute admitted, subacute admitted, emergency services, non-admitted NWAU	166,510
Community mental health NWAU	14,399
Acute Admitted	
Acute admitted DVA	127
Acute admitted TAC	272
Acute Non-Admitted	
Radiotherapy - other	491
Subacute/Non-Acute, Admitted and Non-admitted	
Subacute – DVA	125
Transition care – bed days	8,185
Transition care – home days	15,274
Aged Care	
Residential Aged Care	32,577
HACC	4,707
Mental Health and Drug Services	
Mental health ambulatory	43,993
Mental health residential	19,213
Mental health subacute	17,579
Small Rural	
Small rural acute	1



Mental Health and Wellbeing Act 2022

Throughout 2025–26, Northern Health Mental Health and Wellbeing continued to embed the principles of the Mental Health and Wellbeing Act 2022 across all aspects of service delivery. Building on the significant implementation work undertaken in the previous year, the service strengthened policies, clinical practices, staff education and consumer resources to ensure the Act's principles, including dignity, autonomy, supported decision-making and least restrictive care, are consistently reflected in everyday practice.

Northern Health remains committed to ensuring consumers, families, carers and supporters understand their rights and are actively supported to participate in decisions about their care. Information regarding consumer rights and responsibilities is provided both verbally and in writing at admission or commencement of community-based care. Consumers are also provided with information about the Independent Mental Health Advocacy (IMHA) service, with staff facilitating access to advocacy whenever requested.

Consumer participation and feedback continue to be integral to service improvement. Consumers are encouraged to provide feedback through a range of formal and informal mechanisms, including consumer experience surveys, compliments and complaints processes, anonymous feedback options and direct engagement with clinical teams.

Mutual Help groups, including those facilitated by Lived Experience staff, provide regular opportunities for consumers to raise issues, identify opportunities for improvement and contribute to service development during their admission. Feedback received throughout the year has informed ongoing quality improvement initiatives across the service.

Corporate Information



General Information

Northern Health is a public health service established under the Health Services Act 1988 (Vic).

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

Minister for Health

Minister for Ambulance Services

The Hon Mary-Anne Thomas MP

(1 July 2025 – 15 April 2026)

Minister for Health

Minister for Ambulance Services

Minister for Water

Hon Harriet Shing MP

(15 April 2026 – 30 June 2026)

Northern Health provides a wide range of health care services to the northern growth corridor, a catchment expected to grow from 543,000 residents in 2021 to 970,000 by 2041.

Northern Health comprises Broadmeadows Hospital, Bundoora Centre, Craigieburn Community Hospital, Kilmore District Hospital, Mernda Community Hospital and Northern Hospital Epping.

Northern Health also delivers mental health services from a number of different sites as part of the Northern Area Mental Health Service (NAMHS) and NorthWest Area Mental Health Service (NWAMHS).

Northern Area Mental Health Service includes Northern Hospital adult inpatient units (Epping), Northern Community Care Unit (Preston), Northern PARC (Preston), Hotham Street Community Clinic (Preston), and Noogal Clinic (Mill Park).

NorthWest Area Mental Health Service sites include Broadmeadows Hospital Adult Inpatient Unit, Broadmeadows Community Care Unit (CCU), Broadmeadows Prevention and Recovery Care (PARC), Moreland Community (Coburg) and Craigieburn Community Hospital.

Consultancies

Consultancy fees greater than $10,000 in individual amount

In 2025-26, Northern Health engaged two consultancies with an individual amount greater than $10,000. The total expenditure incurred in 2025-26 in relation to these consultancies was $184,980. This is detailed below:

Consultant	Purpose of Consultant	Start Date	End Date	Total Approved project Fee (excluding GST)	Expenditure 2025-26 (excluding GST)	Future expenditure (excluding GST)
Johnstaff Advisory	Advice in relation to the development of clinical service plan for the North Metro and Mitchell Local Health Service Network	1/01/2026	30/06/2026	164,525	164,525	Johnstaff Advisory
Wallace Health Advisory	Independent review of Maternity services	1/09/2025	30/09/2025	20,455	20,455	Wallace Health Advisory

Consultancies below $10,000

In 2025-26, Northern Health engaged six consultancies with an individual amount less than $10,000. The total value of these consultancies was $31,065.

Information and Communications Technology (ICT Expenditure)

For the 2025-26 reporting period, Northern Health had a total ICT expenditure of $19,804, with the details shown below:

Business as Usual (BAU) ICT Expenditure ($000)		Non-Business as Usual (non-BAU) ICT Expenditure ($000)	
Total (excluding GST)	Total= Operational expenditure and Capital Expenditure (excluding GST)	Operational expenditure (excluding GST) (a)	Capital expenditure (excluding GST) (b)
$19,804	$18,331	$5,753	$12,577

Occupational Health and Safety

Northern Health is committed to providing a safe and healthy working environment for all employees, contractors, volunteers, patients and visitors. Occupational Health and Safety (OHS) risks are managed through a comprehensive framework that includes hazard identification, incident reporting, risk assessment, staff consultation, training, injury prevention, workplace wellbeing initiatives and continuous improvement activities.

Northern Health monitors OHS performance through key indicators including workplace hazards and incidents, lost time injury claims and WorkCover claim costs. Ongoing monitoring of these indicators supports the identification of emerging risks and informs targeted prevention and intervention strategies.

OHS Performance

The number of reported hazards and incidents per 100 FTE was 50.21 during 2025–26, compared with 46.56 in 2024–25 and 40.21 in 2023–24. The increase in reporting rates reflects continued efforts to strengthen workplace safety culture, encourage the reporting of hazards and incidents, and improve organisational awareness of risk management responsibilities.

The number of lost time standard WorkCover claims per 100 FTE was 1.24 in 2025–26, compared with 1.33 in 2024–25 and 1.05 in 2023–24. While the result represents an improvement on the previous year, it remains above the 2023–24 level. The health service continues to focus on injury prevention initiatives, early intervention strategies, effective return-to-work programs and ongoing support for injured employees.

The average cost per Workcover claim was $88,078 in 2025–26, compared with $66,000 in 2024–25 and $153,000 in 2023–24. Variations in claim costs can be influenced by factors such as the nature and complexity of injuries, rehabilitation requirements, claim duration and actuarial adjustments to outstanding liabilities.

Throughout 2025–26, the health service maintained its commitment to employee wellbeing and workplace safety through ongoing risk management activities, workplace inspections, consultation with Health and Safety Representatives and designated work groups, targeted training programs and the continuous review and improvement of workplace safety systems.

Occupational Health and Safety Statistics	2023-24	2024-25	2025-26
The number of reported hazards/incidents for the year per 100 FTE (incl. OVA)	40.21*	46.56*	50.21
The number of 'lost time' standard WorkCover claims for the year per 100 FTE	1.05*	1.33*	1.24
The average cost per WorkCover claim for the year ('000)	$153'000	$66'000	$88'078

**These figures have been restated following a review and reconciliation of the underlying source data. The revisions do not alter the purpose of the reported measures but improve the accuracy and consistency of information presented for comparative purposes.*

Workplace Fatalities

There were no work-related fatalities reported during 2025-26.

Occupational Violence

During 2025–26, occupational violence reporting increased, with 4,626 incidents recorded compared with 4,275 in 2024–25, equating to an increase from 70.99 to 73.52 incidents per 100 FTE. While reported incidents increased, indicators relating to serious injury outcomes improved, with accepted WorkCover claims attributable to occupational violence decreasing from 0.15 to 0.11 per 100 FTE and accepted lost time injury claims reducing from 0.78 to 0.57 per 1,000,000 hours worked.

The increase in reported incidents reflect improved reporting practices, greater staff awareness and a stronger reporting culture across the organisation. However, the proportion of occupational violence incidents resulting in a staff injury, illness or condition increased from 13.95% to 19.02%, indicating that while fewer incidents progressed to compensable injuries, a higher proportion of reported events had a direct impact on staff wellbeing.

Northern Health will continue to focus on preventative measures, staff training, environmental controls and post-incident support to reduce both the frequency and severity of occupational violence incidents.

Occupational Violence	2025-26
Workcover accepted claims with an occupational violence cause per 100 FTE	0.11
Number of accepted Workcover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0.57
Number of occupational violence incidents reported	4,626
Number of occupational violence incidents reported per 100 FTE	73.52
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	19.02%

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 the course of a planned or unplanned Code Grey, the incident must be included.

Accepted Workcover claims – accepted Workcover claims that were lodged in 2025–26.

Lost time – is defined as greater than one day.

Injury, illness or condition – this includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

Safe Patient Care Act 2015

Northern Health has no matters to report in relation to its obligations under section 40 of the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 and Safe Patient Care Amendments 2025.

Workforce Inclusion Policy

Northern Health is committed to being a gender equitable employer and service provider, where all staff and consumers, regardless of gender or intersectional characteristics, are recognised, celebrated and supported. Building on the first Gender Equality Action Plan (GEAP) 2021–2025, launched in June 2022, Northern Health has continued to progress its workforce inclusion initiatives under the Gender Equality Act 2020. Progress over the past 12 months includes:

- **Northern Health Gender Equality Network (NH GEN):** Established and endorsed by the Executive team, NH GEN provides a formal structure for driving gender equality across the organisation. It is supported by Gender Equality Network Champions (GEN-C), who act as advocates and points of contact across services and departments, helping embed gender equality considerations into local decision-making and workplace culture.
- **Policy and procedure review:** Northern Health's policies and procedures have been reviewed to identify opportunities to strengthen the application of a gender lens. Proposed updates have been provided to relevant policy owners for consideration and implementation, supporting ongoing alignment of organisational policy with gender equality obligations.
- **SafeConnect reporting portal:** Northern Health developed and launched SafeConnect, an online self-service portal enabling staff to report staff-to-staff harassment, bullying, or sexual safety incidents from home or work, improving accessibility and confidentiality of reporting, supporting a safer and more inclusive workplace culture.
- **Sexual safety incident investigation feedback tool:** Complementing SafeConnect, this tool seeks reporters' feedback on their experience of the investigation process, including the quality of support provided and how safe they felt throughout. It is automatically triggered upon closure of a sexual safety incident recorded in RiskMan or submitted via SafeConnect, enabling Northern Health to collect data on reporter experience and continuously improve its investigation and support practices.
- **Gender Equality Action Plan 2026–2030:** Following the conclusion of the 2021–2025 plan, Northern Health finalised its next GEAP, developed in consultation with GEN-C members and the broader workforce to reflect staff lived experience and priorities. Seven measurable targets were defined and Northern Health's progress against these initiatives will be measured and reported.

To illustrate Northern Health's progress towards workforce inclusion, workforce composition will be reported annually. Workforce gender representation remains stable and within the parameters set out in the Gender Equality Action Plan 2026 - 2030.

Total Workforce Composition
75% women
24.9% men
0.1% gender diverse

Part Time Composition
82.5% women
17.3% men
0.2% gender diverse

Senior Leadership Composition
54.5% women
45.5% men
0% gender diverse

Director/Manager Composition
62.8% women
37.2% men
0% gender diverse

Freedom of Information Act 1982

During 2025–26, Northern Health received 1,674 applications. Of these requests, 1,158 were personal requests and 516 were non-personal. Northern Health made 1,275 FOI decisions during the 12 months ending 30 June 2026.

There were 344 decisions made within the statutory time periods. Of the decisions made outside time, 717 were made within a further 46 days and 214 decisions were made in greater than 46 days. Of the total decisions made, 791 granted access to documents in full, 414 granted access in part and 4 denied access in full.

Of requests finalised, the average number of days over/under the statutory time (including extended timeframes) to decide the request was 24 days. During 2025–26, 11 requests were subject to a complaint/internal review by Office of the Victorian Information Commissioner. Three requests progressed to the Victorian Civil and Administrative Tribunal (VCAT).

Local Jobs First Act 2003

Northern Health applies the Local Jobs First Policy to applicable procurement activities in accordance with the Local Jobs First Act 2003, associated regulations and government policy requirements.

During 2025–26, Northern Health assessed relevant procurement activities to determine whether the Local Jobs First Policy, Victorian Industry Participation Policy and Major Projects Skills Guarantee requirements applied.

During 2025–26, Northern Health commenced four (4) Local Jobs First Standard Projects and no Local Jobs First Strategic Projects, with a combined contract value of $15.3M.

All four (4) projects required Local Industry Development Plans (LIDPs). The Major Projects Skills Guarantee (MPSG) was not applicable to any of the projects. The successful suppliers committed to a weighted average local content of 56.8% and a combined employment commitment of 19.34 annualised employee equivalents (AEE).

As none of the applicable projects were completed during the reporting period, there are no actual local content or employment outcomes to report. All four projects remain in progress and are subject to the Local Jobs First post-contract review process upon completion. Information on the number of small and medium-sized businesses engaged as principal contractors or through project supply chains is not available at the time of reporting.

No post-contract reviews were due during the 2025–26 reporting period, as all applicable projects remain in progress.

