# Annual Report
## 2025-26












Portland District Health

# Annual Report
## 2025-26

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Portland Distrct Health (PDH) is one of the oldest health services in Victoria.

A public meeting in 1849 led to land being set aside in 1858 for “an Asylum for the benefit of the afflicted or distressed inhabitants and sojouners... of and in the said Town and neighbourhood and for no other purpose whatsoever”. Over 120 years later a Community Health Centre was established.

In 2003, the hospital and community centre amalgamated as PDH, a public hospital under the Health Services Act 1988.

PDH provides integrated care for the Glenelg Shire: acute services such as specialised medicine and surgery, urgent care, and maternity services as well as allied health, community care, and residential aged care. Associated services, Seaview House (residential care) and Active Health Portland (GP Superclinic), are adjacent to PDH.

PDH continues to evolve: from 1 July 2025, PDH will be part of the South West Local Health Service Network, established by government to improve regional cooperation and health services for communities in the South West of Victoria.






# Acknowledgement of Traditional Owners

We acknowledge the traditional owners of the land and waterways in which we live and work, the Gunditjmara people of South West Victoria. We honour and pay respects to elders past, present and emerging.

## Values

# Being part of Portland District Health














## OUR PROMISE

Choice, connection, clarity, consistency | Choice, connection, clarity, consistency | Choice, connection, clarity, consistency | Choice, connection, clarity, consistency |




## OPERATIONAL VALUES

Compassion, accountability, respect, excellence | Compassion, accountability, respect, excellence | Compassion, accountability, excellence | Compassion, accountability, excellence |

# Joint Message from the Chairperson & CEO

As we reflect on the 2025–2026 financial year at Portland District Health, we do so with a strong sense of pride, confidence and purpose. This has been a defining year for our organisation—one marked by meaningful progress, important reform and a continued commitment to delivering safe, compassionate and high-quality healthcare for our community.

While the healthcare environment continues to evolve, our focus has remained constant: ensuring the people of our region receive exceptional care close to home. Throughout the year, our staff have continued to demonstrate remarkable resilience, professionalism and compassion, embracing change while remaining steadfast in their commitment to our patients, residents and community.

A significant achievement this year was Portland District Health's transition from Intensive Mandated Support with the Department of Health to Performance Support. This milestone recognises the considerable progress made across governance, leadership, financial sustainability and organisational performance. It reflects the dedication of our Board, Executive and staff, whose collective efforts have strengthened the organisation and created a solid platform for continued improvement and future success.

This year also marked the commencement of the South West Local Health Service Network, an important milestone in the delivery of healthcare across our region. As one of the seven partner health services within the Network, Portland District Health is committed to working collaboratively to improve access, strengthen equity, enhance quality and safety, support our workforce and deliver more coordinated care for our communities. We see the South West Local Health Service Network as an opportunity to build a stronger, more connected health system while ensuring local decision-making and community needs remain at the centre of everything we do.

In support of this vision, we introduced a new organisational structure to strengthen integration across the organisation and improve continuity of care for our patients and consumers. By bringing our inpatient and community-based services closer together, we are creating more seamless care experiences while fostering stronger collaboration across clinical teams.

The new structure also provides a unified strategic focus, enabling clearer organisational direction and more effective engagement with our partners across the South West Local Health Service Network. Extensive consultation with staff throughout this process has provided a strong foundation for an organisational model that will support Portland District Health well into the future.

Another significant achievement has been the development of our Strategic Plan 2026–2030. Shaped through extensive consultation with staff, consumers, community members and key stakeholders, the Plan sets a clear direction for the future of Portland District Health. It reflects our commitment to delivering integrated, person-centred care that responds to the changing needs of our community. Importantly, it reinforces our focus on supporting people to remain healthy, independent and well in their own homes wherever possible, reducing avoidable hospital admissions while ensuring care is delivered in the right place, at the right time.

We are proud of the continued strengthening of our maternity services during the year. The stabilisation of our birthing service to a consistent 13 out of each 14 days service provides greater certainty for local families, while the recruitment of an obstetrician further strengthens our ability to deliver safe, sustainable maternity care close to home. These achievements represent an important investment in the future of maternity services for our region.

Demand for our Urgent Care Centre continued to grow, exceeding 12,000 presentations. This continued increase reflects both the healthcare needs of our community and the confidence people place in Portland District Health. Our clinical teams have responded with exceptional professionalism and dedication, ensuring patients continue to receive timely, high-quality care in what remains an increasingly busy environment.

Our commitment to First Nations reconciliation and culturally safe healthcare continues to grow. We acknowledge the invaluable partnerships we share with Windamara Aboriginal Corporation and Dhauwurd Wurrung Elderly & Community Health Service. Together, through our Reconciliation Action Plan, cultural capability initiatives and ongoing collaboration, we

continue to strengthen culturally safe, respectful and inclusive care for Aboriginal and Torres Strait Islander peoples across our region.

At the heart of every achievement this year are our people. From nurses, doctors and allied health professionals to administration, support services, environmental services, maintenance staff and volunteers, every member of our team plays a vital role in ensuring Portland District Health remains a trusted place of care. Their dedication, kindness and unwavering commitment to our community are the foundation of our success, and we thank each of them for the extraordinary contribution they make every day.

The Board acknowledges the outstanding contribution of Professor Michael Bailey, who concluded nine years of dedicated service as a Board Director during the year. Professor Bailey's leadership, wisdom and commitment to improving healthcare outcomes have made a lasting contribution to Portland District Health and the broader community.

We also acknowledge the valuable contributions of Ali Georgalis, who concluded four years of service on the Board, and Jed McCartney, who concluded five years of service. We sincerely thank Ali and Jed for their dedication, thoughtful leadership and commitment to strengthening Portland District Health throughout their terms.

Finally, we thank our community for your continued trust, support and partnership. Whether through volunteering, fundraising, providing feedback or participating in consultation, your involvement helps shape the future of Portland District Health and strengthens the services we provide.

As we look ahead, we do so with confidence and optimism. The achievements of this year demonstrate what is possible when people share a common purpose. While challenges will continue to emerge across the healthcare sector, we are well positioned to embrace new opportunities, strengthen partnerships and continue delivering outstanding care for our community.

Together, we are building a health service that is resilient, connected and sustainable—one that remains firmly grounded in our values of Compassion, Accountability, Respect and Excellence.

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



**Emeritus Professor Peter Matthews**

Chairperson, Portland District Health Board
30/06/2026



**Karena Prevett**

Chief Executive Officer, Portland District Health
30/06/2026

# Financial Overview

## Operating Performance

PDH had a challenging breakeven operating result set with the Department of Health through the Statement of Priorities for this financial year and despite ongoing efforts to improve productivity and contain expenditure, PDH recorded an operating deficit of $2.44 million for 2025-26. This is compared with an operating deficit of $313k in 2024-25. The result reflects a combination of increasing workforce costs, inflationary pressures across supplies and services, and ongoing demand for health services.

PDH remains committed to achieving long-term financial sustainability through strong financial governance, strategic planning and continuous improvement initiatives. During the year, the organisation continued to strengthen its participation in the South West Local Health Service Network, leveraging opportunities for greater collaboration, shared expertise and service integration across the region. These arrangements are expected to deliver benefits over time through improved service coordination, workforce resilience and operational efficiencies.

Workforce availability continues to be a key challenge facing rural health services. While labour costs increased during the year, PDH achieved a significant reduction in agency staffing expenditure, with agency costs decreasing from $14.0 million to $7.9 million. This reduction reflects the organisation's focus on recruitment, retention and workforce stabilisation strategies. Partially offsetting these savings was an increase in fee-for-service medical officer costs, reflecting the ongoing challenges in attracting and retaining medical practitioners in regional settings.

PDH reported a comprehensive deficit of $6.8 million in 2025-26 compared with a comprehensive deficit of $3.7 million in 2024-25. Unlike previous years, there were no significant asset revaluation movements impacting the result. The deficit primarily reflects underlying operating pressures, including workforce costs, supplies and consumables, depreciation and increased operating expenditure associated with service delivery.

## Cash

PDH maintained a solid cash position throughout 2025-26 despite the challenging operating environment.

Net cash inflows from operating activities were $258k, compared with net operating cash inflows of $2.0 million in 2024-25. Capital investment of approximately $1.0 million was made during the year to support service delivery and infrastructure requirements. Cash and cash equivalents at 30 June 2026 totalled $8.5 million, compared with $9.1 million at the previous year end.

Of the year-end cash balance, $5.3 million was held in trust, including refundable residential aged care accommodation deposits and patient monies. Operational cash resources remained sufficient to support ongoing service delivery and meet organisational obligations.

## Looking Ahead

The establishment of the South West Local Health Service Network provides significant opportunities to further strengthen financial sustainability across the region. During 2026-27, PDH will continue to work collaboratively with network partners to identify opportunities for shared services, coordinated workforce planning, procurement efficiencies and service redesign initiatives.

Key priorities for the coming year include:

- Improving financial performance and reducing the operating deficit.
- Continuing to reduce reliance on costly temporary workforce solutions.
- Strengthening recruitment and retention of medical, nursing and allied health staff.
- Enhancing regional collaboration through the Local Health Service Network.
- Investing in systems, infrastructure and service improvement initiatives.
- Maintaining safe, high-quality and person-centered care for the community.

We acknowledge the ongoing support of the Department of Health, our Board, staff, volunteers, donors and community partners. Their dedication and contribution continue to be critical in supporting the delivery of healthcare services across the region.

# Performance at a Glance

| Financials | 2026 $'000s | 2025 $'000s | 2024 $'000s | 2023 $'000s | 2022 $'000s |
|---|---|---|---|---|---|
| **Operating Result** | **(2,438)** | **(313)** | **177** | **(97)** | **290** |
| Total Revenue | 71,198 | 70,875 | 69,311 | 63,535 | 59,775 |
| Total Expenses | 78,007 | 74,455 | 69,920 | 66,640 | 63,250 |
| **Net Result from transactions** | **(6,809)** | **(3,580)** | **(609)** | **(3,105)** | **(3,475)** |
| Total other economic flows | 10 | (122) | (1,651) | (105) | (33) |
| **Net Result** | **(6,799)** | **(3,702)** | **(2,260)** | **(3,210)** | **(3,508)** |
| Total Assets | 76,589 | 80,287 | 83,414 | 71,621 | 75,323 |
| Total Liabilities | 23,765 | 20,664 | 20,089 | 17,894 | 18,331 |
| **Net Assets / Total Equity** | **52,824** | **59,623** | **63,325** | **53,727** | **56,992** |

From 2023 the financials no longer include any controlled entities.

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

| Reconciliation of Net Result from Transactions and Operating Result | 2026 Forecast $'000s |
|---|---|
| **Operative Result** | **(2,438)** |
| Capital Purpose Income | 346 |
| Specific Income | 467 |
| Assets Receive Free of Charge | (31) |
| Depreciation and Amortisation | (5,271) |
| Net gain/(loss) on non-financial assets | 31 |
| Total gain from other economic flows | 97 |
| **Net Result from Transactions** | **(6,799)** |

# Board of Directors

The skills and experience of Board of Directors is reviewed annually at the time of recruitment of directors to ensure a balanced board equipped with expertise and knowledge to properly govern a rural health service.

The Board of Directors is responsible to the Minister for Health for setting the strategic direction and governance of PDH, within the framework of government policy. Board Directors are accountable for ensuring the services are efficiently and effectively managed, provide high quality care and service delivery, meet the needs of the community, and meet performance targets.

The Directors are committed to ensuring that the services provided by PDH comply with the legislative requirements and the objectives within the resources provided.

The Directors review governance information monthly in order to continually assess the performance of PDH against its objectives and are also responsible for appointing and evaluating the performance of the Chief Executive Officer.

The Victorian Government has also committed to ensuring government boards and committees broadly mirror the diversity present in Victoria's communities. This includes appropriate representation of women, regional Victorians, Aboriginal people, young Victorians, Victoria's culturally diverse community, the Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) community and Victorians living with a disability.

## Meeting Attendance 2025/2026

| | |
|---|---|
| Peter Matthews | 12/12 |
| Michael Bailey | 10/12 |
| Lucy Cuddihy | 12/12 |
| Jed Macartney | 9/9 |
| Kristin Michaels | 12/12 |
| Andrew Long | 9/12 |
| Alexandra Georgalas | 9/12 |
| Paul Wright | 11/12 |
| Louise Cameron | 12/12 |

## Board Chairperson

**Prof. Peter Matthews**

Appointed: 01 July 2021 (appointed Chairperson by Minister Foley until 30 June 2024)

Elected: 01 July 2024 (elected Chairperson for annual term 01 July 2025-30 June 2026)

Term Expires: 30 June 2027

Committees:

- Ex-officio member all committees

## Deputy Chairperson

(until 10 April 2026)

**Mr. Jed Macartney (OAM)**

Appointed: 01 July 2021

Term Expires: Resigned 10 April 2026 acceptance from Governor Council pending

Committees:

- Finance, Audit & Risk (Chairperson until 10 April 2026),
- Clinical Governance
- Consumer Advisory (Chairperson until 10 Apr 2026)
- Governance Remuneration & Nomination

## Deputy Chairperson

(from 14 April 2026)

**Prof. Michael Bailey**

Appointed: 01 July 2017

Term Expires: 30 June 2026

Committees:

- Clinical Governance
- People & Culture

## Director

**Dr. Lucy Cuddihy**

Appointed: 01 July 2021

Term Expires: 30 June 2027

Committees:

- Clinical Governance (Chairperson)
- People & Culture

## Director

**Mr. Andrew Long**

Appointed: 01 July 2021

Term Expires: 30 June 2027

Committees:

- Finance, Audit & Risk (Chairperson from 14 April 2026)
- Governance, Remuneration & Nomination (Chairperson until 14 April 2026)

## Director

**Ms Alexandra Georgalas**

Appointed: 01 July 2022

Term Expires: 30 June 2028 (resigned 30 June 2026) acceptance from Governor Council pending

Committees:

- Finance, Audit & Risk
- Governance, Remuneration & Nomination
- People & Culture (Chairperson from 05 February 2025)

## Director

Mr Paul Wright

Appointed: 01 July 2022

Term Expires: 30 June 2028

Committees:

- Finance, Audit & Risk
- Consumer Advisory

## Director

**Ms Kristin Michaels**

Appointed 01 July 2025

Term Expires 30 June 2028

Committees

- Governance, Remuneration & Nomination (Chairperson from 14 April 2026)
- Finance, Audit & Risk

## Director

**Ms Louise Cameron**

Appointed: 01 July 2025

Term Expires 30 June 2028

Committees

- Clinical Governance
- Consumer Advisory Committee (Chairperson from 14 April 2026)
- People & Culture

# Executive Management

## Chief Executive Officer

**Karena Prevett**
GAICD BBus

## Executive Director Finance & Corporate Services

**Ian Martin**
CPA, FCMA, CGMA

## Executive Director of Nursing, Aged Care and Midwifery

**Roslyn Nagorcka** – Resigned 18 May 2026
RN, DipMgt, MRCNA

## Acting Director of Nursing, Aged Care and Midwifery

**Michelle Jenner** – 19 May - 27 May 2026

## Acting Director of Nursing, Aged Care and Midwifery

**Michael Ashby** – 1 June - 30 June 2026

## Executive Director of Primary Care & Quality Services

**Rebecca Smith** – Resigned 8 August 2025
RN, MHlth Mgnt, B Soc Sc (Human Services), Grad Dip HRD, Cert IV Training & Assessment