The guidelines require disclosure of the number and value of applicable projects, local content, employment commitments and outcomes, small and medium-sized business participation, and post-contract reviews. Grant-funded activities are excluded from the project disclosure requirement.

National Competition Policy

Northern Health complied with the requirements of the National Competition Policy and Victoria's Competitive Neutrality Policy during 2025–26.

Northern Health's procurement and commercial activities were undertaken in accordance with applicable government procurement policies and competitive neutrality principles. Northern Health did not receive any formal competitive neutrality complaints during the reporting period.

Social Procurement Framework

Northern Health continued to implement Victoria's Social Procurement Framework during 2025–26 through its procurement planning, sourcing, evaluation and contract management activities.

Northern Health prioritised social procurement objectives relevant to its procurement profile, including:

- opportunities for Victorian Aboriginal businesses;
- opportunities for Victorian social enterprises and other social benefit suppliers;
- employment and economic participation opportunities for priority cohorts;
- gender equality and opportunities for women in construction, where applicable;
- environmentally sustainable business practices; and
- safe, fair and responsible supply chains.

Social procurement requirements were considered during procurement planning and were incorporated into tender documentation, evaluation criteria and contractual obligations where proportionate and applicable. Procurement and project teams also monitored contractor commitments through contract reporting and governance processes.

Key activities undertaken during 2025–26 included:

- assessing procurements for applicable social procurement objectives and opportunities;
- including social procurement response requirements in relevant market approaches;
- evaluating supplier commitments as part of tender evaluation processes;
- incorporating social procurement obligations and reporting requirements into relevant contracts;

- monitoring Local Jobs First and Social Procurement Framework commitments on applicable capital projects; and
- continuing engagement with suppliers to improve awareness, performance and reporting.

During 2025–26, Northern Health continued to apply Victoria's Social Procurement Framework across its procurement activities. Northern Health engaged 10 verified social benefit suppliers, comprising 8 Victorian Aboriginal businesses and 2 certified Victorian social enterprises. Total direct expenditure with verified social benefit suppliers was $121k excluding GST.

Building Act 1993

Northern Health complies with the building and maintenance provisions of the Building Act 1993, the regulations made under the Act and the relevant provisions of the National Construction Code.

Northern Health maintains governance and assurance arrangements to support compliance across the buildings it owns or controls. These arrangements include:

- engagement of appropriately registered building practitioners, consultants and building surveyors;
- obtaining building permits, occupancy permits and certificates of final inspection where required;
- review of design and construction documentation for statutory and technical compliance;
- inspection, testing, commissioning and certification of completed works;
- planned and reactive maintenance programs;
- condition assessments, compliance audits and risk-based asset inspections;
- maintenance and monitoring of essential safety measures; and
- recording and prioritisation of identified defects, compliance matters and infrastructure risks.

During 2025–26, Northern Health undertook [5] major building works projects with a value greater than $50,000.

For buildings owned or controlled by Northern Health:

- [14] building permits were issued;
- [3] occupancy permits were issued;
- [8] certificates of final inspection were issued;

Any building compliance issues identified through inspections, maintenance activities or project delivery were recorded, risk assessed and addressed through Northern Health's maintenance, capital works and compliance programs.

Carers Recognition Act 2012

Northern Health is dedicated to providing the highest quality of care in the safest possible environment for every patient. Northern Health complies with the intent of the Carers Recognition Act 2012 which seeks to:

- Recognise, promote and value the role of people in care relationships
- Recognise the different needs of persons in care relationships
- Support and recognise that care relationships bring benefits to the persons in the care relationships and the community
- Mental Health has a Carer Lived Experience workforce and a co-designed framework

Public Interest Disclosures Act 2012

Under the Public Interest Disclosure Act 2012, complaints about certain serious misconduct or corruption involving public health services in Victoria should be made directly to the Independent Broad-based Anti-Corruption Commission (IBAC) in order to remain protected under the Act.

Northern Health encourages individuals to make any disclosures which are protected disclosures within the meaning of the Act with IBAC.

Car Parking Fees

Northern Health complies with the relevant hospital circular on car parking fees. Details of car parking fees and concessions benefits can be viewed at www.nh.org.au.

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 health service 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.

The following information must be retained and made available upon request:

a) a statement that declarations of pecuniary interests have been duly completed by all relevant officers;

b) details of shares held by a senior officer as nominee or held beneficially in a statutory authority or subsidiary;

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

d) details of changes in prices, fees, charges, rates, and levies charged by the entity;

e) details of any major external reviews carried out on the entity;

f) details of major research and development activities undertaken by the entity;

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

h) details of major promotional, public relations and marketing activities undertaken by the entity to develop community awareness of the entity and its services;

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

j) a general statement on industrial relations within the entity and details of time lost through industrial accidents and disputes;

k) a list of major committees sponsored by the entity, the purposes of each committee and the extent to which the purposes have been achieved; and

(l) 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:

Basil Ireland
Chief Financial Officer
Email: Basil.Ireland@nh.org.au



Attestations

Data Integrity Declaration

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



Ms Debra Bourne
Chief Executive
Northern Health
20 August 2026

Conflict of Interest Declaration

I, Debra Bourne, certify that Northern 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 Victorian Public Sector Commission. Declaration of private interest forms have been completed by all executive staff within Northern Health and Board Directors, 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 and Board meeting.



Ms Debra Bourne
Chief Executive
Northern Health
20 August 2026

Integrity, Fraud and Corruption Declaration

I, Debra Bourne, certify that Northern Health has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at Northern Health during the year.



Ms Debra Bourne
Chief Executive
Northern Health
20 August 2026

Compliance with Health Service Victoria (HSV) Purchasing Policies

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



Ms Debra Bourne
Chief Executive
Northern Health
20 August 2026

Northern Health Financial Management Compliance Attestation

I, Alan Lilly, on behalf of the Northern Health Board, certify that Northern Health has no Material Compliance Deficiency with respect to the applicable Standing Directions under the *Financial Management Act 1994* and instructions.



Alan Lilly
Board Chair
Northern Health
20 August 2026





Workforce Information

Northern Health has grown significantly due to the commencement of new services, and being situated in a growth corridor within the northern region. Northern Health will continue to expand over the coming years, to provide a positive and proactive healthcare system to staff, and the community.

Labour information

The Full Time Equivalent (FTE) head count for Northern Health as at 30 June 2025 and 30 June 2026 is provided below.

	June Current Month FTE		Average Monthly FTE	
Labour Category	**2025**	**2026**	**2024/25**	**2025/26**
Total	**6,193.75**	**6,458.37**	**6,076.02**	**6,298.37**
Nursing Services	2,840.68	2,905.22	2,769.20	2,846.57
Administration & Clerical	874.60	882.76	873.79	869.51
Medical Support Services	528.79	547.39	519.47	533.96
Hotel & Allied Services	264.74	273.84	262.38	268.64
Medical Officers	123.83	131.85	123.70	130.69
Hospital Medical Officers	604.59	634.94	606.71	622.87
Sessional Medical Officers	316.00	357.56	293.96	336.22
Ancilliary Support Services	640.52	724.81	626.80	689.92

**FTE stands for full-time equivalent position. All employees of Northern Health are correctly classified in the workforce data collections.*

Employment and Conduct Principles

Northern Health is committed to ensuring all aspects of employment, including recruitment, selection, promotion, training and retention of employees are fair and transparent.

Embedded in Northern Health's policies and procedures are the principles of merit and equity, with appropriate avenues for grievance and complaint processes.

Northern Health provides a dynamic working environment with a culture of teamwork, diversity, safety and respect, based on strong values and Codes of Conduct.

Financial Results

Northern Health's financial objective is to provide the resources necessary to meet service and activity requirements, address capital needs and ensure cash sustainability.

In 2025-26, Northern Health generated a Statement of Priorities (SoP) operating surplus of $2.5M, (2025: $9k surplus). This was achieved in challenging financial circumstances.

Available cash improved to $3M (2025: break-even) due to increases in working capital driven by the growth in employee benefits provisions.

Northern Health is confronted with financial challenges in 2025-26. We will continue to drive efficiency initiatives while working with DH to secure adequate funding to sustain our operations.

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

Item	2026 $000	2025 $000	2024 $000	2023 $000	2022 $000
Operating result (SoP)	2,497	9	(73,927)	483	135
Total revenue	1,512,412	1,341,776	1,149,319	1,202,183	946,952
Total expenses	1,491,206	1,356,278	1,266,113	1,146,538	876,366
Net result from transactions	**21,206**	**(14,502)**	**(116,794)**	**55,645**	**70,586**
Total other economic flows	6,021	709	1,003	(9,251)	4,900
Net result	**27,227**	**(13,793)**	**(115,791)**	**46,394**	**75,486**
Total assets	1,468,587	1,194,842	1,168,249	965,048	822,560
Total liabilities	462,345	420,211	379,847	302,621	242,812
Net assets / Total equity	**1,006,241**	**774,631**	**788,402**	**662,427**	**579,748**

Events occurring after balance date

There are no matters or circumstances that have arisen since the end of the financial year which significantly affect or may affect the operations of Northern Health, the results of the operations or the state of affairs of Northern Health in the future financial years.

Reconciliation of net result from transactions and operating result

Item	2025-26 ($000)
Operating Result (SoP)	**2,497**
Capital purpose income	103,486
Specific income	0
COVID-19 State Supply Arrangements: - Assets received free of charge or for nil consideration under the State Supply	980
State supply items consumed up to 30 June 2026	(980)
Assets received free of charge	
Expenditure for capital purpose	(7,562)
Depreciation and amortisation	(71,646)
Impairment of non-financial assets	(5,062)
Finance costs (other)	(507)
Net result from transactions	**21,206**



Disclosure Index

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

Legislation	Requirement	Page Ref
Report of operations		
Charter and purpose		
FRD 22	Manner of establishment and the relevant Ministers	67
FRD 22	Purpose, functions, powers, and duties	49–53
FRD 22	Nature and range of services provided	5
FRD 22	Activities, programs, and achievements for the reporting period	11–33
FRD 22	Significant changes in key initiatives and expectations for the future	7–8
Management and structure		
FRD 22	Organisational structure	45–46
FRD 22	Workforce data/employment and conduct principles	78
FRD 22	Workforce inclusion policy	71
FRD 22	Occupational Health and Safety	69
Financial and other information		
FRD 22	Summary of the financial results for the year	79–80
FRD 22	Significant changes in financial position during the year	79–80
FRD 22	Operational and budgetary objectives and performance against objectives	64
FRD 22	Subsequent events	79
FRD 22	Details of consultancies under $10,000	68
FRD 22	Details of consultancies over $10,000	68
FRD 22	Disclosure of government advertising expenditure	N/A
FRD 22	Disclosure of ICT expenditure	68
FRD 22	Asset Management Accountability Framework	N/A
FRD 22	Disclosure of emergency procurement	N/A
FRD 22	Disclosure of social procurement activities under the Social Procurement Framework	72–73
FRD 22	Disclosure of procurement complaints	N/A
FRD 22	Disclosure of reviews and study expenses	N/A
FRD 22	Disclosure of grants and transfer payments	N/A
FRD 22	Application and operation of *Freedom Information Act 1982*	71
FRD 22	Compliance with building and maintenance provisions of *Building Act 1993*	73
FRD 22	Application and operation of *Public Interest Disclosure Act 2012*	73
FRD 22	Statement on National Competition Policy	72
FRD 25	*Local Jobs First Act 2003* disclosures	72

Legislation	Requirement	Page Ref
Compliance attestation and declaration		
SD 5.1.4	Financial Management Compliance attestation	75
SD 5.2.3	Declaration in Report of Operations	8
	Attestation on Data Integrity	75
	Attestation on managing Conflicts of Interest	75
	Attestation on Integrity, Fraud and Corruption	75
	Compliance with Health Share Victoria (HSV) Purchasing Policies	75
Other reporting requirements		
Reporting of outcomes from Statement of Priorities 2025–2026		55–65
Occupational Violence reporting		70
Reporting obligations under the *Safe Patient Care Act 2015*		71
Reporting of compliance regarding Car Parking Fees (if applicable)		73

Financial Statements

Declaration		
SD 5.2.2	Declaration in financial statements	86
Other requirements under Standing Directions 5.2		
SD 5.2.1 (a)	Compliance with Australian accounting standards and other authoritative pronouncements	86
SD 5.2.1 (a)	Compliance with Standing Directions	86
SD 5.2.1 (b)	Compliance with Model Financial Report	86
Other disclosures as required by FRDs in notes to the financial statements		
FRD 11	Disclosure of Ex gratia Expenses	140
FRD 103	Non-Financial Physical Assets	133–134
FRD 110	Cash Flow Statements	89–92
FRD 112	Defined Benefit Superannuation Obligations	106
FRD 114	Financial Instruments – general government entities and public non-financial corporations	127–129

Legislation

Freedom of Information Act 1982 (Vic) (FOI Act)	71
Building Act 1993	73
Public Interest Disclosures Act 2012	73
Carers Recognition Act 2012	73
Local Jobs Act 2003	72
Financial Management Act 1994 (b)	75