## Acting Director of Primary Care

**Jenny Roberts** – 11 August 2025 - 30 June 2026

## Executive Director Governance & Strategy

**Carolyn Shaw** – 22 June 2026 - 30 June 2026
MBA, GAICD, CPHR

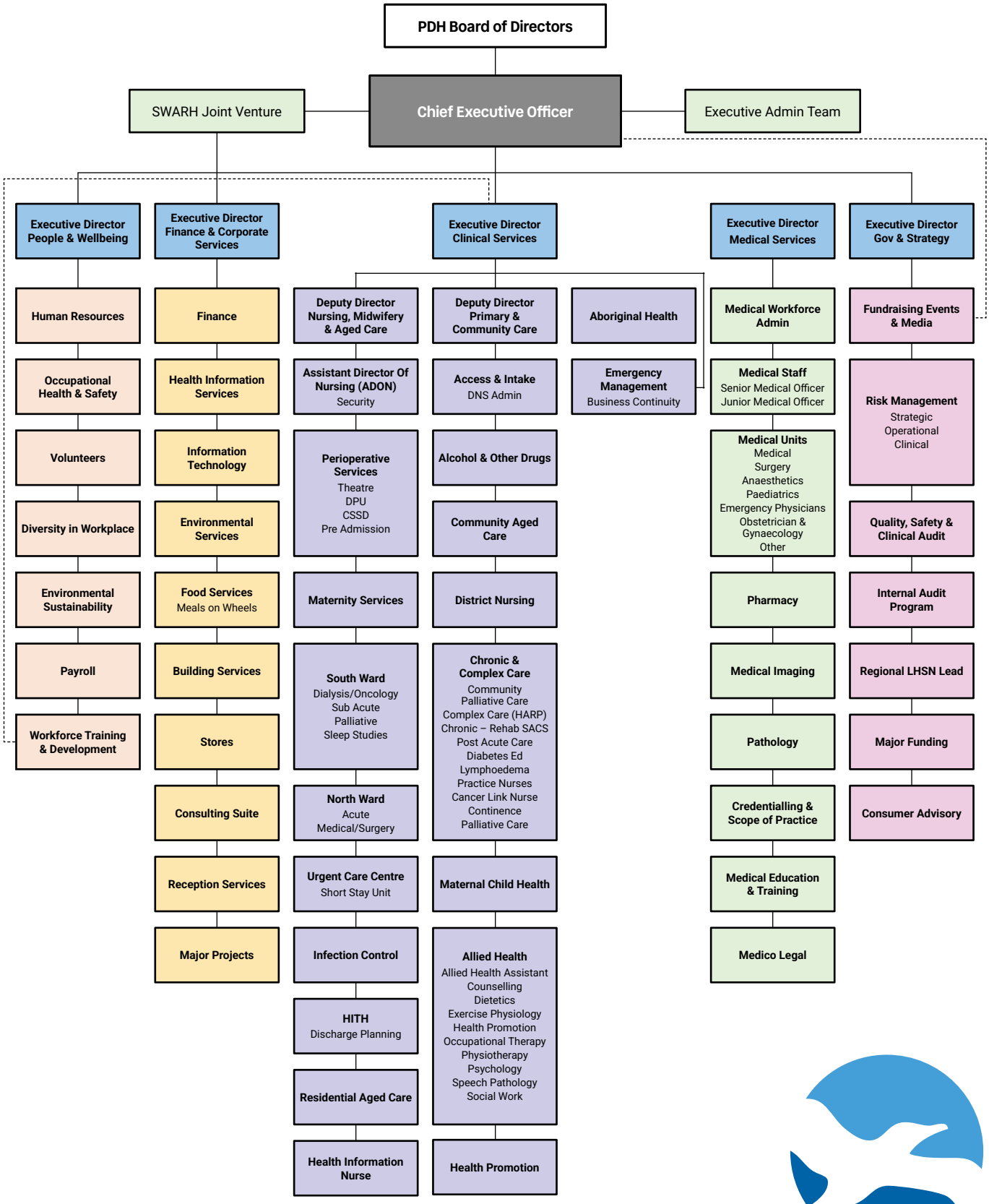
## Acting Executive Director Medical Services

**Dr Rupert Sherwood**
MBBS, FRANZCOG, AFRACMA, FRCOG (Hon)

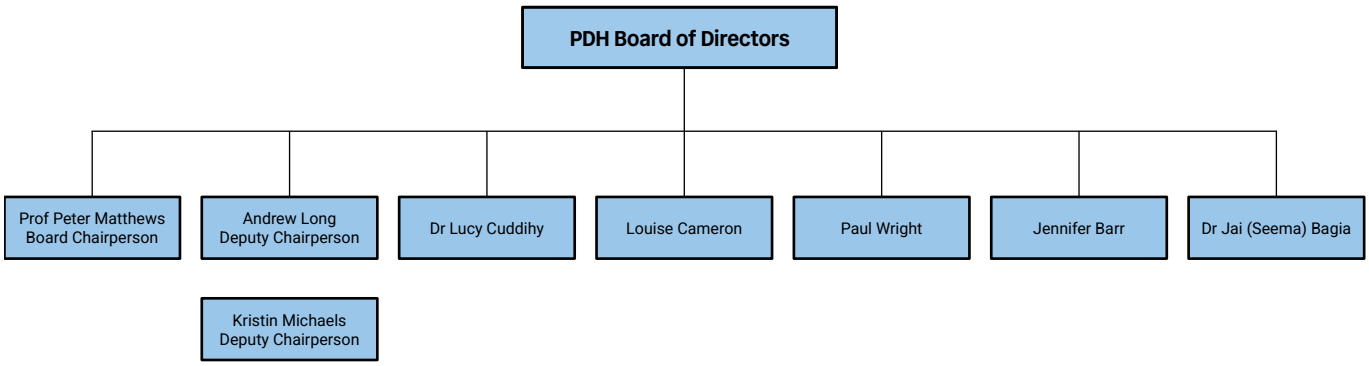


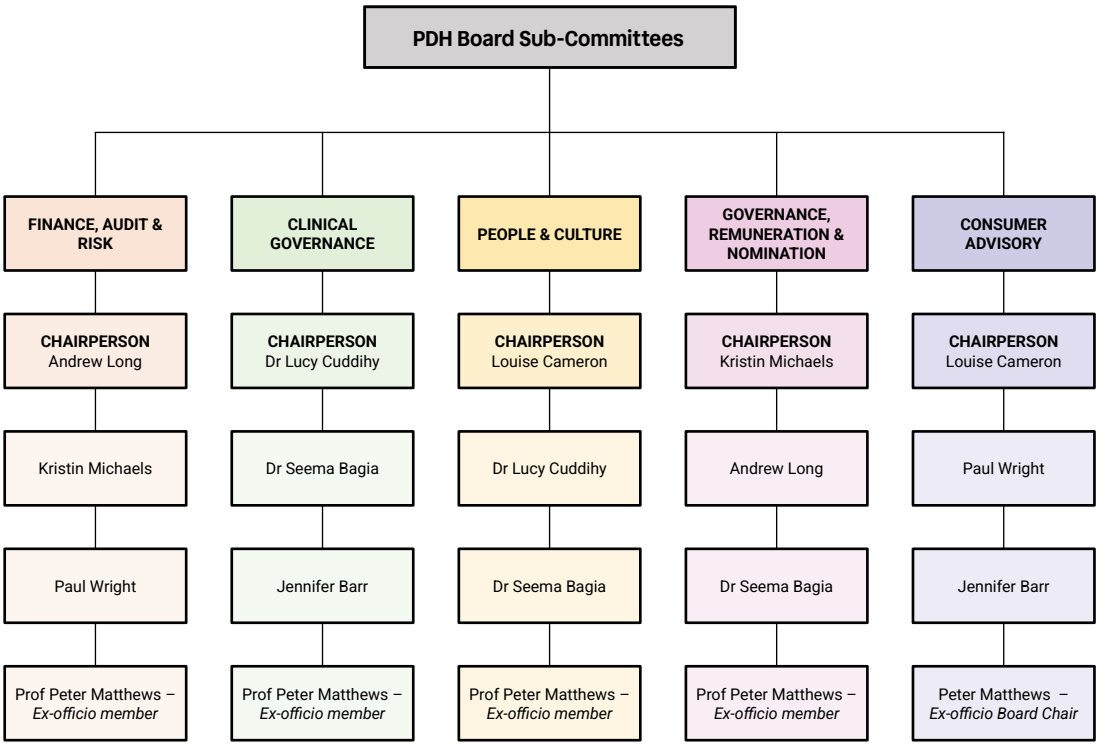
Ros Nagorka, Director of Nursing, Midwifery and Aged Care, concluded her employment with Portland District Health during the reporting period following many years of dedicated service. Ros first joined PDH in 1988 as a Charge Nurse and returned in 2014 to lead Nursing, Midwifery and Aged Care services. Throughout her tenure, she demonstrated high calibre leadership, professionalism, integrity and commitment to delivering high-quality care, while fostering a supportive and capable workforce. Her significant contribution has had a lasting impact on both the organisation and the community it serves. PDH sincerely thanks Ros for her many years of service and wishes her every success in the future.

# Portland District Health Organisational Chart



# Board of Directors and Sub-Committees



# Our Services

## Medical Units

Anaesthetics
Cardiology
Dermatology
Endocrinology
Upper & Lower GI Endoscopy
ENT Surgery
General Surgery –
Emergency and Elective
General Medicine
Geriatric Medicine
Nephrology inc. Renal Dialysis
Obstetrics and Gynaecology
Oncology including Chemotherapy
Orthopaedics
Paediatrics (UCC and Outpatients)
Plastic and Reconstructive Surgery
Respiratory Medicine
Urgent Care (Emergency Medicine)

## Diagnostic

Cardiology
- Stress ECG
- Echocardiography/ Holter Monitoring

Pathology
Pharmacy
Medical Imaging
- CT Scanning
- General X-rays
- Ultrasound
- Breast Screen
- Fluoroscopy
- Bone Density
- OPG/Cone beam CT

Sleep Studies

## Nursing / Midwifery Specialties

Day Procedure
Discharge Planning
Hospital in the Home
Maternal Child Health
Midwifery – Neonatal Care
Palliative Care and End of Life Care
Perioperative Assessment
Residential Aged Care
Sub-Acute care

## Primary, Community & Allied Health

Aboriginal Cancer Support Liaison
Alcohol and other Drug Services
Cancer Support
Community Palliative Care
Community Transport
Continence
Counselling
- Psychology
- Social Worker

Diabetes Education
Dietetics
District Nursing
- Chronic Disease Rehabilitation (SACS)
- Complex Care (HARP)
- Post-Acute Care

Health Promotion
Community Aged Care
- Home Care
- Personal Care
- Social Support
  (Individual & Group)
- Care Call

Lymphoedema
Occupational Therapy
Paediatric Nurse
Physiotherapy
Practice Nurses
Speech Therapy

## Support Services

Finance
Human Resources
Building Services
Administration
Health Informatics
IT
Food Services
- Meals on Wheels

Environmental Services
Staff Education
Quality & Safety
Infection Control & Prevention
Supply
Volunteer Services

# Portland District Health Medical Officers

## Salaried Medical Officers

**Emergency Physician**
Dr T Baker MBBS (Hons) B.MedSc (Hons) FACEM
Dr A Lishman MBBS (Hons) B.MedSc FACEM
Dr M Cooney MBBS (Hons) B.MedSc FACEM

**Specialist Physician**
Dr N Sharma MBBS MS FRACP FCSANZ

**Anaesthetist**
Dr J Parker MBBS FRACGP (GP Anaesthetist)

**Hospital Medical Officer**
Dr A Desai MBBS until October 26
Dr G Howe MBBS
Dr N Solanke MBBS until July 13
Dr D Adhikari MBBS
Dr I Pratt MD
Dr R Lekamwasam MBBS
Dr Z Ghiasi MD

**Senior Medical Officer**
Dr M Pilkington MBBS
Dr A Cameron MBBS FRACGP

**Registrar**
Dr E Pycroft MBBS

**Interns**
Dr Kate Sullivan MD
Dr Karen St George MD

**PGY2**
Dr Noah Kol until 3 May 2026
Dr Thaddeus Grams until 3 May 2026
Dr Charlie Roache
Dr Arqueene Chiong

**Paediatrician**
Dr B Baade MBBS, FRACP, MD

## Visiting Medical Officers

**General Practitioner**
Dr G Patel MBBS FRACGP
Dr M Garde MBBS FRACGP
Dr D Carrington MBBS FRACGP
Dr M Mitu MBBS FRACGP
Dr C Maina MBBS FRACGP
Dr A Sorial MBBS FRACGP
Dr P Rakesh MBBS FRACGP
Dr S Salamisaadatloo MBBS FRACGP
Dr D Singh MBBS FRACGP

**Anaesthetist**
Dr Y Limbu, MBBS

**Endocrinologist**
Prof G Nicholson MBBS FRACP

**Nephrologist**
Dr C Somerville MBBS FRACP PHD
Dr A Tjipto MBBS FRACP
Dr M Desmond MBBS FRACP

**Oncologist**
Assoc Prof I Collins MBBS FRACP
Dr T Hayes MBBS, FRACP

**Radiation Oncologist**
Dr P De Leso MBBS
Dr M Ali MBBS

**Haematologist**
Dr J Brotchie MBBS FRACP

**ENT Surgeon**
Dr A Cass MBBS FRACS

**Obstetrician & Gynaecologist**
Dr Y Diab MBBS MD FRANZCOG
Dr E Coghill, FRANZCOG

**Paediatrician**
Dr G Pallas MBBS, FRACP
Dr P Maude MBBS, FRACP

**Radiologist**
Dr D Cleeve MBBS FRANZCR
Dr J Eng MBBS FRANZCR
Dr R Jarvis MBBS FRANZCR
Dr S Skinner MBBS FRANZCR
Dr J Wilkie MBBS RCR RANZCR
Dr J Tamangani MBBS MSc RCR
Dr S Sweeney-Knapp MBBS RANZCR
Dr D Arhanghelschi MBBS RA

**General Surgeon**
Mr U Naidoo MBCHB FCS (FA)
Mr J Ragg MBBS FRACS
Dr R Milkins MBBS FRACS

**Orthopaedic Surgeon**
Dr K Arogundade MBBS FRACS MD FRCS
Dr A Mitra MBBS FRACS
Dr N Russell MBBS FRACS
Dr Robert Wood MBBS FRACS

**Plastic Surgeon**
Dr R Toma MBBS FRACS (Plast)
Dr J Masters MBBS FRACS (Plast)
Dr R Capstick MBBS FRACS (Plast)
Dr A Gascoigne MBBS FRACS (Plast)
Dr A Amr MBBS FRACS (Plast)

**Urologist**
Dr Anthony Ta MBBS FRACP

**Dermatologist**
Dr M Goh MBBS FACD
Dr F Lai MBBS FACD
Dr P McDonald MBBS FACD
Dr C Tancharoen MBBS FACD
Dr C Higgins MBBS FACD
Dr Quynh Le MBBS  FACD



## Visiting Dental Officers

**Dentist**
Dr A Nascimento BDS until Aug 2025

PDH regulates the appointment, credentialing and definition of scope of clinical practice for all health practitioners who provide services within our health service.

PDH is working with South West Healthcare, Western District Health Service, and Colac Area Health to streamline credentialing services in the region.

# Workforce

PDH is committed to the principles of merit and equity in the workplace with respect to employment, promotion and opportunity.

| Hospitals Labour Category | June Current Month FTE | | Average Monthly FTE | |
|---|---|---|---|---|
| | 2025 | 2026 | 2025 | 2026 |
| Nursing | 149.69 | 163.22 | 146.53 | 158.21 |
| Administration & Clerical | 51.23 | 56.81 | 52.16 | 54.69 |
| Medical Support | 8.24 | 11.04 | 6.63 | 9.97 |
| Hotel and Allied Services | 40.71 | 41.65 | 42.65 | 41.89 |
| Medical Officers | 5.19 | 2.70 | 5.56 | 3.62 |
| Hospital Medical Officers | 6.38 | 9.65 | 7.91 | 7.22 |
| Sessional Clinicians | 0 | 0 | 0 | 0 |
| Ancillary Staff (Allied Health) | 16.96 | 20.51 | 19.68 | 19.42 |
| **Total** | **278.40** | **305.58** | **281.12** | **295.02** |

## Staffing

| | 2025/2026 | 2024/2025 | 2023/2024 |
|---|---|---|---|
| Number of Staff Employed | 479 | 446 | 443 |
| Number of Staff Employed (FTE) | 295.02 | 281.10 | 285.63 |
| Time Lost through Work Cover Claims (FTE) | 0.90 | 0.89 | 0.91 |
| Time Lost through Industrial Disputes (hours) | 21.41 | 0.00 | 0.00 |
| Sick Leave as % of Basic Salaries | 5.80 | 5.15 | 5.97 |

## Statutory Compliance

During 2025/26, PDH made no mandatory report to AHPRA for a health professional.

PDH has an appropriate policy and procedure for disclosures in accordance with the Public Interest Disclosure Act 2012 (Vic) and IBAC Inquiries. PDH will take all steps required by law to protect people who make such disclosures from any detrimental action in reprisal for making the disclosure. It will also afford natural justice for the person who is the subject of the disclosure. Complaints about misconduct or corruption involving public health services in Victoria can be made by individuals directly to the Independent Broad-based Anti-Corruption Commission (IBAC), Victorian Inspectorate or the Victorian Ombudsman. Other entities can receive Public Interest Disclosures in certain circumstances.

## Code of Conduct

All staff receive the Victorian Public Sector Commission (VPSC) Code of Conduct for Victorian Public Sector Employees and the PDH Code of Conduct Policy on commencement of employment. Mandatory training is on Acceptable Workplace Behavior at PDH and staff also undertake mandatory Cultural Awareness training. Mandatory training also covers information contained in the 'Discrimination, Workplace Bullying & Harassment' policy and covers:

- *Occupational Health and Safety Act 2004*
- *Equal Opportunity (Gender Identity & Sexual Orientation Act 2000)*
- *Gender Quality Act 2020*
- *Human Rights and Equal Opportunity Act 1986*
- *Racial Discrimination Act 1975*
- *Sex Discrimination Act 1984*
- *Disability Discrimination Act 1992*
- *Crimes Act 1958*
- *Workplace Relations Act 1996*

## Industrial Relations

21.41 hours were lost at PDH as a result of industrial action during 2025/26.

## Workforce Inclusion Policy

The Gender Equality Act 2020 commenced in March 2021 with the ongoing requirement to submit a Progress Reports and Audit Data. The 2025 Progress Report was submitted on 12 June 2026 which included information on:

- the policies, programs or services that were subject to a gender impact assessment and the actions taken as a result of each gender impact assessment
- progress in relation to the measures and strategies set out in our Gender Equality Action Plan (GEAP), and
- progress in relation to the workplace gender equality indicators.

A key task in PDH's GEAP was to identify ways to capture this data to improve the accuracy of data collection for the next Workplace Gender Audit. To achieve this task, in November 2024, PDH implemented new data collection strategies for new and existing employees to better capture required audit data. Broader staff engagement and ongoing consultation was identified as a key to delivering the expected outcomes from the initial PDH GEAP. PDH is currently working towards compiling the next GEAP due 1 November 2026 and Audit Data due 1 December 2027.

## Workplace Health & Safety

We regularly audit, review and update our Occupational Health & Safety policies, procedures and systems to ensure compliance with the OH&S Act 2004 and applicable regulations.

Our commitment to staff wellbeing is supported through our provision of an Employee Assistance Program (EAP), Fatigue Management Policy and the 'Right to Disconnect' when not at work. This work is also supported by the availability of support and guidance for staff experiencing any issues in the workplace.

PDH empowers staff by providing ongoing training on family violence, elder abuse, bullying, and sexual harassment, occupational violence, values and occupational health and safety.



## Occupational Violence Statistics

PDH is committed to addressing occupational violence incidents. The committee is continuing to implement strategies to reduce incidents and the impacts of occupational violence.

| Occupational Violence Statistics | 2025/26 |
|---|---|
| 1. WorkCover accepted claims with an occupational violence cause per 100 FTE | 0 |
| 2. Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked. | 0 |
| 3. Number of occupational violence incidents reported | 124 |
| 4. Number of occupational violence incidents reported per 100 FTE | 42.03 |
| 5. Percentage of occupational violence incidents resulting in a staff injury, illness or condition | 26.62% |

# Life Governors & Service Awards

PDH values the significant contribution that many individuals make to the overall well-being of the organisation. The most prestigious award available to a person providing outstanding and continued long services to PDH is Life Governorship.

## Life Members of the Former Portland and District Community Health Centre Inc.

Association for the Blind
Portland Neighborhood House
Mr Jeff Knuckey
Mrs Anne Lanyon
Mr W (Bill) Collett
Mr Jeff Baulch
Mrs Marilyn Baulch
Mr David Harris

## Life Governors

Mrs Pam Godfrey-Smith
Mr A K (Keith) Ough
Apex Club of Portland
Mrs Brenda Edwards
Percy Baxter Trust
Miss Eunice Lightbody
Lions Club of Portland
Mrs Ellie Lane
Helen Macpherson Smith (Trust)
Portland Aluminium
Portland Professional Women's Service Club
Mr Stephen Poon
Mrs Margrett Oates
Mrs Maureen Allan
Mrs Noelene Flowers
Mr Michael Noske
Rotary Club of Portland
Mrs S Fyfe
Mrs Mavis L Jennings
Mr Kevin Phillips
Mrs R Smith
Mrs P Mitchell
Miss June Stewart
Miss Sheila M Farrands
Mrs Pat Wilmot
Mr John C Wigan
Mrs Faith Sutterby
Mrs Heather Burton
Mrs Roslyn Jones

## Staff Length of Service Awards

**5 Years**
Michael Ashby
Ellie Baker
Lauren Carmichael
Kylie Cobby
Maddison Cram
Sharon Crockett
Lacey Dyke
Caroline Francis
Lovepreet Kaur
Sarena Lowery
Dana McLeod
Carolanne O'Connor
Emily Pycroft
Tecla Seurey
Melissa Wakefield
Sarah Wall
Jesse Welfare
Imogene Wilson

**10 Years**
Leah Bachmann
Julie Baker
Emma Barton
Susan Clamp
Wendy Crow
Kerry Dean
Riezl Espanta
Donna Farr
Toni Kedzia
Tahnee Lyons
Vicki Martin
Chanel Norris

**10 Years continued**
Kate Nunn
Susanne Ryan
Naveen Sharma
Michael Telfer

**15 Years**
Kathryn Humphries
Tamara McCallum
Brooke Morrissey
Kaye Morton
Lynne Peters

**20 Years**
Natalie Herbertson

**25 Years**
Tania Adams
Joanne Brewster
Gaynor Denboer
Simone Taylor
Penny Wallis

**30 Years**
Susan Holmes
Michelle Petrie

**40 Years**
Lorraine Hiscock
Maddox Myfarwy
Sheralee Radley

**50 Years**
Janine Duckmanton

We thank all of our wonderful and dedicated staff for their input and contribution.

## Volunteer Service Awards

**10 Years**
Marilyn Garner
Judith James
Phillip Petrie

**15 Years**
Valerie Baker

Portland District Health thanks all of our dedicated and valuable volunteers for the many hours of work and support every year for the benefit of our Health Service and community.

# Statement of Priorities

## PART A - STRATEGIC PRIORITIES

**System Priorities**
In 2025-26 PDH Health contributed to the achievement of the Victorian Government's commitments by:

### INNOVATE AND IMPROVE ACCESS AND CARE

**We aim for the best patient experience and care outcomes by assuring safe practice, leadership of safety, an engaged and capable workforce, and continuing to improve and innovate care.**

### GOAL

**Align with the Victorian Clinical Governance Framework to strengthen clinical governance systems, ensuring safe, high-quality care.**

| Health Service Deliverables | Achievements/Outcome |
|---|---|
| Demonstrate high quality care in which consumer engagement and input is activley sought, facilited and used to drive system change to improve consumer experience and outcomes. | **Status: Achieved**<br><br>Commentary:<br><br>Portland District Health (PDH) continues to contribute to the Victorian Government's commitment to improving access, patient experience, and care outcomes through safe clinical practice, strong leadership, workforce capability, and ongoing innovation.<br><br>PDH has aligned its clinical governance systems with the Victorian Clinical Governance Framework to strengthen oversight and ensure the delivery of safe, high-quality care. Consumer engagement remains a key focus, with robust systems in place to actively seek, facilitate, and respond to consumer feedback.<br><br>Feedback is captured through the RiskMan system and is used to drive service improvements and enhance patient outcomes. During the reporting period, feedback levels exceeded both Statement of Priorities targets and the state average. Compliments accounted for 78% of all feedback received, and 88.1% of respondents reported feeling listened to during their episode of care. |

| | |
|---|---|
| Ensure that health service reporting, reviews and decision-making are underpinned by a safety culture and systems that are transparent, accurate and fair for staff and consumers. | **Status: Achieved**<br><br>Commentary:<br><br>PDH has fostered a strong safety culture by ensuring that reporting, reviews, and decision-making processes are transparent, accurate, and fair for both staff and consumers. Incident reporting has increased significantly, with an average of 89 patient-related incidents reported each month compared with approximately 40 incidents per month four years ago. All incident investigations were completed and closed within required timeframes, and People Matter Survey results indicate that staff feel safe to speak up at a rate comparable with the statewide average.<br><br>PDH remains committed to delivering equitable and timely access to planned care in line with the Planned Surgery Reform Blueprint. Theatre optimisation initiatives have been successfully implemented, including adherence to state guidelines for laparoscopic cholecystectomy, laparoscopic hernia repairs, anterior cruciate ligament (ACL) procedures, and tonsil and adenoid surgery. The average length of stay for knee replacement surgery was maintained at 2.3 days, meeting the state target.<br><br>Planned surgery and specialist clinic waitlists continue to be actively managed to ensure patients receive care in a timely manner and are supported into appropriate treatment pathways. Availability of continence and diabetes services has increased, benefiting many patients under 65 years of age. Performance monitoring has continued throughout the year to maintain activity targets, and theatre waiting lists are managed in accordance with Victorian policy and the Treat in Turn principle. Access to services is prioritised using established clinical priority tools, and bowel screening pathways have been enhanced to allow direct access to colonoscopy services in line with Clinical Care Standards. |
| Health Services are able to show evidence of a comprehensive training progarm approach that includes performance management, accountablity, and continuous improvement. | **Status: Achieved**<br><br>Commentary:<br><br>A comprehensive training and performance improvement program supports workforce capability and accountability. Key initiatives during the year included Basic Life Support (BLS) training, SWITCH training, Fraud and Corruption training, Gender Equality training, implementation of a Quality Improvement Register, and the reinstatement of face-to-face staff orientation. |

## INNOVATE AND IMPROVE ACCESS AND CARE CONTINUED

**We aim for the best patient experience and care outcomes by assuring safe practice, leadership of safety, an engaged and capable workforce, and continuing to improve and innovate care.**

## GOAL

**Maintain a commitment to delivering equitable and timely access to planned care and drive reform in alignment with the Planned Surgery Reform Blueprint.**

| Health Service Deliverables | Achievements/Outcome |
|---|---|
| Implement and scale theatre optimisation initiatives in planned surgery, for example same-day surgery and same-day surgery by default models of care, criteria-led discharge, monitoring of theatre measures, and high-throughput approaches such as high-intensity theatre lists. | **Status: Achieved**<br>Commentary:<br>PDH remains committed to delivering equitable and timely access to planned care in line with the Planned Surgery Reform Blueprint. Theatre optimisation initiatives have been successfully implemented, including adherence to state guidelines for laparoscopic cholecystectomy, laparoscopic hernia repairs, anterior cruciate ligament (ACL) procedures, and tonsil and adenoid surgery. The average length of stay for knee replacement surgery was maintained at 2.3 days, meeting the state target. |
| Proactively manage planned surgery and specialist clinics (or outpatients) waitlists, for example validating and supporting patients into optimal care pathways such as evidence-based alternatives to surgery and optimisation pathways. A particular focus should be applied to long-waiting patients and priority population groups (for example, Aboriginal and Torres Strait Islander patients and under-18 patients). | **Status: Achieved**<br>Commentary:<br>Planned surgery and specialist clinic waitlists continue to be actively managed to ensure patients receive care in a timely manner and are supported into appropriate treatment pathways. Availability of continence and diabetes services has increased, benefiting many patients under 65 years of age.<br>Performance monitoring has continued throughout the year to maintain activity targets, and theatre waiting lists are managed in accordance with Victorian policy and the Treat in Turn principle. Access to services is prioritised using established clinical priority tools, and bowel screening pathways have been enhanced to allow direct access to colonoscopy services in line with Clinical Care Standards. |

## PRUDENT, SUSTAINABLE AND EFFECTIVE USE OF RESOURCES

**We are innovative and resourceful in balancing improved patient care, operational performance, and system management to ensure a financially secure health system. We invest in a skilled and future-ready workforce, maintaining a modern, safe, and resilient healthcare system for all Victorians.**

## GOAL

**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.**

| Health Service Deliverables | Achievements/Outcome |
|---|---|
| Deliver the key initiatives outlined in the Budget Action Plan within Government parameters. | **Status: Achieved**<br>Commentary:<br>PDH remains committed to balancing high-quality patient care with sound financial management and operational sustainability. Through innovation, resourcefulness, and workforce investment, PDH continues to strengthen its capacity to provide safe, modern, and sustainable healthcare services for the community.<br>To support long-term financial sustainability, PDH successfully delivered the key initiatives outlined in its Budget Action Plan. The plan was developed and submitted to the Department of Health on a quarterly basis, with ongoing monitoring demonstrating achievement of agreed targets and compliance with government financial parameters. |
| Utilise data analytics and performance metrics to identify areas of inefficiency and waste and make evidence-based decisions to improve financial sustainability and operational performance. | **Status: Achieved**<br>Commentary:<br>PDH has strengthened the use of data analytics and performance reporting to identify inefficiencies, reduce waste, and support evidence-based decision-making. During the year, the organisation implemented robust activity reporting systems that improved the capture and reporting of service data and strengthened governance oversight through established reporting structures.<br>Agency workforce data was closely monitored to understand trends in usage and expenditure, while analysis also identified areas where revenue opportunities were limited by clinical coding requirements. In addition, a dedicated process was introduced to monitor and analyse the use of medical locums, with the objective of reducing associated costs and improving workforce sustainability. |
| Use funding efficiently and effectively to optimise patient facing services. Undertake programs to reduce the cost of service delivery, improve safety, capacity and reduce unnecessary waiting. | **Status: Achieved**<br>Commentary:<br>PDH has focused on using available funding efficiently and effectively to maximise patient-facing services and reduce the cost of service delivery. Service Level Agreements were established with neighbouring health services to create efficiencies and strengthen regional collaboration. Staffing rosters were reviewed to reduce overtime expenditure while supporting improved clinical outcomes. The implementation of a Financial Management Improvement Plan further supported the identification of savings opportunities and reinforced a culture of continuous improvement across the organisation. Through these initiatives, PDH has enhanced operational effectiveness while maintaining a strong focus on safety, capacity, and patient access to services. |

## A STRONGER WORKFORCE

**We strive to foster an equitable, skilled and supported workforce that builds professional capabilities to meet current and future roles.**

## GOAL

**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.**

| Health Service Deliverables | Achievements/Outcome |
|---|---|
| Implement processes to sustain workforce supply and fulfill obligations, including those under the Gender Equality Act 2020 by improving employee experience in leadership, health and safety, flexibility, career development, and agility to ensure safe, high-quality care. | **Status: Achieved**<br><br>Commentary:<br><br>PDH continues to prioritise the development of an equitable, skilled, and supported workforce capable of meeting current and future healthcare needs. In line with the Victorian Health Workforce Strategy, PDH has focused on enhancing employee experience, building workforce capability, and strengthening workforce sustainability.<br><br>Significant progress has been made in sustaining workforce supply and meeting organisational obligations, including those under the Gender Equality Act 2020. The organisation has successfully reduced its reliance on locum staff by increasing its capacity to recruit permanent employees, resulting in a reduction in locum requirements of more than 50 per cent. Agency and locum staffing now represent only a small proportion of the overall workforce. During the year, PDH also undertook a review of Primary Care services and service provision to ensure resources remain aligned to community needs.<br><br>PDH met all reporting obligations under the Gender Equality Act and continues to maintain equal opportunity policies and practices across the organisation. Workplace health and safety remains a priority, with Health and Safety Representatives actively engaged in accordance with legislative requirements and all representatives completing the required training. Leadership capability has also been strengthened through the continuation of leadership development programs and collaboration with Huron Studer through the “When PDH Leads” initiative. The reinstatement of face-to-face orientation has further enhanced staff engagement and integration. Workforce planning and sustainability initiatives have been supported through active participation in the South West Local Health Service Network Workforce Committee and oversight by the Board’s People and Culture Committee. |
| Collaborate with the department to improve workforce data analytics, generate actionable insights, and enhance strategic planning. | **Status: Achieved**<br><br>Commentary:<br><br>PDH has worked closely with the Department of Health to strengthen workforce data analytics and strategic workforce planning. The organisation participated in the Victorian Public Service workforce data collection and contributed to departmental projects examining workforce vacancy rates across health services. PDH shared an agency workforce analysis tool developed within the South West Local Health Service Network and continued to monitor workforce performance through monthly reviews of full-time equivalent staffing and agency workforce data. Feedback received from the Department of Health during the development of the 2026–2029 Strategic Plan was incorporated into planning processes to further strengthen workforce management and organisational sustainability. |

## IMPROVING ABORIGINAL HEALTH AND WELLBEING

**Strengthen cultural safety in Victoria's health service system by fostering strong connections to Aboriginal culture, creating a holistic, accessible, and empowering health system.**

## GOAL

**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.**

| Health Service Deliverables | Achievements/Outcome |
|---|---|
| Deliver high-quality cultural safety training to all executives and staff using independent, expert, community-controlled organisations or a registered Aboriginal business. | **Status: Achieved**<br>Commentary:<br>PDH is committed to strengthening cultural safety and improving health outcomes for Aboriginal and Torres Strait Islander peoples by fostering meaningful connections with Aboriginal communities and ensuring healthcare services are culturally safe, accessible, and responsive. This commitment aligns with the broader goal of creating a health system that is empowering, inclusive, and free from racism.<br>During the year, PDH delivered cultural safety training to staff and executives through engagement with local Aboriginal representatives and community members. Staff feedback was actively sought following the training, and cultural awareness education has now been incorporated into the organisation's face-to-face orientation program. To further strengthen cultural understanding and engagement, a local Community Elder has been engaged to provide ongoing cultural awareness training on a regular basis. |
| Health service executives and senior leaders establish and maintain strong, ongoing partnerships with Aboriginal community-controlled organisations and/or recognised Aboriginal leaders within their local catchments. These partnerships must be based on regular, proactive engagement that prioritises the voices, self-determined priorities, and cultural knowledge of Aboriginal communities in the design, delivery, and evaluation of health and wellbeing services. | **Status: Achieved**<br>Commentary:<br>PDH has continued to build and maintain strong partnerships with Aboriginal organisations and community leaders across the region. The Aboriginal and Torres Strait Islander Working Committee has undertaken cultural safety walk-arounds and is implementing actions arising from those reviews. The organisation's Reconciliation Action Plan has been approved, and an Aboriginal Workforce Plan has been developed to support greater Aboriginal participation within the workforce. PDH has also collaborated with South West Healthcare to provide access to an Aboriginal Cancer Support Worker and has ensured culturally appropriate information is available through services such as Continence Care. Additional initiatives include the commissioning of Aboriginal artwork, active participation in NAIDOC Week celebrations and community events, and ongoing engagement with local Aboriginal organisations. Formal partnerships have been strengthened through Memoranda of Understanding with Dhauwurd-Wurrung Elderly and Community Health Service (DWEC) and Windamara Aboriginal Corporation. |
| Ensure culturally appropriate systems for identifying Aboriginal and Torres Strait Islander patients and implement responsive discharge plans and referral pathways. | Aboriginal & Torres Strait Islander Officer<br>PDH continues to strengthen systems that support the identification and care of Aboriginal and Torres Strait Islander patients. An Aboriginal and Torres Strait Islander Liaison Officer assists in supporting culturally safe care pathways, while patient identification processes ensure Aboriginal and Torres Strait Islander status is routinely and appropriately recorded. The organisation has also implemented initiatives such as culturally appropriate birthing cards and strengthened referral pathways through established partnerships with Aboriginal community-controlled organisations, helping to ensure patients receive coordinated, culturally responsive care throughout their healthcare journey. |