Financial Statements

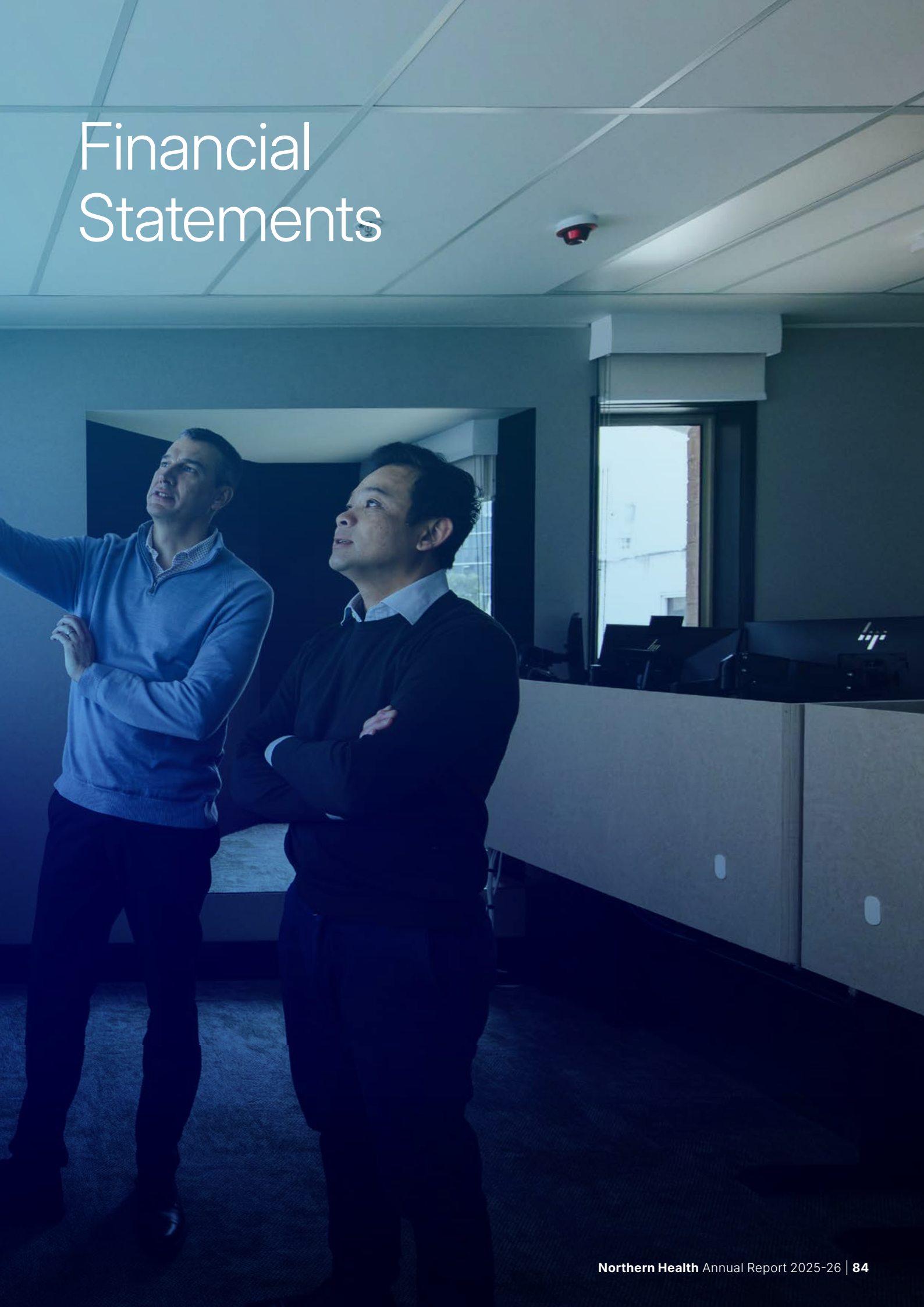


Table of contents

Board members', Accountable Officer's and Chief Finance and Accounting Officer's declaration 86
Auditor-General's Report 87
Consolidated Comprehensive Operating Statement 89
Consolidated Balance Sheet 90
Consolidated Statement of Changes in Equity 91
Consolidated Cash Flow Statement 92
Notes to the financial statements 93
Note 1: About this report 93
Note 1.1: Basis of preparation 93
Note 1.2: Abbreviations and terminology used in financial statements 93
Note 1.3: Principles of consolidation 93
Note 1.4: Material accounting estimates and judgements 94
Note 1.5: Accounting standards issued but not yet effective 94
Note 1.6: Goods and Services Tax (GST) 95
Note 1.7: Reporting entity 95
Note 1.8: Economic dependency 95
Note 1.9: Community Hospital Asset Transfers through Contributed Capital 95
Note 2.: Funding delivery of our services 96
Note 2.1: Revenue and income from transactions 96
Note 3: The cost of delivering our services 102
Note 3.1: Expenses incurred in the delivery of services 102
Note 4: Key assets to support service delivery 108
Note 4.1: Property, plant and equipment 109
Note 4.2: Intangible assets 111
Note 4.3: Depreciation and amortisation 112
Note 4.4: Impairment of assets 112
Note 5: Other assets and liabilities 113
Note 5.1: Receivables 114
Note 5.2: Contract assets 116
Note 5.3: Payables 117
Note 5.4: Contract liabilities 118
Note 5.5: Monies held in trust 119
Note 6: How we finance our operations 120
Note 6.1: Borrowings 121
Note 6.2: Cash and cash equivalents 124
Note 6.3: Commitments for expenditure 125
Note 7: Risks, contingencies and valuation uncertainties 126
Note 7.1: Financial instruments 127
Note 7.2: Financial risk management objectives and policies 130
Note 7.3: Contingent assets and contingent liabilities 132
Note 7.4: Fair value determination 132
Note 8: Other disclosures 136
Note 8.1: Reconciliation of net result for the year to net cash inflow from operating activities 136
Note 8.2: Responsible persons disclosures 137
Note 8.3: Remuneration of executives 138
Note 8.4: Related parties 138
Note 8.5: Remuneration of auditors 140
Note 8.6: Ex-gratia expenses 140
Note 8.7: Events occurring after the balance sheet date 140
Note 8.8: Controlled entities 141
Note 8.9: Equity 141

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

The attached consolidated financial statements for Northern Health and the consolidated entity 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 Consolidated Comprehensive Operating Statement, Consolidated Balance Sheet, Consolidated Statement of Changes in Equity, Consolidated Cash Flow Statement and accompanying notes, fairly presents the financial transactions during the year ended 30 June 2026 and the financial position of Northern Health and the consolidated entity at 30 June 2026.

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

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

Board Member



Adjunct Professor Alan Lilly
Board Chair
Northern Health

3 September 2026

Accountable Officer



Adjunct Professor Debra Bourne
Chief Executive Officer
Northern Health

3 September 2026

Chief Finance and Accounting Officer



Mr Basil Ireland
Chief Finance and Accounting Officer
Northern Health

3 September 2026

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Northern Health

Opinion	I have audited the consolidated financial report of Northern Health (the health service) and its controlled entities (together the consolidated entity), which comprises the: • consolidated entity and health service balance sheets as at 30 June 2026 • consolidated entity and health service comprehensive operating statements for the year then ended • consolidated entity and health service statements of changes in equity for the year then ended • consolidated entity and health service cash flow statements for the year then ended • notes to the financial statements, including material accounting policy information • board members', accountable officer's and chief financial and accounting officer's declaration. In my opinion, the financial report presents fairly, in all material respects, the financial positions of the consolidated entity and 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 and the consolidated entity 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 and the consolidated entity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

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

Auditor's responsibilities for the audit of the financial report

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

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

- identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the health service and the consolidated entity'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 and the consolidated entity'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 and the consolidated entity 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
- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the health service and consolidated entity to express an opinion on the financial report. I remain responsible for the direction, supervision and performance of the audit of the health service and the consolidated entity. I remain solely responsible for my audit opinion.

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
28 September 2026

Simone Bohan
as delegate for the Auditor-General of Victoria

Northern Health
Consolidated Comprehensive Operating Statement
For the Year Ended 30 June 2026

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Revenue and income from transactions			
Revenue from contracts with customers	2.1(a)	1,156,662	1,073,634
Government grants	2.1(b)	320,537	234,361
Other income	2.1(c)	35,212	33,781
Total revenue and income from transactions		**1,512,412**	**1,341,776**
Expenses from transactions			
Employee expenses	3.1(a)	(1,132,197)	(1,034,606)
Depreciation and amortisation	4.3	(71,646)	(69,882)
Supplies and consumables	3.1(d)	(145,124)	(135,438)
Other operating expenses	3.1(e)	(142,239)	(116,352)
Total expenses from transactions		**(1,491,206)**	**(1,356,278)**
Net result from transactions - net operating balance		**21,206**	**(14,502)**
Other economic flows included in net result			
Net gain/(loss) on sale of non-financial assets		(114)	148
Other gain/(loss) from other economic flows		6,136	561
Total other economic flows included in net result		**6,021**	**709**
Net result		**27,228**	**(13,793)**
Other economic flows- other comprehensive income			
Items that will not be reclassified to net result			
Changes in property, plant and equipment revaluation surplus	4.1(a)	(4,412)	-
Changes in the fair value of equity instruments at fair value through other comprehensive income		(14)	20
Total other comprehensive income		**(4,426)**	**20**
Comprehensive result		**22,802**	**(13,773)**

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

Northern Health
Consolidated Balance Sheet
As at 30 June 2026

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Financial assets			
Cash and cash equivalents	6.2	78,451	62,582
Receivables	5.1	121,313	118,060
Contract assets	5.2	3,077	1,743
Investments and other financial assets		2,053	2,540
Total financial assets		**204,895**	**184,926**
Non-financial assets			
Prepayments		58,118	48,540
Inventories		5,105	5,291
Property, plant and equipment	4.1	1,200,366	955,941
Intangible assets	4.2	103	144
Total non-financial assets		**1,263,692**	**1,009,916**
Total assets		**1,468,587**	**1,194,842**
Liabilities			
Payables	5.3	121,626	105,807
Contract liabilities	5.4	1,224	973
Borrowings	6.1	8,709	11,222
Employee benefits	3.1(b)	305,678	276,638
Monies held in trust	5.5	25,109	25,572
Total liabilities		**462,345**	**420,211**
Net assets		**1,006,241**	**774,631**
Equity			
Property, plant and equipment revaluation surplus		486,848	491,260
Financial assets at fair value through other comprehensive income revaluation reserve		(29)	(15)
Restricted specific purpose reserve		10,616	9,927
Contributed capital		424,344	215,535
Accumulated surplus/(deficit)		84,462	57,923
Total equity		**1,006,241**	**774,631**

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

Northern Health
Consolidated Statement of Changes in Equity
For the Year Ended 30 June 2026

Consolidated	Note	Property, plant & equipment revaluation surplus $'000	Financial Assets through Other Comprehensive Income Revaluation Reserve $'000	Restricted specific purpose reserve $'000	Contributed capital $'000	Accumulated surplus/ (deficits) $'000	Total $'000
Balance at 1 July 2024		**491,260**	**(36)**	**8294**	**215,535**	**73,349**	**788,402**
Net result for the year		-	-	-	-	(13,793)	(13,793)
Transfer to restricted specific purpose surplus/(deficit)		-	-	1,633	-	(1,633)	-
Other comprehensive income for the year		-	-	-	-	-	-
Movement in reserves		-	20	-	-	-	20
Contributed capital		-	-	-	-	-	-
Balance at 30 June 2025		**491,260**	**(15)**	**9,927**	**215,535**	**57,923**	**774,631**
Net result for the year		-	-	-	-	27,228	27,228
Transfer to restricted specific purpose surplus/(deficit)		-	-	689	-	(689)	-
Other comprehensive income for the year		(4,412)	-	-	-	-	(4,412)
Movement in reserves		-	(14)	-	-	-	(14)
Contributed capital*		-	-	-	208,808	-	208,808
Balance at 30 June 2026		**486,848**	**(29)**	**10,616**	**424,344**	**84,462**	**1,006,241**

**Transfer of Community Hospital Asset from Department of Health to Northern Health via Contributed Capital. Refer to notes 1.9 and 4.1(a).*

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

Northern Health
Consolidated Cash Flow Statement
For the Year Ended 30 June 2026

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Cash flows from operating activities			
Receipts from Government		1,363,521	1,224,615
Commercial activities, patient and hospital fees received		47,306	46,751
Pharmaceutical sales received		461	313
Donations and bequests received		1,559	2,742
Interest and investment income received		5,910	7,496
Other receipts received		22,259	21,370
Total receipts		**1,441,017**	**1,303,287**
Payments to employees		(1,078,261)	(998,253)
Payments for supplies and consumables		(166,247)	(161,482)
Finance costs		-	(4)
GST paid to ATO		(971)	(2,397)
Other payments		(149,886)	(111,681)
Total payments		**(1,395,365)**	**(1,273,818)**
Net cash flows from/(used in) operating activities	8.1	**45,653**	**29,469**
Cash flows from investing activities			
Proceeds from sale of non-financial assets		-	338
Purchase of non-financial assets		(30,543)	(38,540)
Purchase of financial assets		(27)	(21)
Net cash flows from/(used in) investing activities		**(30,569)**	**(38,223)**
Cash flows from financing activities			
Repayment of borrowings		(54)	(63)
Investments and other financial assets		500	(1,250)
Repayment of accommodation deposits		(6,251)	(4,909)
Receipt of accommodation deposits		6,591	6,293
Net cash flows from/(used in) financing activities		**786**	**71**
Net increase /(decrease) in cash and cash equivalents		**15,869**	**(8,683)**
Cash and cash equivalents at beginning of year		62,582	71,265
Cash and cash equivalents at end of year	6.2	**78,451**	**62,582**

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

Note 1. About this report

These financial statements represent the consolidated financial statements of Northern Health and its controlled entities (the Northern Health Foundation) 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 Northern Health.