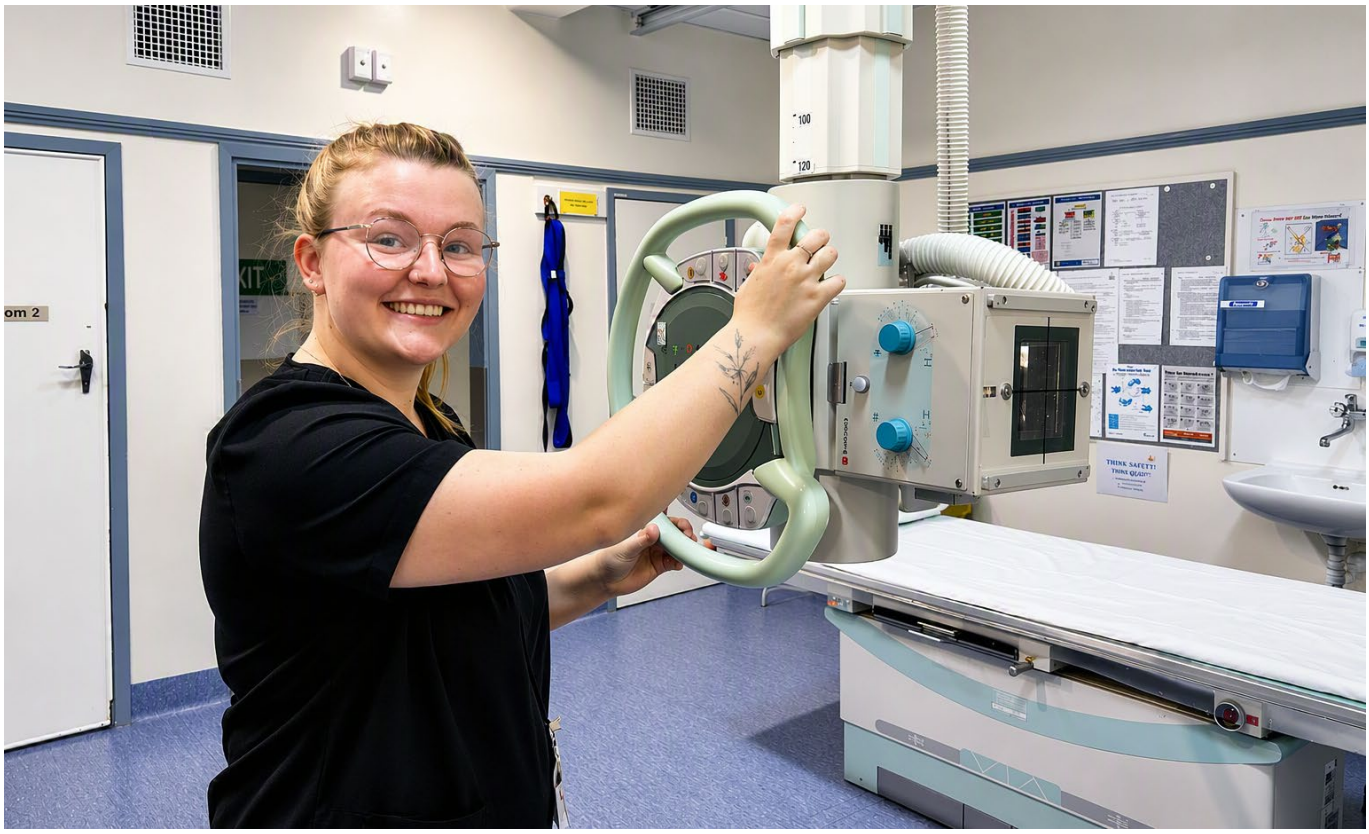
## MOVING FROM COMPETITION TO COLLABORATION

**We are committed to transforming Victoria's health system by partnering with care providers and health services to share knowledge, information, and resources.**

## GOAL

**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.**

| Health Service Deliverables | Achievements/Outcome |
|---|---|
| Meet all objectives agreed to in the Local Health Service Network Statement of Expectations across priority areas (access, equity and flow, workforce, safety and quality, and shared services). | **Status: Achieved**<br><br>Commentary:<br><br>PDH remains committed to strengthening collaboration across the South West Local Health Service Network, recognising that a more integrated and coordinated health system delivers better outcomes for patients, communities, and healthcare providers. Through active participation in network initiatives, PDH continues to work alongside neighbouring health services to improve access, equity, workforce sustainability, patient flow, safety, quality, and shared service delivery.<br><br>Throughout the reporting period, PDH contributed to the objectives outlined in the Local Health Service Network Statement of Expectations and actively participated in collaborative initiatives designed to build a more connected regional health system. This collaborative approach supports improved patient experiences, greater access to services, enhanced workforce capability, and the sustainable delivery of high-quality healthcare across the region. |



# Statement of Priorities

## PART B - PERFORMANCE PRIORITIES

### High Quality and Safe Care

| Key Performance Indicator | Target | Actual |
|---|---|---|
| **Infection prevention and control** | | |
| Percentage of healthcare workers immunised for influenza | 94% | 100% |
| **Adverse Events** | | |
| Percentage of reported sentinel events for which a root cause analysis (RCA) report was submitted within 30 business days from notification of the event | All RCA reports submitted within 30 business days | 100% |
| **Aged Care** | | |
| Public sector residential aged care services overall star rating | Minimum rating of 3 stars | 4 |
| **Patient Experience** | | |
| Percentage of patients who reported positive experiences of their hospital stay | 95% | 99.2% |
| **Aboriginal Health** | | |
| The gap between the number of Aboriginal patients who discharged against medical advice compared to non-Aboriginal patients | 0% | 1.66% |

### Strong governance, leadership and culture

| Key Performance Indicator | Target | Actual |
|---|---|---|
| **Organisational Culture** | | |
| People matter survey – Percentage of staff with an overall positive response to safety culture survey questions | 80% | 70% |

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

### Effective Financial Management

| Key Performance Indicator | Target | Actual |
|---|---|---|
| Operating result ($M) | 0.00 | ($2.44M) |
| Adjusted current asset ratio | 0.7 or 3% improvement from health service base target | 0.59 |
| 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 | 14.7% |

# Statement of Priorities

## PART C - ACTIVITY AND FUNDING

Portland district health funding summary for 1 July 2025-30 June 2026

| Funding type | 2025-26 Activity Achievement |
|---|---|
| **Consolidated Activity Funding** | |
| Acute admitted, subacute admitted, emergency services, non-admitted NWAU | 6425.97 |
| **Acute admitted** | |
| Acute admitted DVA | 15.63 NWAU |
| Acute admitted TAC | 6.45 NWAU |
| **Subacute/Non-Acute, Admitted & Non-Admitted** | |
| Subacute – DVA | 0 NWAU |
| **Aged Care** | |
| Residential Aged Care | 9,781 |
| HACC | 969.47 Hours |
| **Mental Health and Drug Services** | |
| Drug Services | 1 |
| **Primary Health** | |
| Community Health / Primary Care Programs | 7959.08 |

**The data included in this annual report was accurate at the time of publication and is subject to validation by official sources from the Department of Health.*

# Mandatory Reporting

## Our Legislative Compliance

PDH has a statutory obligation to report legislative compliance on a range of matters.

## Attestations:

**FINANCIAL MANAGEMENT COMPLANCE**
I, Peter Matthews, on behalf of the Responsible Body, certify that Portland District Health has no Material Compliance Deficiency with respect to the applicable Standing Directions under the Financial Management Act 1994 and Instructions.



**Peter Matthews**
Chairperson
Portland District Health
Date: 30 June 2026

**DATA INTEGRITY**
I, Karena Prevett certify that Portland District Health has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Portland District Health has critically reviewed these controls and processes during the year.



**Karena Prevett**
Chief Executive Officer
Portland District Health
Date: 30 June 2026

**CONFLICT OF INTEREST**
I, Karena Prevett certify that Portland District 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 (VPSC). Declaration of private interest forms have been completed by all executive staff within Portland District Health and members of the board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each executive board meeting.



**Karena Prevett**
Chief Executive Officer
Portland District Health
Date: 30 June 2026

**INTEGRITY, FRAUD AND CORRUPTION**
I, Karena Prevett, certify that Portland District Health has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at Portland District Health during the year.



**Karena Prevett**
Chief Executive Officer
Portland District Health
Date: 30 June 2026

**SAFE PATIENT CARE ACT 2015**
Portland District 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.

**COMPLIANCE WITH HEALTH SHARE VICTORIA (HSV) PURCHASING POLICIES**
Schedule 1 and 5 health services are required to comply with the requirements of the Purchasing Policies as set out in the Health Services Act 1988 (Vic).

**No compliance issues**

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



**Karena Prevett**
Chief Executive Officer
Portland District Health
Date: 30 June 2026

## Compliments and Complaints

At PDH, we value consumer feedback - whether it's positive, negative, or a suggestion for improvement. Consumer input helps us understand the patient experience and informs our efforts to continuously improve the quality of care and services we provide. It is acknowledged that the organisation will not always be able to meet consumer expectations; however, consumer feedback is seen as an essential component of understanding how consumers perceive our services. This feedback is used in determining quality improvement initiatives and working towards addressing identified gaps.

Consumers can share their feedback in several ways:

- Verbally or in writing, directly to the health service
- Through satisfaction surveys
- By participating in service evaluations, focus groups or the Consumer Advisory Committee
- Via the Health Services Commissioner

**2025/26**

Compliments 304
Complaints 92

| Category | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Compliments | 25 | 22 | 23 | 25 | 37 | 39 | 20 | 21 | 27 | 17 | 20 | 28 |
| Complaints | 10 | 3 | 7 | 11 | 3 | 7 | 12 | 12 | 8 | 10 | 6 | 3 |
| Acknowledged within 5 days | 70% | 100% | 30% | 80% | 100% | 100% | 92% | 100% | 100% | 100% | 83% | 100% |
| Open >30 days | 4 | 1 | 0 | 1 | 2 | 2 | 2 | 0 | 2 | 2 | 1 | 1 |



## Consultancies <$10,000

In 2025-26, there were 4 consultancies where the total fees payable to the consultants were less than $10,000. The total expenditure incurred during 2025-26 in relation to these consultancies is $21,834 (excl GST).

## Consultancies >$10,000

In 2025-26, there were 8 consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2025-26 in relation to these consultancies is $221,926 (excl GST). Details of these consultancies can be viewed below.

| Consultant | Purpose of Consultancy | Start Date | End Date | Total Approved Project Fees (excluding GST) | Expenditure 2025-26 (excluding GST) | Future Expenditure |
|---|---|---|---|---|---|---|
| Workforce Legal Solutions Pty Ltd | Legal Advice | 1 June 2025 | 30 June 2026 | $11,512.50 | $11,512.50 | - |
| The Trustee for Austin Holdings | Change Management Support | 1 June 2025 | 30 June 2026 | $13,330.00 | $13,330.00 | - |
| Catherine Helen Jones | Clinical Governance Documents Review | 1 June 2025 | 30 June 2026 | $16,000.00 | $16,000.00 | - |
| Felicity Anne Topp | Governance & Leadership | 1 June 2025 | 30 June 2026 | $17,400.00 | $17,400.00 | $15,000.00 |
| Thoughtpost Governance Pty Ltd | Board Review | 1 June 2025 | 30 June 2026 | $19,070.00 | $19,070.00 | - |
| Windamara Aboriginal Corporation | Cultural Training | 1 June 2025 | 30 June 2026 | $37,916.70 | $37,916.70 | - |
| Power Solutions DTD Pty Ltd | Professional Services Costing Data collection | 1 June 2025 | 30 June 2026 | $41,696.60 | $41,696.60 | $85,000.00 |
| Workwell Consulting Pty Ltd | PDH Strategy Development | 1 June 2025 | 30 June 2026 | $65,000.00 | $65,000.00 | - |

## Information & Communication Technology (ICT) Expenditure

For the 2025-2026 reporting period, Portland District Health had a total ICT expenditure of $1,580,764, with the details shown below.

| Business As Usual (BAU) ICT expenditure (excluding GST) | Non-Business as Usual (non-BAU) ICT expenditure (excluding GST) | Operational expenditure | Capital expenditure (excluding GST) |
|---|---|---|---|
| $1,580,764 | $0 | $0 | $0 |

## Environmental Performance

Portland District Health remains committed to minimising its environmental impact and embedding sustainable practices across the organisation. Environmental sustainability continues to be a key consideration in operational planning and decision-making, with a focus on improving energy efficiency, reducing waste, lowering greenhouse gas emissions and conserving natural resources.

The organisation recognises that achieving meaningful environmental outcomes requires the collective efforts of staff, contractors and stakeholders. Through ongoing investment in sustainable initiatives and responsible resource management, PDH continues to contribute to a healthier environment and a more sustainable future.

Our solar energy system continues to provide significant environmental and financial benefits, reducing reliance on grid-supplied electricity and supporting our emissions reduction objectives.

**Key Achievements in 2025/2026**

- Completed the final stages of the organisation-wide LED lighting replacement program, significantly improving energy efficiency across PDH facilities.
- Continued the transition of the vehicle fleet to more fuel-efficient, low-emission vehicles to reduce transport-related environmental impacts.
- Maintained the use of biodegradable alternatives for catering supplies, further reducing the organisation's reliance on single-use plastics.
- Sustained compliance with Victorian single-use plastics legislation and promoted environmentally responsible purchasing practices.
- Continued to identify opportunities to improve resource efficiency and support environmental sustainability across all areas of operations particularly with new procurement activity.
- Incorporated sustainability initiatives into grant funding applications to support projects that deliver long-term environmental and operational benefits.

PDH remains committed to continuous improvement in environmental performance and will continue to explore initiatives that support sustainability, reduce operational costs and contribute to improved environmental outcomes for the community.



## 2025-2026 Energy and Water Performance Report

| GREENHOUSE GAS EMISSIONS | | | | |
|---|---|---|---|---|
| **G1 Total Scope 1 (direct) greenhouse gas emissions (t CO2-e)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Carbon Dioxide | 361.88 | 375.80 | 302.35 | -3.71% |
| Methane | 0.70 | 0.68 | 0.52 | 3.38% |
| Nitrous Oxide | 0.21 | 0.33 | 0.33 | -36.02% |
| **Total** | **362.79** | **376.82** | **303.21** | -3.72% |
| **Scope 1 GHG emissions from stationary fuel (F2 Scope 1) (t CO2-e)** | **362.79** | **347.26** | **260.41** | 4.47% |
| **Scope 1 GHG emissions from vehicle fleet (T3 Scope 1) (t CO2-e)** | | **29.55** | **42.80** | |
| **Medical/Refrigerant gases** | | | | |
| **Total Scope 1 (direct) greenhouse gas emissions (t CO2-e)** | **362.79** | **376.82** | **303.21** | -3.72% |
| **G2 Total Scope 2 (indirect electricity) greenhouse gas emissions (t CO2-e)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Electricity | 876.52 | 880.98 | 903.47 | -0.51% |
| **Total Scope 2 (indirect electricity) greenhouse gas emissions (t CO2-e)** | **876.52** | **880.98** | **903.47** | -0.51% |
| **G3 Total Scope 3 (other indirect) greenhouse gas emissions associated with commercial air travel and waste disposal (t CO2-e)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Commercial air travel | | | | |
| Waste emissions (WR5) | 181.43 | 181.43 | 181.96 | 0.00% |
| Indirect emissions from Stationary Energy | 147.20 | 146.59 | 131.78 | 0.41% |
| Indirect emissions from Transport Energy | | 7.43 | 10.77 | |
| Paper emissions | | | | |
| Water emissions | 8.74 | 23.76 | 23.32 | -63.21% |
| Any other Scope 3 emissions | | 0.00 | 0.00 | |
| **Total Scope 3 greenhouse gas emissions (t CO2-e)** | **337.37** | **359.21** | **347.82** | -6.08% |
| **G(Opt) Net greenhouse gas emissions (t CO2-e)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| **Gross greenhouse gas emissions (G1 + G2 + G3) (t CO2-e)** | **1,576.69** | **1,617.01** | **1,554.50** | -2.49% |
| Total gross reported greenhouse gas emissions per bed-day (t CO2-e/OBD) | 0.07 | 0.07 | 0.07 | -6.34% |
| Carbon Neutral Electricity | 0.00 | 0.00 | 0.00 | |
| Green Power Electricity | 0.00 | 0.00 | 0.00 | |
| Purchased LGCs | -1,087.32 | 0.00 | 0.00 | |
| **Any Reduction Measures Offsets purchased (EL4-related)** | **-995.56** | | | |
| **Any Offsets purchased** | **-995.56** | | | |
| **Net greenhouse gas emissions (t CO2-e)** | **581.13** | **1,617.01** | **1,554.50** | -64.06% |

| ELECTRICITY USE | | | | |
|---|---|---|---|---|
| **EL1 Total electricity consumption segmented by source (MWh)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Purchased | 1,318.22 | 1,335.55 | 1,373.64 | -1.30% |
| Self-generated | 360.80 | 391.78 | 402.97 | -7.91% |
| EL1 Total electricity consumption (MWh) | 1,679.02 | 1,727.34 | 1,776.61 | -2.80% |
| **EL2 On site-electricity generated (MWh) segmented by:** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| **Consumption behind-the-meter** | | | | |
| Solar Electricity | 360.80 | 391.78 | 402.97 | -7.91% |
| **Total Consumption behind-the-meter (MWh)** | **360.80** | **391.78** | **402.97** | -7.91% |
| **Exports** | | | | |
| Solar Electricity | 7.20 | | | |
| **Total Electricity exported (MWh)** | **7.20** | | | |
| **EL2 Total On site-electricity generated (MWh)** | **368.00** | **391.78** | **402.97** | -6.07% |
| **EL3 On-site installed generation capacity (kW converted to MW) segmented by:** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Diesel Generator | 0.70 | 0.70 | 0.70 | 0.00% |
| Solar System | 0.14 | 0.14 | 0.14 | 0.00% |
| **EL3 Total On-site installed generation capacity (MW)** | **0.84** | **0.84** | **0.84** | 0.00% |
| **EL4 Total electricity offsets segmented by offset type (MWh)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| LGCs voluntarily retired on the entity's behalf | 1,181.87 | | | |
| RPP (Renewable Power Percentage in the grid) | 236.09 | 244.52 | 257.71 | -3.44% |
| **EL4 Total electricity offsets (MWh)** | **1,318.22** | **244.52** | **257.71** | 439.11% |

| STATIONARY ENERGY | | | | |
|---|---|---|---|---|
| **F1 Total fuels used in buildings and machinery segmented by fuel type (MJ)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Natural gas | 7,040,443.10 | 6,739,042.10 | 5,050,925.80 | 4.47% |
| Diesel | | | 1,922.30 | |
| **F1 Total fuels used in buildings (MJ)** | **7,040,443.10** | **6,739,042.10** | **5,052,848.10** | 4.47% |
| **F2 Greenhouse gas emissions from stationary fuel consumption segmented by fuel type (t CO2-e)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Natural gas | 362.79 | 347.26 | 260.27 | 4.47% |
| Diesel | | | 0.14 | |
| **F2 Greenhouse gas emissions from stationary fuel consumption (t CO2-e)** | **362.79** | **347.26** | **260.41** | 4.47% |

| TOTAL ENERGY USE | | | | |
|---|---|---|---|---|
| **E1 Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Total energy usage from stationary fuels (F1) (MJ) | 7,040,443.10 | 6,739,042.10 | 5,052,848.10 | 4.47% |
| Total energy usage from transport (T1) (MJ) | | 431,335.80 | 624,865.00 | |
| **Total energy usage from fuels, including stationary fuels (F1) and transport fuels (T1) (MJ)** | **7,040,443.10** | **7,170,377.90** | **5,677,713.10** | -1.81% |
| **E2 Total energy usage from electricity (MJ)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Total energy usage from electricity (MJ) | 6,044,469.33 | 6,218,410.76 | 6,395,799.22 | -2.80% |
| **E3 Total energy usage segmented by renewable and non-renewable sources (MJ)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Renewable | 6,044,469.40 | 2,290,676.54 | 2,378,445.89 | 163.87% |
| Non-renewable (E1 + E2 - E3 Renewable) | 7,040,443.03 | 11,098,112.12 | 9,695,066.43 | -36.56% |
| **E4 Units of Stationary Energy used normalised: (F1+E2)/normaliser** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Energy per unit of Aged Care OBD (MJ/Aged Care OBD) | 1,335.06 | 1,332.52 | 1,175.67 | 0.19% |
| Energy per unit of LOS (MJ/LOS) | 975.98 | 1,030.91 | 835.24 | -5.33% |
| Energy per unit of bed-day (LOS+Aged Care OBD) (MJ/OBD) | 563.81 | 581.23 | 488.32 | -3.00% |
| Energy per unit of Separations (MJ/ Separations) | 2,511.02 | 2,534.71 | 2,065.42 | -0.93% |
| Energy per unit of floor space (MJ/m2) | 1,072.27 | 1,061.83 | 938.18 | 0.98% |

## SUSTAINABLE BUILDINGS AND INFRASTRUCTURE

| B1 Discuss how environmentally sustainable design (ESD) is incorporated into newly completed entity-owned buildings | 2025-2026 | 2024-2025 | 2023-2024 | % change previous to selected range |
|---|---|---|---|---|

| B2 Discuss how new entity leases meet the requirement to preference higher-rated office buildings and those with a Green Lease Schedule | 2025-2026 | 2024-2025 | 2023-2024 | % change previous to selected range |
|---|---|---|---|---|

| B3 NABERS Energy (National Australian Built Environment Rating system) ratings of newly completed/occupied Entity-owned office buildings and substantial tenancy fit-outs (itemised) | 2025-2026 | 2024-2025 | 2023-2024 | % change previous to selected range |
|---|---|---|---|---|

| B4 Environmental performance ratings (eg. NABERS, Green Star, or ISCAIS rating scheme) of newly completed Entity-owned non-office building or infrastructure projects or upgrades with a value over $1 million | 2025-2026 | 2024-2025 | 2023-2024 | % change previous to selected range |
|---|---|---|---|---|
| NABERS Energy | | | | |

| B5 Environmental performance ratings achieved for Entity-owned assets portfolio segmented by rating scheme and building, facility, or infrastructure type, where these ratings have been conducted | 2025-2026 | 2024-2025 | 2023-2024 | % change previous to selected range |
|---|---|---|---|---|
| Rating scheme | | | | |

## SUSTAINABLE PROCUREMENT

## WATER USE

| W1 Total units of metered water consumed by water source (kL) | 2025-2026 | 2024-2025 | 2023-2024 | % change previous to selected range |
|---|---|---|---|---|
| Potable water (kL) | 6,230.86 | 14,523.06 | 13,898.40 | -57.10% |
| **Total units of water consumed (kL)** | **6,230.86** | **14,523.06** | **13,898.40** | -57.10% |

| W2 Units of metered water consumed normalised by FTE, headcount, floor area, or other entity or sector specific quantity | 2025-2026 | 2024-2025 | 2023-2024 | % change previous to selected range |
|---|---|---|---|---|
| Water per unit of Aged Care OBD (kL/Aged Care OBD) | 0.64 | 1.49 | 1.43 | -57.43% |
| Water per unit of LOS (kL/LOS) | 0.46 | 1.16 | 1.01 | -59.78% |
| Water per unit of bed-day (LOS+Aged Care OBD) (kL/OBD) | 0.27 | 0.65 | 0.59 | -58.79% |
| Water per unit of Separations (kL/Separations) | 1.20 | 2.84 | 2.51 | -57.91% |
| Water per unit of floor space (kL/m2) | 0.51 | 1.19 | 1.14 | -57.10% |

| WASTE AND RECYCLING | | | | |
|---|---|---|---|---|
| **WR1 Total units of waste disposed of by waste stream and disposal method (kg)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| **Landfill (total)** | | | | |
| General waste - skips | 130,774.50 | 130,774.50 | 131,152.50 | 0.00% |
| **Offsite treatment** | | | | |
| Clinical waste - incinerated | 430.98 | 430.98 | 432.30 | 0.00% |
| Clinical waste - sharps | 564.74 | 564.74 | 566.77 | 0.00% |
| Clinical waste - treated | 7,931.60 | 7,931.60 | 7,954.09 | 0.00% |
| **Recycling/recovery (disposal)** | | | | |
| Cardboard | | 16,784.48 | 16,830.00 | |
| Total units of waste disposed (kg) | 139,701.82 | 156,486.30 | 156,935.66 | -10.73% |
| **WR2 Percentage of office sites covered by dedicated collection services for each waste stream** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Printer cartridges | | | | |
| Batteries | | | | |
| e-waste | | | | |
| Soft plastics | | | | |
| **WR3 Total units of waste disposed normalised by FTE, headcount, floor area, or other entity or sector specific quantity, by disposal method** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Total waste to landfill per patient treated ((kg general waste)/PPT) | 4.60 | 4.77 | 4.52 | -3.57% |
| Total waste to offsite treatment per patient treated ((kg offsite treatment)/PPT) | 0.31 | 0.33 | 0.31 | -3.57% |
| Total waste recycled and reused per patient treated ((kg recycled and reused)/PPT) | | 0.61 | 0.58 | |
| **WR4 Recycling rate (%)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| Weight of recyclable and organic materials (kg) | | 16,784.48 | 16,830.00 | |
| Weight of total waste (kg) | 139,701.82 | 156,486.30 | 156,935.66 | -10.73% |
| **Recycling rate (%)** | | **10.73%** | **10.72%** | |
| **WR5 Greenhouse gas emissions associated with waste disposal (t CO2-e)** | **2025-2026** | **2024-2025** | **2023-2024** | **% change previous to selected range** |
| t CO2-e | 181.43 | 181.43 | 181.96 | 0.00% |

| NORMALISATION FACTORS | | | | |
|---|---|---|---|---|
| | 2025-2026 | 2024-2025 | 2023-2024 | % change previous to selected range |
| 1000km (Corporate) | | | | |
| 1000km (Non-emergency) | | | | |
| Aged Care OBD | 9,801.00 | 9,724.00 | 9,738.00 | 0.79% |
| ED Departures | 0.00 | 0.00 | 0.00 | |
| FTE | 290.00 | 266.00 | 259.00 | 9.02% |
| LOS | 13,407.00 | 12,569.00 | 13,707.00 | 6.67% |
| OBD | 23,208.00 | 22,293.00 | 23,445.00 | 4.10% |
| PPT | 28,419.00 | 27,405.00 | 28,988.00 | 3.70% |
| Separations | 5,211.00 | 5,112.00 | 5,543.00 | 1.94% |
| TotalAreaM2 | 12,203.00 | 12,203.00 | 12,203.00 | 0.00% |

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

# Social Procurement

Reporting Period 2025-2026

## Case Study

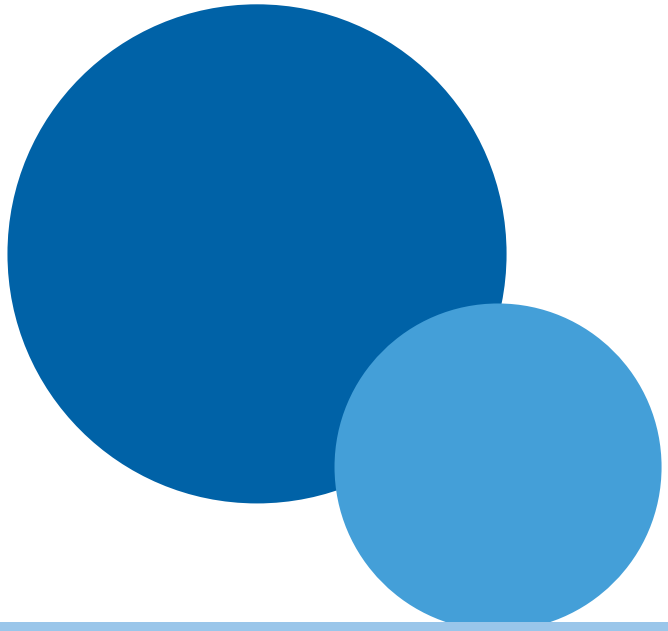
Portland District Health is committed to leveraging its purchasing and procurement activities to create positive social, economic and community outcomes. Throughout 2025-26, PDH continued to engage Aboriginal and Torres Strait Islander businesses and organisations to support the delivery of culturally safe healthcare services and strengthen relationships with First Nations communities.

A key focus during the year was the provision of cultural safety education for staff through partnerships with Aboriginal organisations and service providers. Cultural safety training will now be embedded within PDH's monthly face-to-face staff orientation program, ensuring new employees develop an understanding of Aboriginal culture, local history and health perspectives from the commencement of their employment. This investment supports our commitment to providing culturally safe and respectful care for Aboriginal and Torres Strait Islander patients, families and communities.

PDH also engaged local social enterprise providers to deliver a range of operational support activities, including vehicle cleaning and gardening services. Through these partnerships, PDH contributes to employment and economic participation opportunities while maintaining high-quality services across the organisation. Our social procurement approach reflects a broader commitment to supporting inclusive economic growth and generating meaningful community benefits through our procurement decisions.

This year, PDH directed more than $76,000 in expenditure to recognised local social procurement suppliers, demonstrating our ongoing commitment to creating social value through our purchasing activities.

| All Suppliers | |
|---|---|
| Number of Suppliers Engaged | 347 |
| Total Expenditure (excl GST) | $23,286,107.23 |
| **Social Benefit Suppliers** | |
| Number of Social Benefit Suppliers Engaged | 4 |
| Total Expenditure with Social Benefit Suppliers (excl GST) | $76,783.35 |



| SPF Objective | SPF Outcome | 2025-26 SPF Reporting Metrics | |
|---|---|---|---|
| Opportunities for Victorian Aboriginal People | Purchasing from Victorian Aboriginal Businesses | Number of Victorian Aboriginal Businesses engaged | 1 |
| | | Total expenditure with Victorian Aboriginal Businesses (excl GST) | $41,150.00 |
| Opportunities for Victorians with Disability | Purchasing from Victorian Social Enterprises led by a mission for people with disability and Australian Disability Enterprises. | Number of Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises engaged | 1 |
| | | Total Expenditure with Victorian social enterprises led by a mission for people with disability and Australian Disability Enterprises (excl GST) | $5,861.36 |
| Opportunities for Victorian Priority Jobseekers | Purchasing from Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers | Number of Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers engaged | 1 |
| | | Total expenditure with Victorian social enterprises led by a mission for job readiness and employment of Victorian priority jobseekers (excl GST) | $28,043.99 |
| Sustainable Victorian Social Enterprises and Aboriginal Businesses | Purchasing from Victorian social enterprises and Aboriginal businesses | Number of Victorian social enterprises engaged | 2 |
| | | Total expenditure with Victorian social enterprises (excl GST) | $29,771.99 |
| | | Number of Victorian Aboriginal businesses engaged | 1 |
| | | Total expenditure with Victorian Aboriginal businesses (excl GST) | $41,150.00 |

# Statement of Compliance

## Building Act 1993

Portland District Health complies with the provisions of the Building Act 1993 in accordance with the Department of Health Capital Development Guidelines (Minister for Finance Guideline Building Act 1993 / Standards for Publicly Owned Buildings 1994 / Building Regulations 2005 and Building Code of Australia 2004).

## National Competition Policy

Portland District Health is committed to complying with the Victorian Government's Competitive Neutrality Policy and applies the principles of competitive neutrality to all relevant business activities. In accordance with Victorian public sector full cost recovery and pricing principles, Portland District Health ensures that services operating in competitive environments appropriately recognise and allocate the full costs of service delivery, including direct, indirect and corporate overhead costs. Through its financial management, pricing and governance frameworks, Portland District Health seeks to ensure that no net competitive advantage is derived from public ownership and that services are delivered in a transparent, accountable and equitable manner. During 2025-26, Portland District Health maintained processes and controls that support compliance with competitive neutrality obligations and full cost recovery requirements across its operations.

## Local Jobs First Act 2003

No projects undertaken by Portland District Health during 2025-26 met the threshold for Local Jobs First Policy application. As such, no Local Industry Development Plans were required or submitted.

## Reviews and Study Expenses

During 2025-26, there were no reviews or studies undertaken.

## Grants and Transfer Payments

Not applicable – Portland District Health did not administer any grants, transfer payments or Commercial-in-Confidence grants in 2025-26.

## Emergency Procurement and Procurement Complaints Disclosure

In 2025-26 there were nil reports where emergency procurement was activated.

In 2025-26 there were nil reports of procurement complaints.

## Freedom of Information (FOI)

During 2025-2026, Portland District Health received 79 applications. Of these requests, nil were from Members of Parliament, nil from the media, and the remainder from the general public.

Portland District Health made 79 FOI decisions during the 12 months ended 30 June 2026.

There were **77** decisions made within the statutory time periods. Of the decisions made outside time, 0 were made within a further 45 days and 2 decisions were made in greater than 45 days.

Of the total decisions made, 78 granted access to documents in full, 0 granted access in part and **1** denied access in full. **2** decisions were made after mandatory extensions had been applied or extensions were agreed upon by the applicant.

Of requests finalised, the average number of days over/under the statutory time (including extended timeframes) to decide the request was **7** days.

During 2025-2026, 1 request was subject to a complaint/internal review by Office of the Victorian Information Commissioner. 0 requested progressed to the Victorian Civil and Administrative Tribunal (VACT).

## Occupational Health & Safety Act 2004 Compliance

Portland District Health complies with the Occupational Health & Safety Act 2004 and its associated regulations and codes of practice. Portland District Health is committed to providing a safe and healthy environment for patients, residents, staff, members of the public, volunteers and contractors under the auspices of the Health and Safety Committee. Our commitment is to facilitate effective consultation across all sections of Portland District Health which is essential to improve Health & Safety performance.

All staff injuries and hazards in the workplace are reported and followed up via RiskMan, an electronic incident management reporting system available to all staff. We support our staff both in the provision of training to reduce risk of injury and, if an injury does occur, a comprehensive return to work program.