The financial statements have been prepared on a going concern basis (refer to Note 1.8 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 Northern Health and its controlled entities on 3 September 2026.

Note 1.2. Abbreviations and terminology used in financial statements

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

Reference	Title
AASB	Australian Accounting Standards Board
ATO	Australian Tax Office
AASs	Australian Accounting Standards, which include interpretations
DH	Department of Health
DTF	Department of Treasury and Finance
FMA	Financial Management Act 1994
FRD	Financial Reporting Direction
NWAU	National Weighted Activity Unit
SD	Standing Direction
VAGO	Victorian Auditor General's Office

Note 1.3. Principles of consolidation

The financial statements include the assets and liabilities of Northern Health and its controlled entities as a whole as at the end of the financial year and the consolidated results and cash flows for the year.

Northern Health controls the Northern Health Foundation. Details of the controlled entity are set-out in Note 8.8.

The transactions and balances of the parent entity Northern Health are not disclosed separately in the notes to the financial statements.

An entity is considered to be a controlled entity where Northern Health has the power to govern the financial and operating policies of an organisation to obtain benefits from its activities. In assessing control, potential voting rights that are presently exercisable are considered.

Northern Health consolidates the results of its controlled entities from the date on which it gains control until the date it ceases to have control. Where dissimilar accounting policies are adopted by entities and their effect is considered material, adjustments are made to ensure consistent policies are adopted in these financial statements.

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

Note 1.4. Material accounting estimates and judgements

Management makes estimates and judgements when preparing the financial statements.

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

Revisions to estimates are recognised in the period in which the estimate is revised and also in future periods 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 are disclosed in further detail throughout the accounting policies 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 5.3: Payables
- Note 5.4: Contract liabilities
- Note 6.1(a): Lease liabilities
- Note 7.4: Fair value determination

Note 1.5. Accounting standards issued but not yet effective

The accounting standards and interpretations issued by the AASB that are not yet mandatorily applicable to Northern Health are:

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

- AASB 17 Insurance Contracts, AASB 2022-8 Amendments to Australian Accounting Standards – Insurance Contracts: Consequential Amendments and AASB 2022-9 Amendments to Australian Accounting Standards – Insurance Contracts in the Public Sector

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

- AASB 18 Presentation and Disclosure of Financial Statements

Adoption of these standards is not expected to have a material impact on the financial statements of Northern Health.

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

Note 1.6. Goods and Services Tax (GST)

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

Receivables and payables in the Balance Sheet are stated inclusive of the amount of GST. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the Balance Sheet.

Cash flows are included in the Cash Flow Statement on a gross basis, except for the GST components of cash flows arising from investing and/or financing activities, which are recoverable from, or payable to the ATO. These GST components are disclosed as operating cash flows.

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

Note 1.7. Reporting entity

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

Northern Health's principal address is:
185 Cooper Street
Epping, Victoria, 3076

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

Note 1.8. Economic dependency

Northern 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.

Northern Health provides essential services and is 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 intends to continue Northern Health operations, and, on that basis, the financial statements have been prepared on a going concern basis.

Note 1.9. Community Hospital Asset Transfers through Contributed Capital

During 2025–26, Northern Health received the Craigieburn Community Hospital and Mernda Community Hospital assets from the Department of Health through transfers designated as Transfers through Contributed Capital in accordance with Financial Reporting Direction (FRD) 119 – Transfers through Contributed Capital.

The transfers comprised the completed land, buildings and fit-out assets associated with the two community hospitals and were recognised at fair value as contributions by owners. Accordingly, the transfers have been recognised directly in equity as Contributed Capital and have not been recognised as income in the Comprehensive Operating Statement.

The assets transferred at 30 June 2026 comprised:

Community Hospital	Assets transferred	Fair Value ($'000)	Valuation Approach
Craigieburn Community Hospital	Building and fit-out	106,040	Current replacement cost
Mernda Community Hospital	Building and fit-out	90,356	Current replacement cost
Mernda Community Hospital	Land	12,412	Market value
Total		**208,808**	

The transfers resulted in an increase in contributed capital of $208.81 million, with no impact on the operating result for the year. The movement in contributed capital is reflected in the Statement of Changes in Equity.

Note 2. Funding delivery of services

Structure

Note 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	Northern Health **exercises** judgment when reviewing the terms and conditions of funding agreements and contracts to determine whether they contain sufficiently specific and enforceable performance obligations. If this criterion is met, the contract/funding agreement is treated as a contract with a customer, requiring Northern Health to recognise revenue as or when goods or services are delivered to customers. If this criterion is not met, funding is recognised immediately in the net result from operations.
Determining timing of revenue recognition	**Northern Health exercises 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	**Northern Health exercises judgement t**o determine when its obligation to construct an asset is satisfied. Costs incurred are used to measure the Northern Health'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

		Consolidated 2026 $'000	Consolidated 2025 $'000
Revenue from contracts with customers	2.1(a)	1,156,662	1,073,634
Government grants	2.1(b)	320,537	234,361
Other income	2.1(c)	35,212	33,781
Total revenue and income from transactions		**1,512,412**	**1,341,776**

Note 2.1(a): Revenue from contracts with customers

	Consolidated 2026 $'000	Consolidated 2025 $'000
Government grants (State) – Operating	1,038,901	967,553
Government grants (Commonwealth) – Operating	75,974	68,387
Patient and resident fees	31,501	28,867
Private practice fees	3,263	2,562
Commercial activities[1]	6,572	5,804
Other revenue from operating activities	452	461
Total revenue from contracts with customers	**1,156,662**	**1,073,634**

Northern Health disaggregates revenue by the timing of revenue recognition.

Goods and services transferred to customers:		
At a point in time	1,134,829	1,053,709
Over time[2]	21,833	19,925
Total revenue from contracts with customers	**1,156,662**	**1,073,634**

[1] Commercial activities represent business activities which Northern Health undertakes to support its operations.

[2] Revenue received for patient and resident fees relating to accommodation charges are recognised over time, to reflect the period accommodation is provided.

Note 2.1. Revenue and income from transactions (continued)

How we recognise revenue from contracts with customers

Government operating grants

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

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

Government grant	Performance obligation
Activity Based Funding (ABF) paid as National Weighted Activity Unit (NWAU)	The performance obligations for ABF are the number and mix of patients admitted to hospital (defined as 'case mix') in accordance with the levels of activity agreed to, with DH in the annual Statement of Priorities. NWAU activity is a cost weight that is adjusted for time spent in hospital, and represents a relative measure of resource used for each episode of care in a diagnosis related group (DRG). The performance obligations for NWAU are the number and mix of admissions, emergency department presentations and outpatient episodes, and is weighted for clinical complexity. Revenue is recognised at point in time, which is when a patient is discharged.
Other Victorian and Commonwealth funding	Northern Health receives various funding streams from both 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 such as carpark, retail and rental revenue are recognised on an accrual basis. Commercial activities revenue is recognised at a point in time upon provision of the goods or services to the customer. Rental income from investment properties is recognised on a straight-line basis over the term of the lease, unless another systematic basis is more representative of the pattern of use of the underlying asset.

Note 2.1. Revenue and income from transactions (continued)

Note 2.1(b): Government grants

	Consolidated 2026 $'000	Consolidated 2025 $'000
Operating activities		
Government grants (State) – Operating	228,553	191,923
Government grants (State) – Capital	91,984	42,438
Total government grants	**320,537**	**234,361**

How we recognise government grants

Government operating grants

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

Income from grants without any sufficiently specific performance obligations or that are not enforceable, is recognised when Northern Health has an unconditional right to receive cash which usually coincides with receipt of cash. On initial recognition of the asset, Northern 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
- 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 Northern 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 Northern 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 (DH)

DH makes some payments on behalf of Northern Health as follows:

Supplier	Description
Victorian Managed Insurance Authority	DH purchases various forms of insurance for Northern 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	DH made payments to the Victorian Infrastructure Delivery Authority to fund capital works projects during the year ended 30 June 2026, on behalf of Northern Health.
Department of Health	Long Service Leave (LSL) revenue is recognised upon finalisation of movements in LSL liability in line with the LSL funding arrangements with the DH.

Note 2.1. Revenue and income from transactions (continued)

Note 2.1(c): Other income

		Consolidated 2026 $'000	Consolidated 2025 $'000
Operating activities			
Other capital purpose income		-	737
Capital donations		4,821	3,627
Assets received free of charge or for nominal consideration[1]	2.1(d)	980	321
Salary and other recoveries		6,260	3,227
Research and sundry income		3,057	5,029
Other income from operating activities		1,614	2,836
Total other sources of income		**16,733**	**15,777**
Non-operating activities			
Capital interest		6,680	8,266
Other income from non-operating activities		11,800	9,738
Total other sources of income		**18,480**	**18,004**
Total other sources of income		**35,212**	**33,781**

[1] Assets received free of charge mainly comprise Personal Protective Equipment (PPE) received free of charge from the state-wide supply centre.

How we recognise other income

Interest income

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

Rental income

Northern Health recognised $14.4m of capital rent in advance from the University of Melbourne and La Trobe University for the Northern Centre for Health, Education and Research (NCHER) as part of a lease arrangement executed on 1 January 2015. The $14.4m in funding received from the universities is progressively recognised as rental income on a straight-line basis for the 21-year term of the lease ending 31 December 2035.

Note 2.1. Revenue and income from transactions (continued)

Note 2.1(d): Fair value of assets and services received free of charge or for nominal consideration

	Consolidated 2026 $'000	Consolidated 2025 $'000
Personal protective equipment and other consumables	980	321
Total fair value of assets and services received free of charge or for nominal consideration	**980**	**321**

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 Northern 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.

Personal protective equipment (PPE)

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

Contributions of resources

Northern Health may receive resources for nil or nominal consideration to further its objectives. The resources are recognised at their fair value when Northern Health obtains control over the asset, irrespective of whether restrictions or conditions are imposed over the use of the contributions.

On initial recognition of the asset, Northern Health recognises related amounts being contributions by owners, lease liabilities, financial instruments, provisions and revenue or contract liabilities arising from a contract with a customer.

Northern Health recognises income immediately in the profit or loss as the difference between the initial fair value of the asset and the related amounts.

The exception to this policy is when an asset is received from another government agency or department as a consequence of a restructuring of administrative arrangements, in which case the asset will be recognised at its carrying value in the financial statements of Northern Health as a capital contribution transfer.

Voluntary services

Northern Health is supported by volunteers from the community. Northern Health recognises contributions by volunteers in its financial statements, only if the fair value can be reliably measured and the services would have been purchased had they not been donated. Northern Health greatly values the services contributed by volunteers but it does not depend on volunteers to deliver its services.

Note 3. The cost of delivering our services

This section provides an account of the expenses incurred by the Northern Health in delivering services and outputs. In Section 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

Note 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	Northern Health **exercises** judgment when classifying its employee benefit liabilities. Employee benefit liabilities are classified as a current liability if Northern Health does not have an unconditional right to defer payment beyond 12 months. Annual leave, accrued days off and LSL 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 Northern Health has a conditional right to defer payment beyond 12 months. LSL leave entitlements (for staff who have not yet exceeded the minimum vesting period) fall into this category.
Measuring employee benefit liabilities	Northern Health **exercises** judgment when measuring its employee benefit liabilities. The health service 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 4.150% 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 25% and 48%; and • Discounting at the rate of 4.736%, 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	Consolidated 2026 $'000	Consolidated 2025 $'000
Employee expenses	3.1(a)	1,132,197	1,034,606
Supplies and consumables	3.1(d)	145,124	135,438
Other operating expenses	3.1(e)	142,239	116,352
Total expenses incurred in the delivery of services		**1,419,560**	**1,285,396**

Note 3.1(a): Employee expenses

	Consolidated 2026 $'000	Consolidated 2025 $'000
Salaries and wages	860,903	772,387
On-costs	237,036	226,001
Agency expenses	11,617	12,144
Fee-for-service medical officer expenses	7,698	9,922
Workcover premium	14,943	14,152
Total employee expenses	**1,132,197**	**1,034,606**

How we recognise employee expenses

Employee expenses include:

- Salaries and wages (including fringe benefits tax, leave entitlements, termination payments);
- On-costs;
- Agency expenses;
- Fee-for-service medical officer expenses; and
- WorkCover premium.