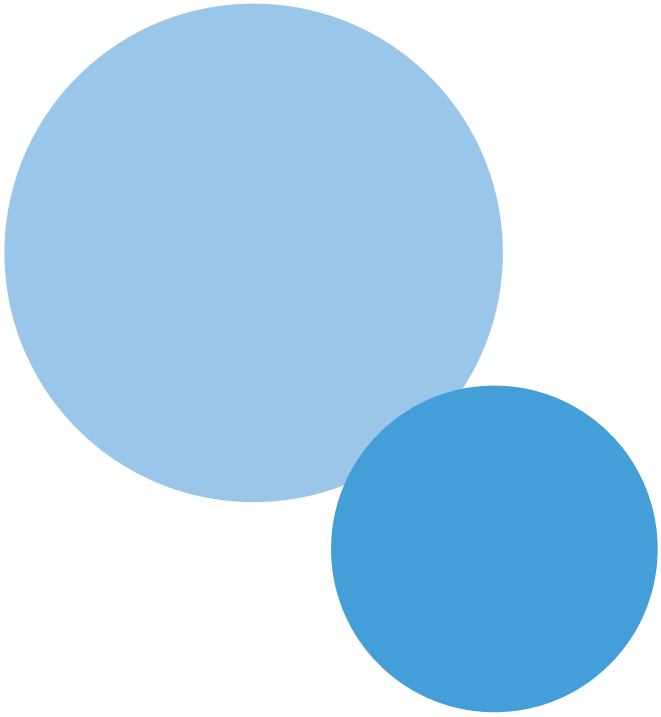
Occupational, Health & Safety training continues to occur on a regular basis throughout the Health Service. All Health and Safety Representatives have undertaken health and safety training.

| Occupational, Health & Safety Reporting | 2023-24 | 2024-25 | 2025-26 |
|---|---|---|---|
| 1. The number of reported hazards/incidents for the year per 100 FTE | 67.22 | 84.30 | 84.40 |
| 2. The number of 'lost time' standard WorkCover claims for the year per 100 FTE | 0.6912 | 0.71 | 1.0169 |
| 3. The average cost per WorkCover claim for the year ('000) | $16,408 | $46,849 | $58,410 |

One new physical injury claim has been allocated a large SCE (future cost estimate) in comparison to other claims lodged. There has been no increase in the number of claims lodged over the year.

## Public Interest Disclosures Act 2012

Portland District Health has in place appropriate procedures for disclosures in accordance with the Public Interest Disclosure Act 2012 (formally known as the Protected Disclosures Act 2012). No public interest disclosures were made under the Act in 2025/2026.



## Carers Recognition Act 2012

Portland District Health has taken all practical measures to comply with its obligations under the Carers Recognition Act 2012. These include:

- promoting the principles of the Act to people in care relationships who receive our services and to the wider community (e.g. distributing printed material about the Act at community events or service points; providing links to state government resource materials on our website; providing digital and/or printed information about the Act to our partner organisations)
- ensuring our staff have an awareness and understanding of the care relationship principles set out in the Act (e.g. developing and implementing a staff awareness strategy about the principles in the Act and what they mean for staff; induction and training programs offered by the organisation include discussion of Act and the statement of principles therein)
- considering the care relationships principles set out in the Act when setting policies and providing services (e.g. reviewing our employment policies such as flexible working arrangements and leave provisions to ensure that these comply with the statement of principles in the Act, development a satisfaction survey for distribution at assessment and review meetings between workers, carers and those receiving care)
- implementing priority actions in Victorian Carer Strategy 2025-2035.

**Karena Prevett**
Chief Executive Officer
Portland District Health
Date: 30 June 2026

# Governance

Strong governance provides the foundation for safe, high quality and sustainable healthcare. PDH is committed to the highest standards of corporate and clinical governance, ensuring accountability, transparency and effective stewardship of public resources while delivering exceptional care for our community.

The Board of Directors are appointed by the Victorian Minister for Health and is responsible for the strategic direction, performance and long-term sustainability of PDH. Working in partnership with the Chief Executive Officer and Executive Leadership Team, the Board oversees organisational performance, financial stewardship, risk management, clinical quality and safety, workforce culture and compliance with legislative and regulatory obligations.

Throughout 2025–26, the Board continued to strengthen governance systems, providing leadership during a period of significant organisational reform while maintaining a clear focus on improving outcomes for patients, residents, staff and the broader community.

## Board Committee Structure

To support effective governance and informed decision making, the Board has established specialist committees that provide detailed oversight and assurance across key areas of organisational performance. These committees enable focused review of strategic priorities while ensuring matters are appropriately scrutinised before consideration by the Board.

## Clinical Governance Committee

**Bi-Monthly**

The Clinical Governance Committee provides assurance to the Board that effective systems are in place to support safe, person centered and high quality care.

The Committee oversees quality and safety performance across all clinical services, monitoring patient outcomes, consumer experience, clinical risk, accreditation, quality improvement, mandatory training and compliance with the Victorian Clinical Governance Framework. The Committee also promotes a culture of continuous improvement, learning and openness through oversight of consumer participation, incident management, open disclosure and the Statutory Duty of Candour.

## Finance, Audit and Risk Committee

**Monthly**

The Finance, Audit and Risk Committee provides independent oversight of the organisation's financial management, enterprise risk framework, internal controls and audit functions.

The Committee monitors financial performance, budget delivery, statutory reporting, compliance, enterprise risk management and internal and external audit findings, providing assurance to the Board that appropriate governance systems are operating effectively to support sound decision making and long-term sustainability.

## People and Culture Committee

**Quarterly**

The People and Culture Committee supports the Board in overseeing workforce strategy, organisational culture and leadership capability.

Responsibilities include monitoring workforce sustainability, employee wellbeing, leadership development, occupational health and safety, diversity and inclusion and compliance with the Department of Health's Positive Workplace Culture Framework. The Committee also oversees initiatives designed to strengthen employee engagement, capability and organisational performance.

## Governance, Remuneration and Nominations Committee

**Quarterly**

The Governance, Remuneration and Nominations Committee provides oversight of Board governance, executive performance and succession planning.

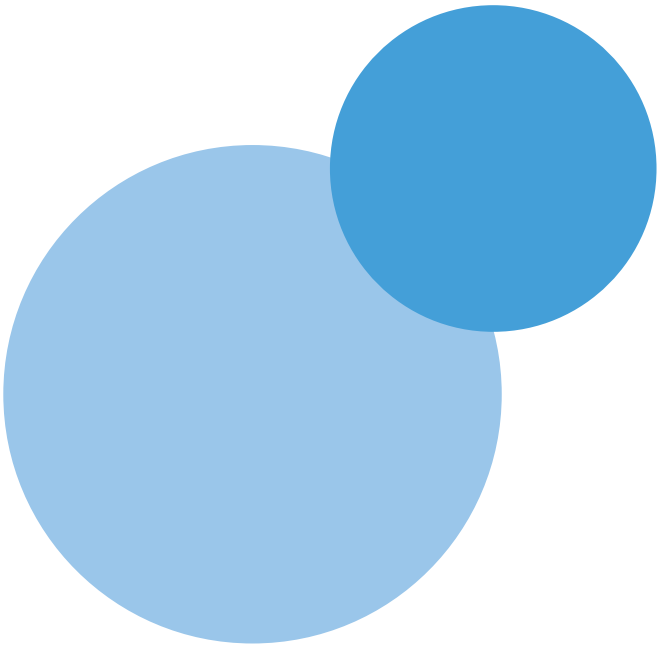
The Committee supports continuous improvement in governance practices through regular review of Board effectiveness, governance frameworks and organisational policies. It also oversees Chief Executive Officer performance and remuneration, executive succession planning and Board capability to ensure PDH remains well positioned to meet future challenges.

## Consumer Advisory Committee

**Bi-Monthly**

PDH recognises that meaningful community engagement strengthens healthcare services and improves outcomes.

The Consumer Advisory Committee provides an important link between the organisation and the community, ensuring consumer perspectives inform strategic planning, service design and quality improvement. The Committee provides advice to the Board on community priorities and consumer experiences while supporting implementation of the Consumer Participation Plan and Safer Care Victoria's Partnering in Healthcare Framework.



## Responsible Minister

PDH is a public hospital established under the *Health Services Act 1988* (Vic).

The responsible Minister for the reporting period were:

**Minister for Health**
The Hon Mary-Anne Thomas MP
(1 July 2025 to 15 April 2026)
Hon Harriet Shing MP
(15 April 2026 to 30 June 2026)

**Minister for Ambulance Services**
The Hon Mary-Anne Thomas MP
(1 July 2025 to 13 April 2026)
Hon. Harriet Shing MP
(15 April 2026 to 30 June 2026)

## Other Relevant Ministers

**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 Disability/Minister for Children**
The Hon Lizzie Blandthorn MP
(1 July 2025 to 30 June 2026)

## Ethical Standards

The Board promotes the continued maintenance of corporate governance practice and ethical conduct by Board directors and employees of PDH. The Board has endorsed a code of conduct which applies to Board directors, officers and all employees and is consistent with applicable guidelines.

## 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:
pdh@swarh.vic.gov.au

# Donations

## Community Support

PDH is fortunate to be supported by a generous and engaged community whose contributions help enhance healthcare services beyond what can be achieved through government funding alone.

Donations received throughout the year have supported the purchase of equipment, improvements to facilities, patient comfort initiatives and other projects that directly benefit our patients, residents and community.

Every donation, regardless of its size, reflects the community's confidence in Portland District Health and its commitment to improving healthcare outcomes for current and future generations.

## Thank You to Our Donors

We sincerely thank the individuals, community groups, service clubs, businesses and philanthropic organisations whose generosity has supported Portland District Health throughout the year.

Their ongoing support enables us to continue investing in equipment, programs and initiatives that improve the patient experience and strengthen healthcare services across our region.

Together, we are making a meaningful difference to the health and wellbeing of our community.

- Portland Golf Club
- Heywood Golf Club
- Australian Blue Gum Plantations
- TILNAK Fine Arts Portraits
- Portland Signworks
- Mixx FM / Ace Radio
- Helloworld Travel
- Assets Real Estate
- Qube Ports
- Powerhouse Productions
- Admellas Fruit n Veg
- Sports Power
- Wannon Water
- TwelveFold
- Body Bloom Collective
- United Way Glenelg
- Portland & District Motoring Enthusiasts Club Inc
- Cancer Council Victoria - Portland Branch
- Chiro Life
- St John Lutheran Ladies Guild
- Bryden Tyrepower
- Rotary Club of Portland
- Portland Funeral Services
- HBH Legal
- Heywood Bendigo Bank
- Beats Cycle for Hope

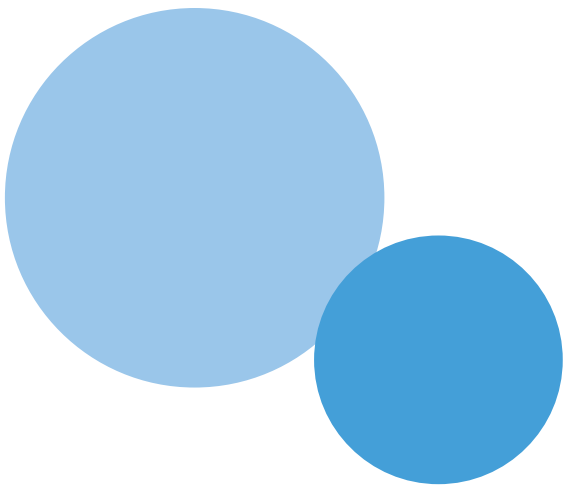
## Events and Activities of Significance

- NAIDOC Week Celebration
- Dying to Know Day Forum
- Cruise for Charity
- Volunteers End of Year Event and Awards Celebration
- St John's Christmas Tree Exhibition
- Beats Cycle for Hope
- Winter Drive
- Portland Salvation Army/Kmart Wishing Tree Appeal
- Medtronic Diabetes community forum
- International Nurses Day
- International Women's Day
- R U OK Day
- Reconciliation Week

## Bequests

A lasting gift through a bequest provides an enduring legacy that supports healthcare for future generations.

Portland District Health gratefully acknowledges those who have chosen to remember the organisation in their estate planning. These gifts make an important contribution to enhancing facilities, equipment and services that benefit our community well into the future.



# Disclosure Index

The annual report of the Portland District 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.

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

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

# Annual Financial Statements

ABN 19 736 725 377

**Year ended 30 June 2026**

Portland District Health

# Financial Report

**How this report is structured**
Portland District Health presents its audited Tier 2 general-purpose financial statements for the financial year ended 30 June 2026 in the following structure to provide users with information about Portland District Health's stewardship of the resources entrusted to it.


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# Financial Statements

Financial Year ended 30 June 2026

## Board member's, accountable officer's, and chief finance & accounting officer's declaration

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

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2026 and the financial position of Portland District Health at 30 June 2026.

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

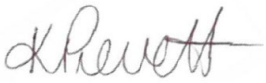
We authorise the attached financial statements for issue on 11 September 2026.

*Board member*



P Matthews
Chair
Portland
11 September 2026

*Accountable Officer*



K Prevett
Chief Executive Officer
Portland
11 September 2026

*Chief Finance & Accounting Officer*



I Martin
Chief Finance and Accounting Officer
Portland
11 September 2026

# Independent Auditor's Report

Victorian Auditor-General's Office

***To the Board of Portland District Health***

| | |
|---|---|
| **Opinion** | I have audited the financial report of Portland District Health (the health service) which comprises the:<br>• balance sheet as at 30 June 2026<br>• comprehensive operating statement for the year then ended<br>• statement of changes in equity for the year then ended<br>• cash flow statement for the year then ended<br>• notes to the financial statements, including material accounting policy information<br>• board member's, accountable officer's and chief finance & accounting officer's declaration.<br>In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2026 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and Australian Accounting Standards – Simplified Disclosures. |
| **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.<br>My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants (including Independence Standards)* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.<br>I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion. |
| **Other information** | The board is responsible for the other information. The other information obtained at the date of this auditor's report is information included in the Annual Report, (but does not include our auditor's report thereon).<br>Our opinion on the financial report does not cover the other information and accordingly we do not express any form of assurance conclusion thereon.<br>In connection with our audit of the financial report, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial report, or our knowledge obtained in the audit, or otherwise appears to be materially misstated.<br>If, based on the work we have performed on the other information obtained prior to the date of this auditor's report, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard. |

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

| | |
|---|---|
| **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 – Simplified Disclosures 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.<br><br>In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so. |
| **Auditor's responsibilities for the audit of the financial report** | As required by the *Audit Act 1994,* my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.<br><br>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:<br><br>• 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.<br>• obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the health service's internal control.<br>• evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.<br>• conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the health service's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the health service to cease to continue as a going concern.<br>• 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. |

| | |
|---|---|
| **Auditor's responsibilities for the audit of the financial report** ***continued*** | 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
14 September 2026

Simone Bohan
*as delegate for the Auditor-General of Victoria*

# Portland District Health

## Comprehensive Operating Statement

For the Financial Year Ended 30 June 2026

| | Note | 2026 $'000 | 2025 $'000 |
|---|---|---|---|
| **Revenue and income from transactions** | | | |
| Revenue from contracts with customers | 2.1(a) | 57,144 | 55,347 |
| Government grants | 2.1(b) | 10,280 | 11,537 |
| Other sources of income | 2.1(c) | 3,720 | 3,991 |
| **Total revenue and income from transactions** | | **71,144** | **70,875** |
| | | | |
| **Expenses from transactions** | | | |
| Employee expenses | 3.1(a) | (54,598) | (52,397) |
| Supplies and consumables | 3.1(c) | (9,175) | (8,802) |
| Depreciation and amortisation | 4.1(a) | (5,271) | (5,137) |
| Other operating expenses | 3.1(d) | (8,909) | (8,119) |
| **Total Expenses from transactions** | | **(77,953)** | **(74,455)** |
| | | | |
| **Net result from transactions - net operating balance** | | **(6,809)** | **(3,580)** |
| | | | |
| **Other economic flows included in net result** | | | |
| Net gain/(loss) on sale of non-financial assets | | 31 | 18 |
| Net gain/(loss) on financial instruments | | (118) | (129) |
| Other gain/(loss) from other economic flows | | 97 | (11) |
| **Total other economic flows included in net result** | | **10** | **(122)** |
| | | | |
| **Net result** | | **(6,799)** | **(3,702)** |
| | | | |
| **Comprehensive result** | | **(6,799)** | **(3,702)** |

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

# Portland District Health

## Balance Sheet

As at 30 June 2026

| | Note | 2026 $'000 | 2025 $'000 |
|---|---|---|---|
| **Financial assets** | | | |
| Cash and cash equivalents | 6.1 | 8,538 | 9,146 |
| Receivables | 5.1 | 2,061 | 1,729 |
| **Total financial assets** | | **10,599** | **10,875** |
| | | | |
| **Non-financial assets** | | | |
| Prepayments | | 874 | 309 |
| Inventories | | 87 | 63 |
| Property, plant and equipment | 4.1 | 57,103 | 61,114 |
| Investment property | 4.3 | 7,926 | 7,926 |
| **Total non-financial assets** | | **65,990** | **69,412** |
| | | | |
| **Total assets** | | **76,589** | **80,287** |
| | | | |
| **Liabilities** | | | |
| Payables | 5.2 | 4,196 | 2,924 |
| Contract liabilities | | 1,415 | 718 |
| Borrowings | | 1,287 | 945 |
| Employee benefits | 3.1(b) | 11,534 | 11,170 |
| Monies held in trust | 5.3 | 5,333 | 4,907 |
| **Total liabilities** | | **23,765** | **20,664** |
| | | | |
| **Net assets** | | **52,824** | **59,623** |
| | | | |
| **Equity** | | | |
| Reserves | | 70,756 | 70,756 |
| Contributed capital | | 35,695 | 35,695 |
| Accumulated (deficit) | | (53,627) | (46,828) |
| **Total equity** | | **52,824** | **59,623** |