Note 3.1. Expenses incurred in the delivery of services (continued)

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

	Consolidated 2026 $'000	Consolidated 2025 $'000
Current employee benefits and related on-costs		
Accrued days off		
Unconditional and expected to be settled wholly within 12 months [1]	2,653	2,329
	2,653	**2,329**
Annual leave		
Unconditional and expected to be settled wholly within 12 months [1]	92,392	81,274
Unconditional and expected to be settled wholly after 12 months [2]	15,607	12,922
	107,999	**94,196**
Long Service leave		
Unconditional and expected to be settled wholly within 12 months [1]	13,471	11,469
Unconditional and expected to be settled wholly after 12 months [2]	114,719	108,266
	128,190	**119,735**
Provision related to employee benefit on-costs		
Unconditional and expected to be settled within 12 months [1]	14,638	12,694
Unconditional and expected to be settled after 12 months [2]	18,233	17,258
	32,871	**29,952**
Total current employee benefits and related on-costs	**271,714**	**246,212**
Non-current employee benefits and related on-costs		
Conditional long service leave	29,789	26,615
Provisions related to employee benefits and on-costs	4,175	3,811
Total non-current employee benefits and related on-costs	**33,965**	**30,426**
Total employee benefits and related on-costs	**305,678**	**276,638**

[1] The amounts disclosed are nominal amounts.
[2] The amounts disclosed are discounted to present values.

Provision for related on-costs movement schedule

	Consolidated 2026 $'000	Consolidated 2025 $'000
Carrying amount at start of year	33,762	28,867
Additional provisions recognised	1,416	1,148
Amounts incurred during the year	1,859	3,688
Net gain/(loss) arising from revaluation of long service liability	10	59
Carrying amount at end of year	**37,047**	**33,762**

Note 3.1. Expenses incurred in the delivery of services (continued)

How we recognise employee benefits

Employee benefits are accrued for employees in respect of accrued days off, annual leave and long service leave, for services rendered to the reporting date.

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

Annual leave and accrued days off

Liabilities for annual leave and accrued days off are recognised in the provision for employee benefits as current liabilities, because Northern Health does not have an unconditional right to defer settlement 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 Northern Health expects to wholly settle within 12 months; or
- Present value: If Northern Health does not expect to wholly settle within 12 months.

Long service leave (LSL)

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

Unconditional LSL is disclosed in the notes to the financial statements as a current liability, even where Northern Health does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months. An unconditional right arises after a period of 10 years of continuous service.

The components of this LSL liability are measured at:

- Nominal value: If Northern Health expects to wholly settle within 12 months; or
- Present value: If Northern Health does not expect to wholly settle within 12 months.

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

Termination benefits

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

Provision for on-costs related to employee benefits

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. Expenses incurred in the delivery of services (continued)

Note 3.1(c): Superannuation

	Paid contributions for the year		Contributions outstanding at 30 June[1]	
	Consolidated 2026 $'000	Consolidated 2025 $'000	Consolidated 2026 $'000	Consolidated 2025 $'000
Defined benefit plans[2]				
Aware Super	-	-	-	-
Defined contribution plans				
Aware Super	35,696	32,570	1,751	1,250
HESTA	37,071	33,259	1,747	1,413
Other	25,441	20,660	1,316	886
Total superannuation	**98,208**	**86,489**	**4,815**	**3,548**

[1] The contribution outstanding at year end refers to the accrual taken up at year end relating to the last pay period in June 2026.
[2] The basis for determining the level of contribution is determined by the various actuaries of the defined benefit superannuation plans.

How we recognise superannuation

Employees of Northern Health are entitled to receive superannuation benefits and it 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 Northern Health to the superannuation plans in respect of the services of current Northern Health's 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.

Northern Health does not recognise any unfunded defined benefit liability in respect of the plans because Northern 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 DTF discloses the State's defined benefits liabilities in its disclosure for administered items. However, superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the Comprehensive Operating Statement of Northern Health.

Defined contribution superannuation plans

Defined contribution (i.e. accumulation) superannuation plan expenditure is 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. Expenses incurred in the delivery of services (continued)

Note 3.1(d): Supplies and consumables

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Drug supplies		45,490	44,059
Medical and surgical supplies (including prostheses)		48,117	45,103
Diagnostic and radiology supplies		14,357	10,081
Other supplies and consumables		37,159	36,195
Total supplies and consumables		**145,124**	**135,438**

Supplies and consumables

Supplies and services 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

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Finance cost		507	644
Patient transport		4,118	4,677
Other administrative expenses		15,975	10,126
Fuel, light, power and water		7,939	7,433
Repairs and maintenance		7,646	6,157
Maintenance contracts		6,854	6,511
Domestic services and supplies		21,116	20,722
Medical indemnity insurance		26,469	20,135
Computer and communication		13,972	11,640
Staff training and development		13,164	7,191
Security costs		10,464	9,108
Shared service costs		1,008	1,221
Expenditure for capital purposes		7,164	7,141
Specific expenses		781	742
Bad and doubtful debts expenses		5,063	2,904
Total other operating expenses		**142,239**	**116,352**

How we recognise expenses from transactions

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

Specific expenses

Specific expenses include costs associated with employee departures and separations.

Note 4. Key assets to support service delivery

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

Structure

- Note 4.1. Property, plant and equipment
- Note 4.2. Intangible assets
- Note 4.3. Depreciation and amortisation
- Note 4.4. Impairment of assets

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	Description
Measuring fair value of property, plant and equipment	Northern Health obtains independent valuations for its non-current assets at least once every five years. Under FRD 103 a formal, independent revaluation occurs every five years with the revaluation performed by the VGV. In each year in between, a fair value assessment of land and buildings is undertaken utilising land and building indices issued by the VGV.
Estimating useful life of property, plant and equipment	Northern Health assigns an estimated useful life to each item of property, plant and equipment. This is used to calculate depreciation of the asset. The health service reviews the useful life and depreciation rates of all assets at the end of each financial year and where necessary, records a change in accounting estimate.
Estimating useful life of right-of-use assets	The useful life of each right-of-use asset is typically the respective lease term, except where the Northern Health is reasonably certain to exercise a purchase option contained within the lease (if any), in which case the useful life reverts to the estimated useful life of the underlying asset. Northern Health exercises judgement to determine whether or not it is reasonably certain to exercise such purchase options.
Estimating restoration costs at the end of a lease	Where a lease agreement requires Northern Health to restore a right-of-use asset to its original condition at the end of a lease, Northern Health estimates the present value of such restoration costs. This cost is included in the measurement of the right-of-use asset, which is depreciated over the relevant lease term.

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	62,934	54,934	-	-	62,934	54,934
Land at fair value: Freehold	13,013	13,013	-	-	13,013	13,013
Buildings at fair value	1,051,425	837,516	(116,721)	(61,995)	934,705	775,521
Leasehold improvements at fair value	2,818	2,805	(1,276)	(920)	1,543	1,885
Works in progress at cost	116,952	51,245	-	-	116,952	51,245
Plant, equipment and vehicles at fair value	181,572	156,239	(110,351)	(96,896)	71,220	59,343
Total property, plant and equipment	**1,428,714**	**1,115,752**	**(228,348)**	**(159,811)**	**1,200,366**	**955,941**

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[1] $'000	Buildings[1] $'000	Works in progress $'000	Leasehold Improvements $'000	Plant, equipment and vehicles $'000	Total $'000
Balance at 1 July 2024		**65,947**	**797,681**	**51,702**	**1,845**	**52,621**	**969,796**
Additions		2,000	7,076	40,173	387	6,644	56,279
Asset transfer-in via contributed equity		-	-	-	-	-	-
Disposals		-	-	-	-	(414)	(414)
Revaluation increments/(decrements)		-	-	-	-	-	-
Net transfers between classes		-	23,906	(40,630)	-	16,724	-
Depreciation	4.3	-	(53,141)	-	(347)	(16,233)	(69,721)
Balance at 30 June 2025	4.1	**67,947**	**775,521**	**51,245**	**1,885**	**59,343**	**955,941**
Additions		-	4,941	91,760	14	14,977	111,691
Asset transfer-in via contributed equity		12,412	196,396	-	-	-	208,808
Disposals		-	-	-	-	(114)	(114)
Revaluation increments/(decrements)		(4,412)	-	-	-	-	(4,412)
Net transfers between classes		-	12,746	(26,053)	-	13,307	-
Depreciation	4.3	-	(54,900)	-	(356)	(16,292)	(71,548)
Balance at 30 June 2026	4.1	**75,947**	**934,705**	**116,952**	**1,543**	**71,220**	**1,200,366**

[1] Land and buildings are 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 revaluation was not required per FRD 103. In accordance with FRD 103, Northern 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*. As per FRD 103, the amendments to AASB 13 only apply if a full revaluation is conducted prior to the next scheduled valuation, which is planned for 2029, in line with Northern Health's revaluation cycle.

Note 4.1. Property, plant and equipment (continued)

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 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
Buildings[1]	38,400	38,385	(16,689)	(12,901)	21,711	25,484
Plant, equipment and vehicles[1]	-	-	-	-	-	-
Total right-of-use assets	**38,400**	**38,385**	**(16,689)**	**(12,901)**	**21,711**	**25,484**

	Note	Buildings at fair value $'000	Plant, equipment and vehicles at fair value $'000	Total $'000
Balance at 1 July 2024		**28,815**	**240**	**29,055**
Additions		717	-	717
Disposals		-	(224)	(224)
Revaluation increments/(decrements)		-	-	-
Net transfers between classes		-	-	-
Depreciation		(4,048)	(16)	(4,064)
Balance at 30 June 2025[1]		**25,484**	**-**	**25,484**
Additions		189	-	189
Disposals		-	-	-
Revaluation increments/(decrements)		-	-	-
Net transfers between classes		-	-	-
Depreciation		(3,962)	-	(3,962)
Balance at 30 June 2026		**21,711**	**-**	**21,711**

[1]As a result of the 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 Northern Health enters a contract, which provides the health services 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(a) 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.

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	8,783	8,726	(8,679)	(8,582)	103	144
Total intangible assets	**8,783**	**8,726**	**(8,679)**	**(8,582)**	**103**	**144**

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

	Note	Software $'000	Work in progress $'000	Total $'000
Balance at 1 July 2024		**305**	**-**	**305**
Additions		-	-	-
Disposals		-	-	-
Net transfers between classes		-	-	-
Amortisation	4.3	(161)	-	(161)
Balance at 30 June 2025	4.2	**144**	**-**	**144**
Additions		57	-	57
Disposals		-		-
Net transfers between classes		-	-	-
Amortisation	4.3	(98)	-	(98)
Balance at 30 June 2026	4.2	**103**	**-**	**103**

How we recognise intangible assets

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

Initial recognition

Purchased intangible assets are initially recognised at cost.

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

	Consolidated 2026 $'000	Consolidated 2025 $'000
Depreciation		
Buildings at fair value	54,900	53,141
Leasehold improvements at fair value	356	347
Plant, equipment and vehicles at fair value	16,292	16,233
Total depreciation	**71,548**	**69,721**
Amortisation		
Software	98	161
Total amortisation	**98**	**161**
Total depreciation and amortisation	**71,646**	**69,882**

How we recognise depreciation

All buildings, plant and equipment and other non-financial physical assets that have finite lives are depreciated. This excludes assets held for sale and land. 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 Northern Health 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	4 – 56 years	5 – 53 years
Leasehold improvements	10 years	11 years
Plant, equipment and vehicles (including leased assets)	3 – 10 years	3 – 10 years
Intangible assets	3 years	3 years

As the two new Community Hospitals have been completed, the building values have been separated into their respective components, with each component assessed based on its estimated useful life, as presented 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 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.

Northern Health did not record any impairment losses for the year ended 30 June 2026 (2025: nil).

Note 5. Other assets and liabilities

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

Structure

- Note 5.1. Receivables
- Note 5.2. Contract assets
- Note 5.3. Payables
- Note 5.4. Contract liabilities
- Note 5.5. Monies held in trust

Material judgements and estimates

This section contains the following material judgements and estimates:

Material judgements and estimates	Description
Classifying a sub-lease arrangement as either an operating lease or finance lease	**Northern Health exercises judgement t**o determine if a sub-lease arrangement, where we are a lessor, meets the definition of an operating lease or finance lease. Northern Health considers a range of scenarios when classifying a sub-lease. A sub-lease typically meets the definition of a finance lease if: • The lease transfers ownership of the asset to the lessee at the end of the term; • The lessee has an option to purchase the asset for a price that is significantly below fair value at the end of the lease term; • The lease term is for the majority of the asset's useful life; • The present value of lease payments amount to the approximate fair value of the leased asset; and • The leased asset is of a specialised nature that only the lessee can use without significant modification. All other sub-lease arrangements are classified as an operating lease.
Measuring contract liabilities	**Northern Health exercises judgement** to measure its progress towards satisfying a performance obligation as detailed in Note 2. Where a performance obligation is yet to be satisfied Northern Health assigns funds to the outstanding obligation and records this as a contract liability until the promised good or service is transferred to the customer.
Recognition of other provisions	Other provisions include Northern Health's obligation to restore leased assets to their original condition at the end of a lease term. **Northern Health exercises judgement** and estimate to determine the present value of such restoration costs.

Note 5.1. Receivables

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Current receivables			
Contractual			
Inter hospital debtors		-	778
Trade receivables		7,473	4,711
Patient fees		11,536	8,218
Allowance for impairment losses	5.1(a)	(5,744)	(3,528)
Amounts receivable from governments and agencies		-	10,000
Total contractual receivables		**13,266**	**20,179**
Statutory			
GST Receivable		7,146	6,175
Total statutory receivables		**7,146**	**6,175**
Total current receivables		**20,412**	**26,354**
Non-current receivables			
Contractual			
Long service leave – Department of Health		100,901	91,706
Total contractual receivables		**100,901**	**91,706**
Total non-current receivables		**100,901**	**91,706**
Total receivables		**121,313**	**118,060**
(i) Financial assets classified as receivables (Note 7.1)			
Total receivables		121,313	118,060
GST receivable		(7,146)	(6,175)
Total financial assets classified as receivables	7.1	**114,167**	**111,885**

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 cost'. They are initially recognised at fair value plus any directly attributable transaction costs. Northern 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; and
- **Statutory receivables** include 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. Northern Health applies AASB 9 for initial measurement of the statutory receivables and, as a result, statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

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

Note 5.1. Receivables (continued)

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

	Consolidated 2026 $'000	Consolidated 2025 $'000
Balance at the beginning of the year	(3,528)	(5,659)
Increase in allowance	(5,063)	(2,344)
Amount written off during the year	2,848	4,475
Balance at the end of the year	**(5,744)**	**(3,528)**

Impairment losses of contractual receivables

Refer to Note 7.2 (a) for Northern Health's contractual impairment losses.

Note 5.2. Contract assets

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Current			
Contract assets		3,077	1,743
Total current contract assets		**3,077**	**1,743**
Total contract assets	5.2(a)	**3,077**	**1,743**

Note 5.2(a): Movement in contract assets

	Consolidated 2026 $'000	Consolidated 2025 $'000
Balance at the beginning of the year	1,743	2,315
Add: Additional costs incurred that are recoverable from the customer	3,077	1,743
Less: Transfer to revenue recognition	(1,743)	(2,315)
Total contract assets	**3,077**	**1,743**

How we recognise contract assets

Contract assets relate to the Northern 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. Payables

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Current payables			
Contractual			
Payables		2,669	13,325
Accrued employee costs		69,744	50,181
Accrued expenses		31,160	33,159
Deferred capital grant income	5.3(a)	6,116	7,983
Other		11,937	1,159
Total contractual payables		121,626	105,807
Total current payables		121,626	105,807
Total payables		121,626	105,807
(i) Financial liabilities classified as payables (Note 7.1)			
Total payables		121,626	105,807
Deferred capital grant income		(6,116)	(7,983)
Total financial liabilities classified as payables	7.1	115,510	97,824

How we recognise payables and contract liabilities

Payables consist of:

- **Contractual payables**, including 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 Northern Health prior to the end of the financial year that are unpaid; and
- **Statutory payables**, including 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.

Standard credit terms for accounts payable are usually net 30 days.

Note 5.3(a): Movement in deferred capital grant income

	Consolidated 2026 $'000	Consolidated 2025 $'000
Opening balance of deferred capital grant income	7,984	10,095
Grant consideration for capital works received during the year	14,998	23,230
Deferred capital grant income recognised as income due to completion of capital works	(16,866)	(25,342)
Closing balance of deferred capital grant income	6,116	7,983

How we recognise deferred capital grant income

Grant consideration was received from DH to support the construction of infrastructure assets.

Capital grant income is recognised progressively as the asset is constructed, since this is the time when Northern Health meets 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, Northern Health has deferred recognition of a portion of the grant consideration received as a liability for the outstanding obligations.

Northern Health expects to recognise the remaining deferred capital grant income in line with the delivery of capital works in future years.

Note 5.4. Contract liabilities

	Consolidated 2026 $'000	Consolidated 2025 $'000
Opening balance of contract liabilities	973	2,363
Add: payment received for performance obligations yet to be completed during the period	14,367	15,619
Less: revenue recognised in the reporting period for the completion of a performance obligation	(14,116)	(17,009)
Total contract liabilities	**1,224**	**973**
Represented by		
Current contract liabilities	1,224	973
Non-current contract liabilities	-	-

How we recognise contract liabilities

Contract liabilities include consideration received in advance from customers in respect of 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.

Maturity analysis of payables

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

Note 5.5. Monies Held in Trust

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Current monies held in trust			
Patient monies		21	19
Refundable accommodation deposits		17,249	16,909
Other income in advance - current		2,010	2,062
Total current monies held in trust		**19,280**	**18,991**
Non-current monies held in trust			
Other income in advance – non current[1]		5,829	6,581
Total non-current monies held in trust		**5,829**	**6,581**
Total monies held in trust		**25,109**	**25,572**
***Represented by:**			
Cash assets	6.2	17,319	17,317
Investment and other financial assets		7,790	8,255
		25,109	**25,572**

[1]As a lessor, Northern Health classifies its leases as either operating or finance leases. A lease is classified as a finance lease if it transfers substantially all the risks and rewards incidental to ownership of the underlying asset, and is classified as an operating lease if it does not. The Northern Centre for Health Education Research building was classified, assessed and accounted for as an operating lease at inception under AASB 117 and continues to be accounted for as such under AASB 16. These amounts represent the prepaid contributions made by respective tenants.

How we recognise other liabilities

Refundable Accommodation Deposit (RAD) /Accommodation bonds

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

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

Note 6. How we finance our operations

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

- Note 6.1. Borrowings
- Note 6.2. Cash and cash equivalents
- Note 6.3. Commitments for expenditure

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	Northern Health exercises judgement to determine if a contract is or contains a lease by considering: • If it has the right-to-use an identified asset; • If it has the right to obtain substantially all economic benefits from the use of the leased asset; and • If it can decide how and for what purpose the asset is used throughout the lease.
Discount rate applied to future lease payments	Northern 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 Northern Health's lease arrangements, Northern Health uses its incremental borrowing rate, which is the amount we 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, Northern Health estimated the incremental borrowing rate to be between 4.293% and 5.753%.
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 Northern Health is reasonably certain to exercise such options. Northern 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), Northern Health is typically reasonably certain to extend (or not terminate) the lease; • If any leasehold improvements are expected to have a significant remaining value, the Northern Health is typically reasonably certain to extend (or not terminate) the lease; and • Northern Health considers historical lease durations and the costs and business disruption to replace such leased assets.

Note 6.1. Borrowings

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Current borrowings			
Lease liability[1]	6.1(a)	2,827	2,604
Advances from government[2]		-	54
Total current borrowings		2,827	2,658
Non-current borrowings			
Lease liabilities[1]	6.1(a)	5,882	8,564
Advances from government[2]		-	-
Total non-current borrowings		5,882	8,564
Total borrowings	7.1	8,709	11,222

[1] The borrowing rate is between 4.293% and 5.753%.
[2] These are secured loans which bear no interest.

How we recognise borrowings

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

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

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

Interest expense

	Consolidated 2026 $'000	Consolidated 2025 $'000
Interest on lease liabilities	507	644
Total interest expense	507	644

Interest expense includes costs incurred in connection with the borrowing of funds and includes interest on bank overdrafts and short- term and long-term borrowings, interest component of lease repayments and the increase in financial liabilities and non-employee provisions due to the unwinding of discounts to reflect the passage of time.

Interest expense is recognised in the period in which it is incurred.

Northern 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 or breaches of any of the loans.

Note 6.1(a): Lease liabilities

Northern Health's lease liabilities are summarised below:

	Consolidated 2026 $'000	Consolidated 2025 $'000
Current lease liabilities		
Lease liability	2,827	2,604
Total current lease liabilities	2,827	2,604
Non-current lease liabilities		
Lease liability	5,882	8,564
Total non-current lease liabilities	5,882	8,564
Total lease liabilities	8,709	11,168

Note 6.1. Borrowings (continued)

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

	Consolidated 2026 $'000	Consolidated 2025 $'000
No longer than one year	3,203	3,106
Longer than one year but not longer than five years	5,288	7,756
Longer than five years	1,222	1,806
Minimum future lease liability	**9,713**	**12,668**
Less unexpired finance expenses	(1,004)	(1,500)
Present value of lease liability	**8,709**	**11,168**

How we recognise lease liabilities

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

To apply this definition, Northern 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 Northern Health and for which the supplier does not have substantive substitution rights;
- Northern 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 Northern Health has the right to direct the use of the identified asset throughout the period of use; and
- Northern Health has the right to take decisions in respect of 'how and for what purpose' the asset is used throughout the period of use.

Northern Health's lease arrangements consist of the following:

Type of asset leased	Lease term
Leased land	13 to 28 years
Leased buildings	4 to 6 years

All leases are recognised on the balance sheet, with the exception of low value leases (less than $10,000 AUD) and short-term leases of less than 12 months. Northern 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; rather, 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 Northern Health's incremental borrowing rate. Our lease liability has been discounted by rates between 4.293% and 5.753%.

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.

Note 6.1. Borrowings (continued)

The following types of lease arrangements contain extension and termination options:

- Building leases:
  Options to extend can vary from one fixed-term of two years and up to two fixed-terms of five years.

These terms are used to maximise operational flexibility in terms of managing contracts. Extension and termination options are exercisable only by Northern Health and not by the respective lessor.

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.

During the current financial year, no extension or termination option was exercised in recognised lease liabilities and right-of-use assets.

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

Northern Health holds lease arrangements which contain significantly below-market terms and conditions, which are principally to enable Northern Health to further its objectives. These are commonly referred to as a peppercorn or concessionary lease arrangement.

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

Description of leased asset	Our dependence on lease	Nature and terms of lease
Broadmeadows Hospital campus land	The leased land is used to accommodate the Broadmeadows Hospital buildings. Northern Health's dependence on this lease is considered high given its nature (i.e. land).	There are no lease payments associated with this lease. The current lease commenced in August 2018 with a lease term of 10 years. The lease extension will be negotiated between Northern Health and DH. There are no restrictions placed on the use of the asset other than the standard conditions that apply to all land and buildings controlled by Northern Health.
Craigieburn Community Hospital campus land	The leased land is used to accommodate the Craigieburn Community Hospital buildings. Northern Health's dependence on this lease is considered high given its nature (i.e. land).	There are no lease payments associated with this lease. The current lease commenced in April 2017 with a lease term of 20 years. The lease extension will be negotiated between Northern Health and DH. There are no restrictions placed on the use of the asset other than the standard conditions that apply to all land and buildings controlled by Northern Health.

Note 6.2. Cash and cash equivalents

		Consolidated 2026 $'000	Consolidated 2025 $'000
Cash on hand (excluding monies held in trust)		24	35
Cash at bank - CBS (excluding monies held in trust)		61,109	45,230
Total cash held for operations		**61,132**	**45,265**
Cash at bank - CBS (monies held in trust)		17,319	17,317
Total cash held as monies in trust		**17,319**	**17,317**
Total cash and cash equivalents	7.1	**78,451**	**62,582**

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	42,640	4,765	-	47,405
Operating expenditure commitments	77,196	83,378	3,494	164,068
Non-cancellable short-term and low value lease commitments	11	1	-	12
Total commitments (inclusive of GST)	**119,847**	**88,144**	**3,494**	211,485
Less GST recoverable				(19,226)
Total commitments (exclusive of GST)				192,259
30 June 2025				
Capital expenditure commitments	49,692	2,838	-	52,530
Operating expenditure commitments	82,606	136,314	4,915	223,835
Non-cancellable short- term and low value lease commitments	20	11	-	31
Total commitments (inclusive of GST)	**132,318**	**139,163**	**4,915**	276,396
Less GST recoverable				(25,127)
Total commitments (exclusive of GST)				251,269

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. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant projects are stated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the Balance Sheet.

Northern Health has entered into commercial leases on certain medical equipment, computer equipment and property where it is not in the interest of Northern Health to purchase these assets. These leases have an average life of between 1 and 20 years with renewal terms included in the contracts. Renewal is at the option of Northern Health. There are no restrictions placed upon Northern Health by entering into these leases.

Short-term and low value leases

Northern 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(a) for further information.