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

# Portland District Health

## Cash Flow Statement

For the Financial Year Ended 30 June 2026

| | Note | 2026 $'000 | 2025 $'000 |
|---|---|---|---|
| **Cash Flows from operating activities** | | | |
| Receipts from Government | | 63,118 | 60,851 |
| Patient fees received | | 4,365 | 3,838 |
| GST received from ATO | | 1,815 | 1,576 |
| Interest and investment income received | | 430 | 595 |
| Other receipts | | 2,154 | 4,130 |
| **Total receipts** | | **71,882** | **70,990** |
| Payments to employees | | (53,746) | (51,678) |
| Payments to suppliers and consumables | | (16,028) | (15,700) |
| GST paid to ATO | | (1,850) | (1,565) |
| **Total payments** | | **(71,624)** | **(68,943)** |
| **Net cash flows from/(used in) operating activities** | | **258** | **2,047** |
| **Cash Flows from investing activities** | | | |
| Proceeds from sale of non-financial assets | | 122 | 18 |
| Purchase of non-financial assets | | (1,095) | (968) |
| **Net cash flows from/(used in) investing activities** | | **(973)** | **(950)** |
| **Cash flows from financing activities** | | | |
| Repayment of borrowings and principal portion of lease liabilities | | (313) | (111) |
| Repayment of accommodation deposits | | (1,400) | (2,072) |
| Receipt of accommodation deposits | | 1,820 | 2,220 |
| **Net cash flows from/(used in) financing activities** | | **107** | **37** |
| **Net increase/(decrease) in cash and cash equivalents held** | | **(608)** | **1,134** |
| Cash and cash equivalents at beginning of year | | 9,146 | 8,012 |
| **Cash and cash equivalents at end of year** | 6.1 | **8,538** | **9,146** |

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

# Portland District Health

## Statement of Changes in Equity

For the Financial Year Ended 30 June 2026

| | Property, Plant and Equipment Revaluation Surplus | Restricted Specific Purpose Reserve | Contributed Capital | Accumulated (Deficit) | Total |
|---|---|---|---|---|---|
| | $'000 | $'000 | $'000 | $'000 | $'000 |
| **Balance at 1 July 2024** | **69,745** | **1,011** | **35,695** | **(43,126)** | **63,325** |
| Net result for the year | - | - | - | (3,702) | (3,702) |
| Other comprehensive income for the year | - | - | - | - | - |
| **Balance at 30 June 2025** | **69,745** | **1,011** | **35,695** | **(46,828)** | **59,623** |
| Net result for the year | - | - | - | (6,799) | (6,799) |
| Other comprehensive income for the year | - | - | - | - | - |
| **Balance at 30 June 2026** | **69,745** | **1,011** | **35,695** | **(53,627)** | **52,824** |

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

# Portland District Health

## Notes to the Financial Statements

For the Financial Year Ended 30 June 2026

**Structure**

**1.1 Basis of preparation**
**1.2 Material accounting estimates and judgements**
**1.3 Reporting entity**
**1.4 Economic dependency**

**Note 1 About this Report**

These financial statements represent the financial statements of Portland District Health for the year ended 30 June 2026.

Portland District Health is a not-for-profit entity established as a public agency under the *Health Services Act 1988 (Vic).* A description of the nature of its operations and its principal activities is included in the Report of Operations, which does not form part of these financial statements.

This section explains the basis of preparing the financial statements.

**Note 1.1 Basis of preparation**

These financial statements are general purpose financial statements which have been prepared in accordance with AASB 1060 *General Purpose Financial Statements – Simplified Disclosures for For-Profit and Not-for-Profit Tier 2 Entities* (AASB 1060) and Financial Reporting Direction 101 *Application of Tiers of Australian Accounting Standards* (FRD 101).

These general purpose financial statements have been prepared in accordance with the 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 Portland District Health.

The financial statements have been prepared on a going concern basis (refer to Note 1.4 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 Portland District Health on 11 September 2026.

**Note 1.2 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 that are affected by the revision.

The material accounting judgements and estimates used, and any changes thereto, are disclosed within the relevant accounting policy.

**Note 1.3 Reporting Entity**

Portland District Health's principal address is:
141-151 Bentinck Street
PORTLAND VIC 3305

**Note 1.4 Economic dependency**

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

## Note 2 Funding delivery of our services

Portland District Health's overall objective is to provide quality health service that will improve the health, wellbeing and the quality of life for our community. Portland District Health is predominantly funded by grant funding for the provision of outputs. Portland District Health also receives income from the supply of services.

**Structure**
**2.1 Revenue and income from transactions**

**Note 2.1 Revenue and income from transactions**

| | Note | 2026 $'000 | 2025 $'000 |
|---|---|---|---|
| Revenue from contracts with customers | 2.1(a) | 57,144 | 55,347 |
| Government grants | 2.1(b) | 10,280 | 11,537 |
| Other sources of income | 2.1(c) | 3,720 | 3,991 |
| **Total revenue and income from transactions** | | **71,144** | **70,875** |

**Note 2.1(a) Revenue from contracts with customers**

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| Government grants (State) - Operating | 44,530 | 43,722 |
| Government grants (Commonwealth) - Operating | 7,872 | 7,184 |
| Patient and resident fees | 4,335 | 4,003 |
| Commercial activities | 407 | 438 |
| **Total revenue from contracts with customers** | **57,144** | **55,347** |

**How we recognise revenue from contracts with customers**

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

This policy applies to each of Portland District Health's revenue streams, with information detailed below relating to Portland District Health's material revenue streams:

| Government grant | Performance obligation |
|---|---|
| Activity Based Funding (ABF) paid as National Weighted Activity Unit (NWAU) | NWAU is a measure of health service activity expressed as a common unit against which the national efficient price (NEP) is paid.<br>The performance obligations for NWAU are the number and mix of admissions, emergency department presentations and outpatient episodes, and is weighted for clinical complexity.<br>Revenue is recognised at point in time, which is when a patient is discharged. |
| Commonwealth Residential Aged Care Grants | Funding is provided for the provision of care for aged care residents within facilities at Portland District Health. The performance obligations include provision of residential accommodations and care from nursing staff and personal care workers. Revenue is recognised at the point in time when the service is provided with the aged care facility. |

**Patient and resident fees**

Patient and resident fees are charges incurred by patients for services they receive. Patient and resident fees are recognised under AASB 15 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.

**2.1 Revenue and income from transactions (cont.)**

**Note 2.1(b) Government grants**

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| Government grants (State) - Operating | 9,934 | 10,367 |
| Government grants (State) - Capital | 346 | 1,170 |
| **Total Government grants** | **10,280** | **11,537** |

**How we recognise government grants**

**Government grants**

Portland District 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 Portland District Health has an unconditional right to receive cash which usually coincides with receipt of cash. On initial recognition or the asset, Portland District 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 Portland District 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 Portland District Health's obligation to construct the asset. The progressive percentage of costs incurred is used to recognise income, as this most accurately reflects the stage of completion.

*Non-cash contributions from the Department of Health*

The DH makes some payments on behalf of Portland District Health as follows:

| Supplier | Description |
|---|---|
| Victorian Managed Insurance Authority | The Department of Health purchases non-medical indemnity insurance for Portland District 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. |
| Department of Health | Long Service Leave (LSL) revenue is recognised upon finalisation of movements in LSL liability in line with the long service leave funding arrangements with the DH. |

**Note 2.1(c) Other sources of income**

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| Other capital purpose income | 35 | 121 |
| Assets received free of charge or for nominal consideration | - | 20 |
| Other income from operating activities | 3,206 | 3,255 |
| Income from non-operating activities | 479 | 595 |
| **Total other sources of income** | **3,720** | **3,991** |

## Note 3 The cost of delivering our services

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

**Structure**
**3.1 Expenses incurred in the delivery of services**

**Note 3.1 Expenses incurred in the delivery of services**

| | Note | 2026 $'000 | 2025 $'000 |
|---|---|---|---|
| Employee expenses | 3.1(a) | 54,598 | 52,397 |
| Supplies and consumables | 3.1(c) | 9,175 | 8,802 |
| Other operating expenses | 3.1(d) | 8,909 | 8,119 |
| **Total expenses incurred in the delivery of services** | | **72,682** | **69,318** |

**Note 3.1(a) Employee expenses**

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| Salaries and wages | 36,306 | 33,573 |
| Superannuation expense[(i)] | 3,849 | 3,369 |
| Agency expenses | 7,947 | 14,043 |
| Fee for service medical officer expenses | 6,496 | 1,412 |
| **Total employee expenses** | **54,598** | **52,397** |

[(i)] Defined contribution superannuation expense and defined benefit superannuation expense have been combined.

***How we recognise employee expenses***

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

The amount recognised in relation to superannuation is employer contributions for members of both defined benefit and defined contribution superannuation plans that are paid or payable during the reporting period.

**Note 3.1(b) Employee-related provisions**

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| **Current provisions for employee benefits** | | |
| Accrued days off | 80 | 67 |
| Annual leave | 3,776 | 3,674 |
| Long service leave | 5,088 | 4,870 |
| Provision for on-costs | 1,871 | 1,884 |
| **Total current provisions for employee benefits** | **10,815** | **10,495** |
| | | |
| **Non-current provisions for employee benefits** | | |
| Long service leave | 633 | 593 |
| Provision for on-costs | 86 | 82 |
| **Total non-current provisions for employee benefits** | **719** | **675** |
| | | |
| **Total provisions for employee benefits** | **11,534** | **11,170** |

**How we recognise employee-related provisions**

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

**3.1 Expenses incurred in the delivery of services (cont.)**

**Note 3.1(b) Employee-related provisions (cont.)**

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.

Management have applied judgements and assumptions in the measurement of the present value of employee benefits including inflation, discount rate, probability factors.

**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 Portland District 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 Portland District Health expects to wholly settle within 12 months or
- present value – if Portland District Health does not expect to wholly settle within 12 months.

**Long service leave**

The liability for long service leave (LSL) is recognised in the provision for employee benefits.

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

The components of this current LSL liability are measured at:

- nominal value – if Portland District Health expects to wholly settle within 12 months or
- present value – if Portland District Health does not expect to wholly settle within 12 months.

Conditional LSL is measured at present value and is disclosed as a non-current liability. There is a conditional right to defer the settlement of the entitlement until the employee has completed the requisite years of service.

**Provisions**

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

**Note 3.1(c) Supplies and consumables**

| | 2026<br>$'000 | 2025<br>$'000 |
|---|---|---|
| Drug supplies | 3,069 | 2,667 |
| Medical and surgical supplies (including Prostheses) | 2,623 | 2,893 |
| Diagnostic and radiology supplies | 1,814 | 1,597 |
| Other supplies and consumables | 1,669 | 1,645 |
| **Total supplies and consumables** | **9,175** | **8,802** |

**How we recognise supplies and consumables**

Supplies and consumable costs are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.

### 3.1 Expenses incurred in the delivery of services (cont.)

**Note 3.1(d) Other operating expenses**

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| Short term lease expenses | 845 | 970 |
| Fuel, light, power and water | 469 | 475 |
| Finance costs | 47 | 49 |
| Repairs and maintenance | 732 | 632 |
| Maintenance contracts | 298 | 326 |
| Medical indemnity insurance | 769 | 593 |
| Communication and IT costs | 2,545 | 2,223 |
| Other administration expenses | 3,204 | 2,851 |
| **Total other operating expenses** | **8,909** | **8,119** |

**How we recognise other operating expenses**

**Expense recognition**

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

**Other operating expenses**

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

The DH also makes certain payments on behalf of Portland District Health. These amounts have been brought to account in determining the operating result for the year, by recording them as revenue (Refer to Note 2.1(b)) and recording a corresponding expense.

## Note 4 Key assets to support service delivery

Portland District 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 Portland District Health to be utilised for delivery of services.

**Significant judgement – Fair value measurement**

Where the assets included in this section are carried at fair value, additional information is disclosed in Note 7.3 in connection with how those fair values were determined.

**Structure**
**4.1 Property, plant and equipment**
**4.2 Depreciation and amortisation**
**4.3 Investment property**

### Note 4.1 Property, plant and equipment

| | Gross carrying amount | | Accumulated depreciation | | Net carrying amount | |
|---|---|---|---|---|---|---|
| | 2026 | 2025 | 2026 | 2025 | 2026 | 2025 |
| | $'000 | $'000 | $'000 | $'000 | $'000 | $'000 |
| Land at fair value - Crown | 3,206 | 3,206 | - | - | 3,206 | 3,206 |
| Buildings at fair value | 57,784 | 57,321 | (8,423) | (4,172) | 49,361 | 53,149 |
| Plant, equipment and vehicles at fair value | 19,346 | 18,907 | (14,810) | (14,148) | 4,536 | 4,759 |
| **Total property, plant and equipment** | **80,336** | **79,434** | **(23,233)** | **(18,320)** | **57,103** | **61,114** |

**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.

### 4.1(a) Reconciliation of the carrying amount of each class of asset

| | Land | Buildings | Works in progress | Plant, equipment and vehicles | Total |
|---|---|---|---|---|---|
| | $'000 | $'000 | $'000 | $'000 | $'000 |
| **Balance at 1 July 2025** | **3,206** | **53,149** | **-** | **4,759** | **61,114** |
| Additions | - | - | 463 | 888 | 1,351 |
| Disposals | - | - | - | (91) | (91) |
| Net transfers between classes | - | 463 | (463) | - | - |
| Depreciation | - | (4,251) | - | (1,020) | (5,271) |
| **Balance at 30 June 2026** | **3,206** | **49,361** | **-** | **4,536** | **57,103** |

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, Portland District Health has elected to apply the practical expedient in FRD 103 Non-Financial Physical Assets and has therefore not applied the amendments to AASB 13 Fair Value Measurement. The amendments to AASB 13 will be applied at the earlier of an interim revaluation or the next scheduled formal revaluation.

**Note 4.1 Property, plant and equipment (cont.)**

**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 |
| Plant, equipment and vehicles | 1,314 | 1,119 | (300) | (178) | 1,014 | 941 |
| **Total right-of-use assets** | **1,314** | **1,119** | **(300)** | **(178)** | **1,014** | **941** |

**4.1(c) Reconciliation of the carrying amount of each class of right of use asset**

| | Plant, equipment and vehicles $'000 | Total $'000 |
|---|---|---|
| **Balance at 1 July 2025**[(i)] | **941** | **941** |
| Additions | 256 | 256 |
| Depreciation | (183) | (183) |
| **Balance at 30 June 2026** | **1,014** | **1,014** |

(i) As a result of a change in FRD104 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 7.3.

**How we recognise right-of-use assets**

**Initial recognition**

When Portland District 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 the contract gives rise to a right-of-use asset and corresponding lease liability.

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

- any lease payments made at or before the commencement date
- any initial direct costs incurred and
- an estimate of costs to dismantle and remove the underlying asset or to restore the underlying asset or the site on which it is located, less any lease incentive received.

**Subsequent measurement**

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

Further information regarding fair value measurement is disclosed in Note 7.3.

**4.1(d) Impairment of property, plant and equipment**

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

Portland District Health has assessed all right-of-use assets for impairment, and no indicators of impairment are identified as at 30 June 2026.

**Note 4.1 Property, plant and equipment (cont.)**

**Note 4.2 Depreciation and amortisation**

**How we recognise depreciation**

All buildings, plant and equipment and other non-financial physical assets (excluding items under assets held for sale, land and investment properties) that have finite useful lives are depreciated. Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life.

Right-of-use assets are depreciated over the lease term or useful life of the underlying asset, whichever is the shortest. Where a lease transfers ownership of the underlying asset or the cost of the right-of-use asset reflects that the health service anticipates exercising 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 | 10 to 38 years | 20 to 60 years |
| Plant, equipment and vehicles (including leased assets) | 3 to 20 years | 3 to 20 years |

**Note 4.3 Investment property**

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| Investment property at fair value | 7,926 | 7,926 |
| **Total investment property at fair value** | **7,926** | **7,926** |
| | | |
| **Balance at Beginning of Period** | 7,926 | |
| Net gain/(loss) from fair value adjustments | - | |
| **Balance at End of Period** | **7,926** | |

**How we recognise investment properties**

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

**Initial recognition**

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

**Subsequent measurement**

Subsequently investment properties are measured at fair value, determined by independent valuers. Fair values are determined based on a market comparable approach that reflects recent transaction prices for similar properties. Investment properties are neither depreciated nor tested for impairment.

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

The fair value of the health service's investment properties has been arrived on the basis of an independent valuation carried out by the Valuer-General Victoria effective 30 June 2024. The valuation was determined with reference to market evidence of properties including location, condition and lease terms.

Further information regarding fair value measurement is disclosed in Note 7.3.