Note 7. Risks, contingencies and valuation uncertainties

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

Structure:

- Note 7.1. Financial instruments
- Note 7.2. Financial risk management objectives and policies
- Note 7.3. Contingent assets and contingent liabilities
- Note 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, Northern Health has assumed the current use is its highest and best use. Northern Health uses a range of valuation techniques to estimate fair value and selects a valuation technique which is considered most appropriate, and for which there is sufficient data available to measure fair value, maximising the use of relevant observable inputs and minimising the use of unobservable inputs. Subsequently, the Northern Health **exercises judgement** to categorise and disclose such assets within a fair value hierarchy, which includes: • Level 1, using quoted prices (unadjusted) in active markets for identical assets that Northern Health can access at measurement date. Northern Health does not categorise any fair values within this level; • Level 2, inputs other than quoted prices included within Level 1 that are observable for the asset, either directly or indirectly. Northern Health categorises non-specialised land and right-of-use concessionary land in this level; and • Level 3, where inputs are unobservable. Northern Health categorises specialised land, non-specialised buildings, specialised buildings, plant, equipment, furniture, fittings, vehicles, right-of-use buildings and right-of-use plant, equipment, furniture and fittings in this level. The Northern Health Foundation, which is the controlled entity of Northern Health, applies the same judgements and estimates above in measuring the fair value of its non-financial assets.

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

The carrying amount excludes statutory receivables (i.e. GST receivable and DH receivable) and statutory payables (i.e. DH payable).

Categorisation of financial instruments

Consolidated 2026	Note	Financial assets at amortised cost $'000	Financial Assets at Fair Value Through Other Comprehensive Income $'000	Financial liabilities at amortised cost $'000	Total $'000
Contractual financial assets					
Cash and cash equivalents	6.2	78,451	-	-	78,451
Receivables	5.1	114,167	-	-	114,167
Contract assets	5.2	3,077	-	-	3,077
Investment and other financial assets		1,500	553	-	2,053
Total financial assets		**197,196**	**553**	**-**	**197,749**
Financial liabilities					
Payables	5.3	-	-	115,510	115,510
Borrowings	6.1	-	-	8,709	8,709
Other financial liabilities - refundable accommodation deposits	5.5	-	-	17,249	17,249
Other financial liabilities – patient monies held in trust	5.5	-	-	21	21
Total financial liabilities		-	**-**	**141,489**	**141,489**

Consolidated 2025	Note	Financial assets at amortised cost $'000	Financial Assets at Fair Value Through Other Comprehensive Income	Financial liabilities at amortised cost $'000	Total $'000
Contractual financial assets					
Cash and cash equivalents	6.2	62,582	-	-	62,582
Receivables	5.1	111,885	-	-	111,885
Contract assets	5.2	1,743	-	-	1,743
Investment and other financial assets		2,000	540	-	2,540
Total financial assets		**178,210**	**540**	**-**	**178,750**
Financial liabilities					
Payables	5.3	-	-	97,824	97,824
Borrowings	6.1	-	-	11,222	11,222
Other financial liabilities - refundable accommodation deposits	5.5	-	-	16,909	16,909
Other financial liabilities – patient monies held in trust	5.5	-	-	19	19
Total financial liabilities		-	**-**	**125,974**	**125,974**

Note 7.1. Financial instruments (continued)

How we categorise financial instruments

Categories of financial assets

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

- The assets are held by Northern 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 are subsequently measured at amortised cost using the effective interest method less any impairment.

Northern Health recognises the following assets in this category:

- Cash and deposits;
- Receivables (excluding statutory receivables); and
- Term deposits.

Categories of financial liabilities

Financial liabilities are recognised when Northern 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.

Northern Health recognises the following liabilities in this category:

- Payables (excluding statutory payables and contract liabilities);
- Borrowings; and
- Other liabilities (including monies held in trust).

Note 7.1. Financial instruments (continued)

Offsetting financial instruments

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

Some master netting arrangements do not result in an offset of balance sheet assets and liabilities. Where Northern Health does not have a legally enforceable right to offset recognised amounts, because the right to offset is enforceable only on the occurrence of future events such as default, insolvency or bankruptcy, they are reported on a gross basis.

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

De-recognition 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 de-recognition 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 and fair value through other comprehensive income when, and only when, Northern 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, Northern 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.

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

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. Northern Health's exposure to credit risk arises from the potential default of a counterparty on their contractual obligations resulting in financial loss to Northern Health. Credit risk is monitored on a regular basis.

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

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

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

Contractual financial assets are written off against the carrying amount when there is no reasonable expectation of recovery. Bad debt written off by mutual consent is classified as a transaction expense. Bad debt written off following a unilateral decision is recognised as other economic flows in the net result. Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Northern Health's maximum exposure to credit risk without taking account of the value of any collateral obtained.

There has been no material change to Northern Health's credit risk profile in 2025-26.

Impairment of financial assets under AASB 9

Northern Health records the allowance for expected credit losses for the relevant financial instruments by applying AASB 9's Expected Credit Loss approach. Subject to AASB 9, the impairment assessment includes Northern Health's contractual receivables. Equity instruments are not subject to impairment under AASB 9. Other financial assets mandatorily measured or designated at fair value through net result are not subject to an impairment assessment under AASB 9.

The credit loss allowance is classified as other economic flow in the net result.

Contractual receivables and contract assets at amortised costs

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

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

	Note	Current	Less than 1 month	1-3 Months	3 months - 1 Year	1-5 Years	Total
30 June 2026		$'000	$'000	$'000	$'000	$'000	$'000
Expected loss rate		11.9%	21.8%	45.8%	47.8%	31.8%	
Gross carrying amount of contractual receivables and contract assets[1]	5.1, 5.2	9,316	2,453	593	4,574	5,152	22,087
Loss allowance		(1,111)	(534)	(271)	(2,188)	(1,640)	(5,744)
30 June 2025							
Expected loss rate		4.6%	27.6%	16.9%	43.5%	37.7%	
Gross carrying amount of contractual receivables and contract assets[1]	5.1, 5.2	6,487	1,445	940	3,271	3,307	15,450
Loss allowance		(301)	(398)	(159)	(1,423)	(1,247)	(3,528)

[1] Contractual receivables in this schedule exclude amounts receivable from governments and agencies.

Note 7.2. Financial risk management objectives and policies (continued)

Note 7.2 (b): Liquidity risk

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

Northern Health is exposed to liquidity risk mainly through the financial liabilities as disclosed in the balance sheet.

Northern Health manages its liquidity risk by:

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

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

The following table discloses the contractual maturity analysis for Northern Health's financial liabilities. The interest rates applicable to each class of liability are covered in note 6.1 Borrowings. The ageing analysis of financial liabilities excludes statutory financial liabilities (i.e. GST payable).

				Maturity Dates				
Consolidated	Note	Carrying Amount	Nominal Amount	Less than 1 Month	1-3 Months	3 months - 1 Year	1-5 Years	Over 5 years
30 June 2026		$'000	$'000	$'000	$'000	$'000	$'000	$'000
Financial liabilities at amortised cost								
Payables	5.3	115,510	115,510	68,385	12,866	34,259	-	-
Borrowings	6.1	8,709	9,713	267	534	2,402	5,288	1,222
Other financial liabilities - refundable accommodation deposits	5.5	17,249	17,249	17,249	-	-	-	-
Other financial liabilities – patient monies held in trust	5.5	21	21	21	-	-	-	-
Total financial liabilities		141,489	142,493	85,922	13,400	36,661	5,288	1,222
30 June 2025								
Financial liabilities at amortised cost								
Payables	5.3	97,824	97,824	62,235	9,987	25,602	-	-
Borrowings	6.1	11,222	12,668	259	518	2,329	7,756	1,806
Other financial liabilities - refundable accommodation deposits	5.5	16,909	16,909	16,909	-	-	-	-
Other financial liabilities – patient monies held in trust	5.5	19	19	19	-	-	-	-
Total financial liabilities		125,974	127,420	79,422	10,505	27,931	7,756	1,806

Note 7.2. Financial risk management objectives and policies (continued)

Note 7.2 (c): Market risk

Northern Health's exposures to market risk 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

Northern Health's sensitivity to market risk is determined based on the observed range of actual historical data for the preceding five-year period. Northern 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 one per cent up or down and changes in the top ASX 200 index of 15 per cent 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. Northern 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. Northern Health has minimal exposure to cash flow interest rate risks through cash and deposits and term deposits.

Note 7.3. Contingent assets and contingent liabilities

Northern Health does not have any contingent assets or liabilities as at 30 June 2026 (2025: nil).

Note 7.4. Fair value determination

How we measure fair value

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

The following assets and liabilities are carried at fair value:

- Financial assets and liabilities at fair value through other comprehensive income; and
- 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.

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

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

Note 7.4. Fair value determination (continued)

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 non-financial physical assets

	Note	Consolidated carrying amount 30 June 2026 $'000	Fair value measurement at 30 June 2026 using: Level 1 $'000	Level 2 $'000	Level 3 $'000
Non-specialised land		2,200	-	2,200	-
Specialised land		73,747	-	15,500	58,247
Total land at fair value	4.1	**75,947**	**-**	**17,700**	**58,247**
Non-specialised buildings		9,664	-	1,898	7,766
Specialised buildings		926,583	-	254,909	671,674
Total buildings at fair value	4.1	**936,247**	**-**	**256,807**	**679,440**
Plant, equipment and vehicles at fair value		71,220	-	785	70,436
Total plant, equipment and vehicles at fair value	4.1	**71,220**	**-**	**785**	**70,436**
Total non-financial physical assets at fair value		**1,083,414**	**-**	**275,292**	**808,123**

	Note	Consolidated carrying amount 30 June 2025 $'000	Fair value measurement at 30 June 2025 using: Level 1 $'000	Level 2 $'000	Level 3 $'000
Non-specialised land at fair value		2,200	-	2,200	-
Specialised land at fair value		65,747	-	7,500	58,247
Total of land at fair value	4.1	**67,947**	**-**	**9,700**	**58,247**
Non-specialised buildings at fair value		12,601	-	2,247	10,354
Specialised buildings at fair value		764,805	-	44,765	720,040
Total buildings at fair value	4.1	**777,406**	**-**	**47,012**	**730,394**
Plant, equipment and vehicles at fair value		59,343	-	666	58,677
Total plant, equipment and vehicles at fair value	4.1	**59,343**	**-**	**666**	**58,677**
Total non-financial physical assets at fair value		**904,695**	**-**	**57,378**	**847,317**

Note 7.4. Fair value determination (continued)

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.

Northern 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, Northern Health performs 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%, Northern 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 Northern 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, the Northern Health will apply Appendix F of AASB 13 prospectively in its next scheduled formal revaluation in 2029 or interim revaluation process (whichever is earlier). Northern 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, investment properties and cultural assets

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

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

The CSO adjustment 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.

Note 7.4. Fair value determination (continued)

For Northern 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 Northern 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

Consolidated	Note	Land $'000	Buildings $'000	Plant, equipment, furniture, fittings and vehicles $'000
Balance at 1 July 2024		**58,247**	**780,906**	**51,967**
Additions/(Disposals)		-	717	6,218
Asset transfer-in- via contributed equity		-	-	-
Net transfers between classes		-	-	16,724
Gains/(Losses) recognised in net results				
Depreciation and amortisation		-	(51,229)	(16,233)
Items recognised in other comprehensive income				
Revaluation		-	-	-
Balance at 30 June 2025	7.4(a)	**58,247**	**730,394**	**58,677**
Additions/(Disposals)		-	189	14,744
Asset transfer-in- via contributed equity		-	-	-
Net transfers between classes		-	-	13,307
Gains/(Losses)recognised in net result				
Depreciation and amortisation		-	(51,142)	(16,292)
Items recognised in other comprehensive income				
Revaluation		-	-	-
Balance at 30 June 2026	7.4(a)	**58,247**	**679,440**	**70,436**

Fair value determination of level 3 fair value measurement

Asset class	Likely valuation approach	Significant inputs (Level 3 only)
Specialised land (Crown/freehold)	Market approach	Community Service Obligations Adjustment (range of 0%-30%)
Specialised buildings	Current replacement cost approach	Cost per square metre Useful life
Non-specialised buildings	Current replacement cost approach	Cost per square metre Useful life
Plant, equipment, furniture, fittings and vehicles	Current replacement cost approach	Cost per unit Useful life

Note 8. Other disclosures

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

Structure:

- Note 8.1. Reconciliation of net result to net cash flow from operating activities
- Note 8.2. Responsible persons disclosures
- Note 8.3. Remuneration of executives
- Note 8.4. Related parties
- Note 8.5. Remuneration of auditors
- Note 8.6. Ex-gratia expenses
- Note 8.7. Events occurring after the balance sheet date
- Note 8.8. Controlled entities
- Note 8.9. Equity

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

	Note	Consolidated 2026 $'000	Consolidated 2025 $'000
Net Result for the year		27,228	(13,793)
Non-cash movements			
Depreciation of non-current assets	4.3	71,548	69,721
Amortisation of non-current assets	4.3	98	161
Net (gain) / loss from other economic flows in net result		(6,021)	(709)
Government non-cash grants		(75,119)	(16,954)
Movements in assets and liabilities			
(Increase)/Decrease in receivables		(3,253)	(31,197)
(Increase)/Decrease in contract assets		(1,285)	572
(Increase)/Decrease in inventories		186	(390)
(Increase)/Decrease in prepaid expenses		(9,578)	(16,986)
Increase/(Decrease) in payables		15,819	3,680
Increase/(Decrease) in contract liabilities		251	(1,390)
Increase/(Decrease) in borrowings		(2,459)	(2,070)
Increase/(Decrease) in employee benefits		29,040	40,992
Increase/(Decrease) in other provisions		(802)	(2,169)
Net cash flow from operating activities		**45,653**	**29,469**

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
Responsible Minister	
Minister for Health, The Hon. Mary-Anne Thomas MP	1 July 2025 to 14 April 2026
Minister for Health, 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 Ambulance Services, The Hon. Mary-Anne Thomas MP	1 July 2025 to 14 April 2026
Minister for Ambulance Services, The Hon. Harriet Shing MP	15 April 2026 to 30 June 2026
Minister for Mental Health, The Hon. Ingrid Stitt MP	1 July 2025 to 30 June 2026
Minister for Ageing, The Hon. Ingrid Stitt MP	1 July 2025 to 30 June 2026
Minister for Children, The Hon. Lizzie Blandthorn MP	1 July 2025 to 30 June 2026
Governing Board	
Adjunct Professor Alan Lilly (Chair)	1 July 2025 to 30 June 2026
Associate Professor Cate Kelly	1 July 2025 to 30 June 2026
Ms Nirasha Parsotam	1 July 2025 to 30 June 2026
Mr Domenic Isola	1 July 2025 to 30 June 2026
Dr Andrea Kattula	1 July 2025 to 30 June 2026
Associate Professor Jo-Anne Mazzeo	1 July 2025 to 30 June 2026
Mr Peter McDonald	1 July 2025 to 30 June 2026
Dr Michael Walsh	1 July 2025 to 30 June 2026
Mr John Watson	1 July 2025 to 30 June 2026
Accountable Officer	
Ms Debra Bourne, Chief Executive	1 July 2025 to 30 June 2026

Remuneration of Responsible Persons The number of responsible persons is shown in their relevant income bands: **Income band**	Consolidated **2026** **No.**	Consolidated **2025** **No.**
$40,000 - $49,999	8	8
$90,000 - $99,999	1	1
$120,000 - $129,999	-	1
$420,000 - $429,999	-	1
$450,000 - $459,999	1	-
Total numbers	**10**	**11**

	2026 **$'000**	**2025** **$'000**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:	**920**	**992**

Amounts relating to the Governing Board Members and Accountable Officer are disclosed in Northern Health's controlled entities financial statements.

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 Officers, and their total remuneration during the reporting period is 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)	Consolidated 2026 $'000	Consolidated 2025 $'000
Short-term employee benefits	2,986	2,916
Other long-term benefits	92	90
Post-employment benefits	358	335
Total remuneration of Executive Officers[1]	**3,436**	**3,341**
Total number of executives	9	9
Total annualised employee equivalent[2]	9	9

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

[2] The annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered, and is disclosed in the following categories:

Short-term employee benefits

Salaries and wages, annual leave or sick leave 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 contribution) paid or payable on a discrete basis when employment has ceased.

Other long-term benefits

LSL, other LSL benefits or deferred compensation.

Termination benefits

Termination of employment payments, such as severance packages.

Note 8.4. Related parties

Northern Health is a wholly owned and controlled entity of the State of Victoria.

Related parties of Northern Health include:

- All key management personnel (KMP) and their close family members;
- All cabinet ministers and their close family members;
- Controlled entities (the Northern Health Research, Training and Equipment Trust and the Northern Health Research, Training and Equipment Foundation Limited); and
- All hospitals and public sector entities that are controlled and consolidated into the State of Victoria financial statements.

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

Note 8.4. Related parties (continued)

The Board Directors and Executive of Northern Health and its controlled entities are deemed to be KMPs. The KMPs during the year were as follows.

KMP	Position
Adjunct Professor Alan Lilly (Chair)	Director Northern Health (Chair)
Associate Professor Cate Kelly	Director Northern Health
Ms Nirasha Parsotam	Director Northern Health
Mr Domenic Isola	Director Northern Health
Dr Andrea Kattula	Director Northern Health
Associate Professor Jo-Anne Mazzeo	Director Northern Health
Mr Peter McDonald	Director Northern Health
Dr Michael Walsh	Director Northern Health
Mr John Watson	Director Northern Health
Ms Debra Bourne	Chief Executive
Associate Professor Jason Cirone	Chief Allied Health Officer
Mr Basil Ireland	Chief Financial Officer
Professor Prahlad Ho	Chief Medical Officer
Ms Lisa Cox	Chief Nursing and Midwifery Officer
Ms Linda Romano	Chief Operating Officer
Associate Professor Anthony Gust	Chief Executive Director Digital Health
Ms Belinda Scott	Executive Director Mental Health
Dr Bill Shearer	Executive Director High Reliability Office (HRO)
Ms Michelle Fenwick	Executive Director People and Culture (ended 23 November 2025)
Ms Rebecca Hodges	Chief People Officer (commenced 12 January 2026)

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

Compensation - KMPs	Consolidated 2026 $'000	Consolidated 2025 $'000
Short-term employee benefits[1]	3,802	3,798
Other long-term benefits	104	104
Post-employment benefits	450	431
Total compensation - KMPs[2]	**4,356**	**4,333**

[1]Total remuneration paid to KMPs employed as a contractor during the reporting period through accounts payable has been reported under short-term employee benefits.
[2]KMPs are also reported in Note 8.2 Responsible Persons or Note 8.3 Remuneration of Executives.

Note 8.4. Related parties (continued)

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 Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with Northern Health, there were no related party transactions have been identified that involve KMPs, their close family members or their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

There were no related party transactions required to be disclosed for the Northern Health Board of Directors, Chief Executive Officer and Executive Directors in 2026 (2025: none).

Except for the transaction listed below, there were no other related party transactions required to be disclosed for the Northern Health Foundation Board of Directors in 2026 (2025: none).

Transactions with controlled entities

During the financial year transactions were conducted between Northern Health and the Foundation. The following transactions were conducted as part of Northern Health's normal operations and are on normal commercial terms.

Controlled entities related party transactions

	Consolidated 2026 $'000	Consolidated 2025 $'000
Distribution of funds by the Foundation	1,051	1,666
Total distribution of funds by the Foundation	**1,051**	**1,666**

Note 8.5. Remuneration of auditors

	Consolidated 2026 $'000	Consolidated 2025 $'000
Victorian Auditor-General's Office		
Audit of financial statements	95	91
Total remuneration of Auditors	**95**	**91**

Note 8.6. Ex-gratia Expenses

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. Northern Health did not make any ex-gratia payments for the year ended 30 June 2026 (2025: nil).

Note 8.7. Events occurring after the Balance Sheet Date

There are no other matters or circumstances that have arisen since the end of the financial year which significantly affected or may affect the operations of Northern Health, the results of the operations or the state of affairs of Northern Health in the future financial years.

Note 8.8. Controlled entities

The Northern Health's interest in controlled entities is detailed below. The amounts are included in the consolidated financial statements under their respective categories.

Name of entity	Country of incorporation	Ownership Interest %	Equity holding
Northern Health Research, Training and Equipment Foundation Ltd	Australia	100	Limited by guarantee
Northern Health Research, Training and Equipment Trust	Australia	100	100%

Controlled entities contribution to the consolidated results:	Consolidated 2026	Consolidated 2025
Net Result for the year	$'000	$'000
Northern Health Research, Training and Equipment Foundation Ltd	-	-
Northern Health Research, Training and Equipment Trust	782	1,097

Contingent liabilities and capital commitments

There are no known contingent liabilities or capital commitments held by controlled entities at balance date.

Note 8.9. Equity

Contributed capital

Contributions by owners (that is, contributed capital and its repayment) are treated as equity transactions and, therefore, do not form part of the income and expenses of the Northern 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 infrastructure, land and buildings. The revaluation surplus is not normally transferred to the accumulated surpluses/(deficits) on derecognition of the relevant asset.

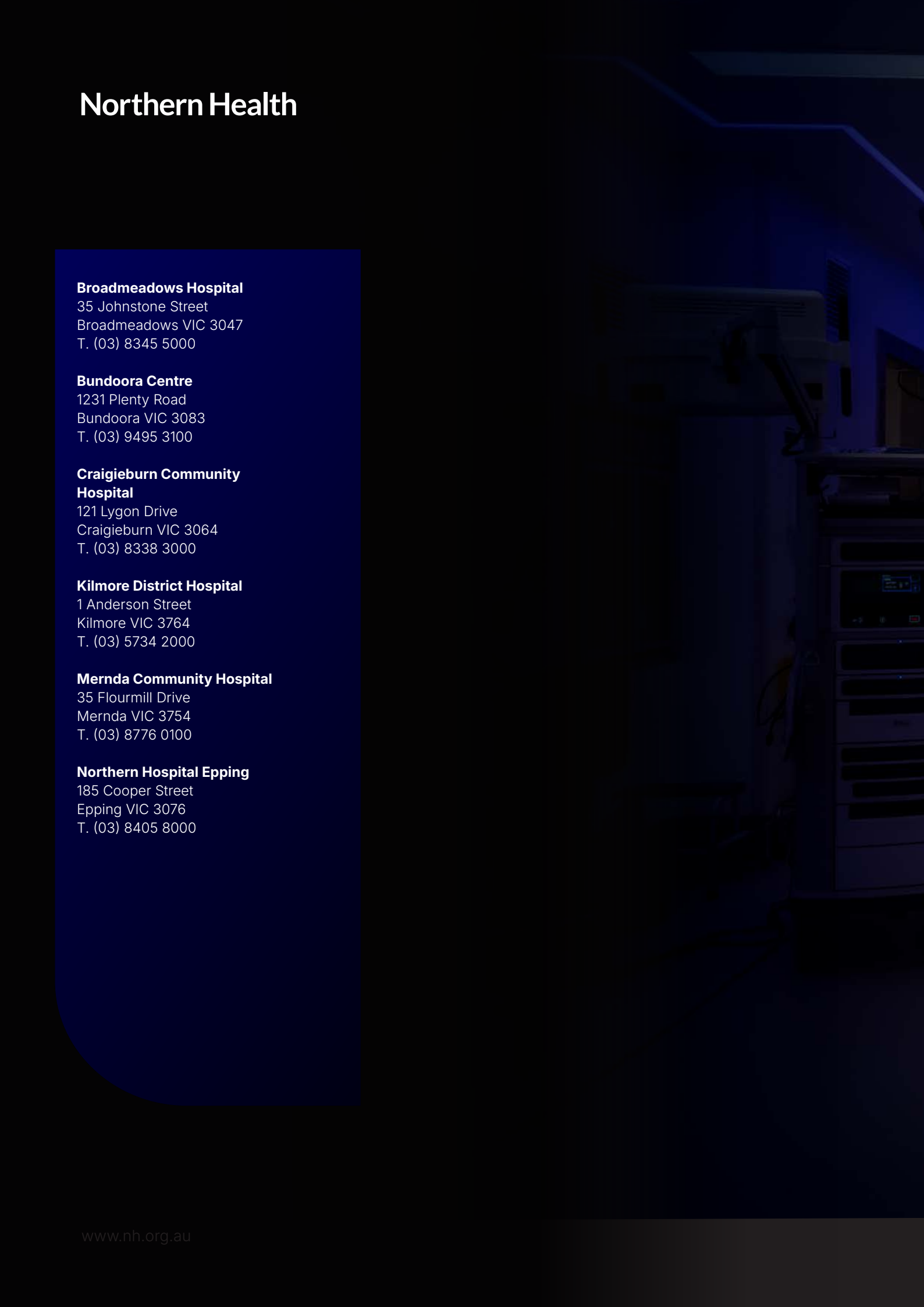
Financial assets at fair value through comprehensive income revaluation reserve

The financial assets at fair value through other comprehensive income revaluation reserve arises on the revaluation of financial assets (such as equity instruments) measured at fair value through other comprehensive income. Where such a financial asset is sold, that portion of the reserve which relates to that financial asset may be transferred to accumulated surplus/deficit.

Restricted specific purpose reserve

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

Northern Health



Broadmeadows Hospital
35 Johnstone Street
Broadmeadows VIC 3047
T. (03) 8345 5000

Bundoora Centre
1231 Plenty Road
Bundoora VIC 3083
T. (03) 9495 3100

Craigieburn Community Hospital
121 Lygon Drive
Craigieburn VIC 3064
T. (03) 8338 3000

Kilmore District Hospital
1 Anderson Street
Kilmore VIC 3764
T. (03) 5734 2000

Mernda Community Hospital
35 Flourmill Drive
Mernda VIC 3754
T. (03) 8776 0100

Northern Hospital Epping
185 Cooper Street
Epping VIC 3076
T. (03) 8405 8000