## Note 5 Other assets and liabilities

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

**Structure**
**5.1 Receivables**
**5.2 Payables**
**5.3 Monies held in trust**

### Note 5.1 Receivables

| | Note | 2026 $'000 | 2025 $'000 |
|---|---|---|---|
| **Current receivables** | | | |
| **Contractual** | | | |
| Inter hospital debtors | | 25 | 24 |
| Trade receivables | | 400 | 328 |
| Patient fees | | 323 | 353 |
| Allowance for impairment losses | | (363) | (245) |
| Share of JV receivables | | 311 | 358 |
| Accrued revenue | | 11 | 8 |
| Amounts receivable from governments and agencies | | 334 | 47 |
| **Total contractual receivables** | | **1,041** | **873** |
| **Statutory** | | | |
| GST receivable | | 263 | 227 |
| **Total statutory receivables** | | **263** | **227** |
| **Total current receivables** | | **1,304** | **1,100** |
| **Non-current receivables** | | | |
| **Contractual** | | | |
| Long service leave - Department of Health | | 757 | 629 |
| **Total non-current receivables** | | **757** | **629** |
| **Total receivables** | | **2,061** | **1,729** |
| *(i) Financial assets classified as receivables* | | | |
| Total receivables | | 2,061 | 1,729 |
| GST receivable | | (263) | (227) |
| Total financial assets classified as receivables | 7.1 | **1,798** | **1,502** |

**How we recognise receivables**

Receivables consist of:

**Contractual receivables**, including debtors that relate to 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. The health service holds contractual receivables with the objective to collect the contractual cash flows and therefore they are subsequently measured at amortised cost using the effective interest method, less any impairment.

**Statutory receivables**, including Goods and Services Tax (GST) input tax credits that are recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment) but are not classified as financial instruments for disclosure purposes. The health service applies AASB 9 for initial measurement of the statutory receivables and as a result, statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

**Note 5.2 Payables**

| | Note | 2026 $'000 | 2025 $'000 |
|---|---|---|---|
| **Current payables** | | | |
| **Contractual** | | | |
| Trade creditors | | 259 | 333 |
| Accrued salaries and wages | | 1,175 | 784 |
| Accrued expenses | | 1,439 | 767 |
| Inter hospital creditors | | 866 | 599 |
| Amounts payable to governments and agencies | | 52 | 26 |
| Share of JV payables | | 384 | 395 |
| **Total contractual payables** | | **4,175** | **2,904** |
| | | | |
| **Statutory** | | | |
| GST payable | | 21 | 20 |
| **Total statutory payables** | | **21** | **20** |
| | | | |
| **Total payables** | | **4,196** | **2,924** |
| | | | |
| *(i) Financial liabilities classified as payables* | | | |
| Total payables | | 4,196 | 2,924 |
| Total financial liabilities classified as payables | 7.1 | **4,175** | **2,904** |

***How we recognise payables***

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 the Portland District Health prior to the end of the financial year that are unpaid.

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

The normal credit terms for accounts payable are usually Net 60 days.

**Note 5.3 Monies held in trust**

| | Note | 2026 $'000 | 2025 $'000 |
|---|---|---|---|
| Patient monies | | 33 | 27 |
| Refundable accommodation deposits | | 5,300 | 4,880 |
| **Total monies held in trust** | | **5,333** | **4,907** |
| | | | |
| *** Represented by:** | | | |
| - Cash assets | 6.1 | 5,333 | 4,907 |
| | | **5,333** | **4,907** |

**How we recognise monies held in trust**

Refundable Accommodation Deposit (RAD)/Accommodation Bond liabilities

RADs/accommodation bonds are non-interest-bearing deposits made by some aged care residents to Portland District Health upon admission. These deposits are liabilities which fall due and payable when the resident leaves the home.

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 2024*.

## Note 6 How we finance our operations

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

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

**Structure**
**6.1 Cash and cash equivalents**

### Note 6.1 Cash and cash equivalents

| | Note | 2026 $'000 | 2025 $'000 |
|---|---|---|---|
| Cash on hand (excluding monies held in trust) | | 11 | 11 |
| Cash at bank (excluding monies held in trust) | | 3,194 | 4,228 |
| **Total cash held for operations** | | **3,205** | **4,239** |
| | | | |
| Cash at bank (monies held in trust) | | 5,333 | 4,907 |
| **Total cash held as monies in trust** | | **5,333** | **4,907** |
| | | | |
| **Total cash and cash equivalents** | 7.1 | **8,538** | **9,146** |

## Note 7 Financial instruments, contingencies and valuation judgements

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

**Structure**
**7.1 Financial instruments**
**7.2 Contingent assets and contingent liabilities**
**7.3 Fair value determination**

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

| 30 June 2026 | Note | Carrying amount $'000 | Net gain/(loss) $'000 | Total interest income/ (expense) $'000 | Fee income/ (expense) $'000 | Impairment loss $'000 |
|---|---|---|---|---|---|---|
| **Financial assets at amortised cost** | | | | | | |
| Cash and cash equivalents | 6.1 | 8,538 | - | 430 | - | - |
| Receivables | 5.1 | 1,798 | - | - | - | (118) |
| **Total financial assets** [i] | | **10,336** | **-** | **430** | **-** | **(118)** |
| | | | | | | |
| **Financial liabilities at amortised cost** | | | | | | |
| Payables | 5.2 | 4,175 | - | - | - | - |
| Borrowings | | 1,287 | - | (47) | - | - |
| Other financial liabilities - Refundable Accommodation Deposits | 5.3 | 5,300 | - | - | - | - |
| Other financial liabilities - patient monies held in trust | 5.3 | 33 | - | - | - | - |
| **Total financial liabilities** [i] | | **10,795** | **-** | **(47)** | **-** | **-** |

| 30 June 2025 | Note | Carrying amount | Net gain/(loss) $'000 | Total interest income/ (expense) $'000 | Fee income/ (expense) $'000 | Impairment loss $'000 |
|---|---|---|---|---|---|---|
| **Financial assets at amortised cost** | | | | | | |
| Cash and cash equivalents | 6.1 | 9,146 | - | 595 | - | - |
| Receivables | 5.1 | 1,502 | - | - | - | (129) |
| **Total financial assets** [i] | | **10,648** | **-** | **595** | **-** | **(129)** |
| | | | | | | |
| **Financial liabilities at amortised cost** | | | | | | |
| Payables | 5.2 | 2,904 | - | - | - | - |
| Borrowings | | 945 | - | (49) | - | - |
| Other financial liabilities - Refundable Accommodation Deposits | 5.3 | 4,880 | - | - | - | - |
| Other financial liabilities - patient monies held in trust | 5.3 | 27 | - | - | - | - |
| **Total financial liabilities** [i] | | **8,756** | **-** | **(49)** | **-** | **-** |

[i] The carrying amount excludes statutory receivables (i.e. GST receivable) and statutory payables (i.e. GST payable) and revenue in advance.

**Note 7.1 Financial instruments (cont.)**

**How we categorise financial instruments**

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 Portland District 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.

Portland District Health recognises the following assets in this category:

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

**Categories of financial liabilities**

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.

Portland District 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 7.2 Contingent assets and contingent liabilities**

At balance date, the Board are not aware of any contingent assets or liabilities.

**Note 7.3 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:

- Property, plant and equipment, with the exception of right-of-use assets arising under AASB 16, which are measured using the cost model; and
- Investment properties.

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

**Valuation hierarchy**

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

- Level 1 – quoted (unadjusted) market prices in active markets for identical assets or liabilities
- Level 2 – valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable, and
- Level 3 – valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

Portland District 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.

**Note 7.3 Fair value determination (cont.)**

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

**Fair value determination: non-financial physical assets**

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 *Fair Value Measurement* 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. Appendix F will be applied at the earlier of an interim revaluation or the next scheduled formal revaluation.

The last scheduled full independent valuation of all of Portland District Health's non-financial physical assets was performed by VGV on 30 June 2024. The annual fair value assessment for 30 June 2026 using VGV indices does not identify material changes in value. In accordance with FRD 103, Portland District Health will reflect Appendix F in its next scheduled formal revaluation on 30 June 2029 or interim revaluation process (whichever is earlier). All annual fair value assessments thereafter will continue compliance with Appendix F.

For all assets measured at fair value, Portland District Health considers the current use as its highest and best use.

**Investment properties**

Investment properties are valued using the market approach. Under this valuation method, the assets are compared to recent comparable sales or sales of comparable assets which are considered to have nominal or no added improvement value. From this analysis, an appropriate rate per square metre has been applied to the asset.

**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, Portland District 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.

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.

For Portland District Health, the current replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation.

**Vehicles**

Vehicles are valued using the current replacement cost method. Portland District Health acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by experienced fleet managers in Portland District Health's who set relevant depreciation rates during use to reflect the utilisation of the vehicles.

**Furniture, fittings, plant and equipment**

Furniture, fittings, plant and equipment (including medical equipment, computers and communication equipment) are held at fair value. When plant and equipment is specialised in use, such that it is rarely sold, fair value is determined using the current replacement cost method.

**Note 7.3 Fair value determination (cont.)**

**Significant assumptions**

Description of significant assumptions applied to fair value measurement:

| Asset class | Valuation technique | Significant assumption | Range (weighted average) |
|---|---|---|---|
| Specialised land | Market approach | Community Service Obligations Adjustments (i) | 20% |
| Specialised buildings | Current replacement cost approach | Cost per square metre | $1,607 |
| | | Useful life | 15 years |
| Plant, equipment and motor vehicles | Current replacement cost approach | Cost per unit | $17,410 |
| | | Useful life | 10 years |

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

## Note 8 Other disclosures

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

**Structure**

**8.1 Responsible persons disclosures**
**8.2 Remuneration of executives**
**8.3 Related parties**
**8.4 Remuneration of auditors**
**8.5 Events occurring after the balance date**
**8.6 Controlled entities**
**8.7 Joint arrangements**

### Note 8.1 Responsible persons disclosures

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

| | Period |
|---|---|
| The Honourable Mary-Anne Thomas MP: | |
| Minister for Health | 27 Jun 2022 – 14 April 2026 |
| Minister for Ambulance Services | 2 Oct 2023 – 14 April 2026 |
| The Honourable Harriet Shing MP: | |
| Minister for Health | 15 April 2026 - 30 June 2026 |
| Minister for Ambulance Services | 15 April 2026 - 30 June 2026 |
| The Honourable Melissa Horne MP: | |
| Minister for Health Infrastructure | 19 December 2024 - 30 June 2026 |
| Minister for Prevention of Family Violence | 15 April 2026 - 30 June 2026 |
| The Honourable Ingrid Stitt MP: | |
| Minister for Mental Health | 2 Oct 2023 - 30 June 2026 |
| Minister for Ageing | 2 Oct 2023 - 30 June 2026 |
| Minister for Multicultural Affairs | 2 Oct 2023 – 14 April 2026 |
| Minister for Multicultural and Multifaith Victoria | 15 April 2026 – 30 June 2026 |
| Minister for Prevention of Family Violence | 18 December 2025 – 14 April 2026 |
| The Honourable Lizzy Blandthorn MP: | |
| Minister for Children | 2 Oct 2023 - 30 June 2026 |
| Minister for Disability | 2 Oct 2023 - 30 June 2026 |
| **Governing Boards** | |
| Prof P Matthews (Chairperson of the Board) | 1 July 2025 - 30 June 2026 |
| Prof M Bailey | 1 July 2025 - 30 June 2026 |
| Mr A Long | 1 July 2025 - 30 June 2026 |
| Mr J Macartney OAM | 1 July 2025 – 10 April 2026 |
| Dr L Cuddihy | 1 July 2025 - 30 June 2026 |
| Ms A Georgalas | 1 July 2025 - 30 June 2026 |
| Mr P Wright | 1 July 2025 - 30 June 2026 |
| Ms Kristin Michaels | 1 July 2025 - 30 June 2026 |
| Ms Louise Cameron | 1 July 2025 - 30 June 2026 |
| **Accountable Officers** | |
| Ms K Prevett | 1 July 2025 - 30 June 2026 |

**Note 8.1 Responsible persons disclosures (cont.)**

*Remuneration of Responsible Persons*

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

| Income Band | 2026 No | 2025 No |
|---|---|---|
| $0 - $9,999 | 7 | 6 |
| $10,000 - $19,999 | 2 | 1 |
| $20,000 - $29,999 | - | 1 |
| $320,000 - $329,999 | 1 | - |
| $330,000 - $339,999 | - | 1 |
| **Total Numbers** | **10** | **9** |

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| **Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to:** | **400** | 409 |

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

**Note 8.2 Remuneration of executives**

The number of executive officers, other than Ministers and the Accountable Officer, and their total remuneration during the reporting period are shown in the table below. Total annualised employee equivalent provides a measure of full time equivalent executive officers over the reporting period.

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered. Accordingly, remuneration is determined on an accrual basis.

Several factors affected the total remuneration payable to executives over the year, including termination payments, appointments and acting roles during the year.

| | Total Remuneration | |
|---|---|---|
| | 2026 $'000 | 2025 $'000 |
| Total remuneration [i] | 1,289 | 1,131 |
| Total number of executives | 8 | 6 |
| Total annualised employee equivalent [ii] | 4.0 | 3.9 |

[i] The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of Portland District Health under AASB 124 *Related Party Disclosures* and are also reported within Note 8.3 Related Parties.

[ii] Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

**Note 8.3 Related parties**

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

- all key management personnel (KMP) and their close family members and personal business interests
- cabinet ministers (where applicable) and their close family members
- jointly arrangements –the SWARH Joint Venture Alliance and
- all health services and public sector entities that are controlled and consolidated into the State of Victoria financial statements.

*Significant transactions with government related entities*

Portland District Health received funding from the government of $62.7m (2025: $62.4m). Balances outstanding as at 30 June 2026 are $282k (2025: $21k).

**Note 8.3 Related parties (cont.)**

Expenses incurred by Portland District Health in delivering services are in accordance with HealthShare Victoria requirements. Goods and services including procurement, diagnostics, patient meals and multi-site operational support are provided by other Victorian Health Service Providers on commercial terms. Professional medical indemnity insurance and other insurance products are obtained from the Victorian Managed Insurance Authority.

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

*Key management personnel*

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

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

| KMPs | Position Title | KMPs | Position Title |
|---|---|---|---|
| Prof P Matthews | Chair of the Board | Ms K Prevett | Chief Executive Officer |
| Prof M Bailey | Board Member | Dr R Sherwood | Acting Executive Director Medical Services |
| Mr A Long | Board Member | Ms R Nagorcka | Director of Nursing, Midwifery & Aged Care |
| Mr J Macartney OAM | Board Member | Mrs M Jenner | Acting Director of Nursing, Midwifery & Aged Care |
| Dr L Cuddihy | Board Member | Mr M Ashby | Acting Director of Nursing, Midwifery & Aged Care |
| Ms A Georgalas | Board Member | Mr I Martin | Executive Director Finance & Corporate Services |
| Mr P Wright | Board Member | Ms R Smith | Executive Director Primary Care Services & Quality |
| Ms K Michaels | Board Member | Mrs M Roberts | Acting Executive Director Primary Care Services & Quality |
| Ms L Cameron | Board Member | Ms C Shaw | Executive Director Governance & Strategy |

*Remuneration of key management personnel*

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

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| Total compensation - KMPs[i] | 1,689 | 1,540 |

[i] KMPs are also reported in Note 8.1 Responsible Persons or Note 8.2 Remuneration of Executives.

*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 occurs on terms and conditions consistent with the *Public Administration Act 2004* and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the HealthShare Victoria and Victorian Government Procurement Board requirements.

Outside of normal citizen type transactions with the Portland District Health, there were no related party transactions that involved key management personnel, their close family members or their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties. There were no related party transactions with Cabinet Ministers required to be disclosed in 2026 (2025: none).

There were no related party transactions required to be disclosed for the Portland District Health Board of Directors, Chief Executive Officer and Executive Directors in 2026 (2025: Ms R Nagorcka $3k rental of property).

**Note 8.4 Remuneration of auditors**

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| **Victorian Auditor-General's Office** | | |
| Audit of the financial statements | 29 | 27 |
| **Total remuneration of auditors** | **29** | **27** |

**Note 8.5 Events occurring after the balance sheet date**

There are no events occurring after the Balance Sheet date.

**Note 8.6 Controlled entities**

Management has considered whether Portland District Health controls Active Health Portland Ltd under AASB 10. This assessment involved significant judgement, particularly in determining whether rights held by PDH under lease and funding arrangements are protective or substantive. Although AHPL operates from premises owned by PDH and is required to operate the Portland GP Super Clinic in accordance with Commonwealth funding obligations, PDH does not hold membership rights, board appointment rights or ordinary-course decision-making authority over AHPL's relevant activities. Management has concluded that PDH's rights are protective in nature and that PDH does not control AHPL. Accordingly, AHPL has not been consolidated.

**Note 8.7 Joint arrangements**

| | Principal Activity | Ownership Interest 2026 % | Ownership Interest 2025 % |
|---|---|---|---|
| South West Alliance of Rural Health | ICT provision and support | 3.78 | 3.83 |

For the year ended 30 June 2026, Portland District Health's share of the jointly controlled operations financials was:

| | 2026 $'000 | 2025 $'000 |
|---|---|---|
| Total revenue and income | 1,367 | 1,427 |
| Total expenses | (1,393) | (1,350) |
| Total net result | (26) | 77 |
| Total other economic flows | 4 | 13 |
| Comprehensive result for the year | (22) | 90 |
| Total assets | 1,259 | 1,477 |
| Total liabilities | 996 | 1,192 |
| Total equity | 263 | 285 |

*Contingent liabilities and capital commitments*

There are no known contingent liabilities or capital commitments held by the jointly controlled operations at balance date. Portland District Health is involved in joint arrangements where control and decision-making are shared with other parties. Portland District Health has determined the entities detailed in the above table are joint operations and therefore recognises its share of assets, liabilities, revenues and expenses in accordance with its rights and obligations under the arrangement.

# Portland District Health

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