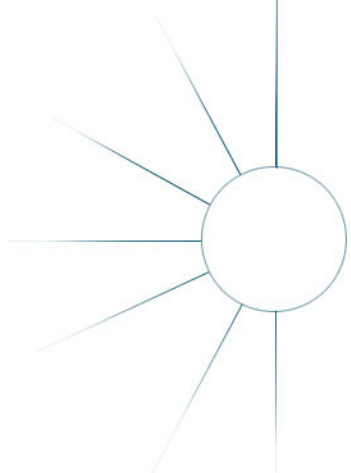


Lower Great Southern Health Service Board



Annual Report 2001/2002



Department of Health
Government of Western Australia

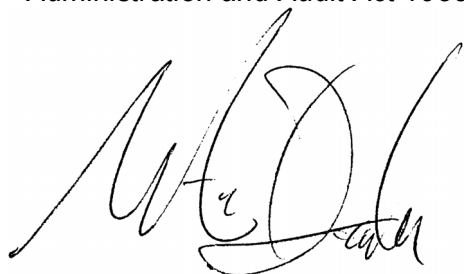
Statement of Compliance

To the Hon Bob Kucera MLA

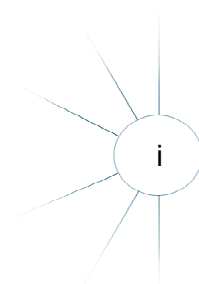
MINISTER FOR HEALTH

In accordance with Section 66 of the *Financial Administration and Audit Act 1985*, I hereby submit for your information and presentation to Parliament, the Report of Lower Great Southern Health Service for the year ended 30 June 2002.

This report has been prepared in accordance with the provisions of the *Financial Administration and Audit Act 1985*.



Mike Daube
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY
14 March 2003



ANNUAL REPORT

The past year has seen significant changes in the WA health system, in the context of an increasing recognition of its place in to our national health system.

The State Government health system does not exist in isolation. We work alongside other Government and non-Government services in the context of a national health system that remains fragmented and at times competitive. Much of our work and many of our challenges are informed by national and international trends, and decisions taken elsewhere. Nowhere is this clearer than in areas that tend to attract most public attention and place the greatest stresses for our system, such as workforce issues and the pressures on our teaching hospitals. These are understandably seen locally as local problems for local solution, but the reality is that they are significantly influenced by international trends and national policy and funding decisions.

We in Western Australia face all the challenges of contemporary health systems, together with high community expectations and often optimistic or disingenuous expectations that long-standing problems faced by all health systems can be resolved overnight in our State.

Against this backdrop have been steadily implementing change to ensure that the WA Government health system is as well placed as possible to face the challenges of the future. While ever more conscious of the size and complexity of our system and the challenges we face, remain optimistic that with good support and community understanding we can move well towards achieving our common objectives.

Our community enjoys outstanding health and health care by any standards. When we see and hear about problems we face, it is tempting to imagine that our system is failing us overall or that we are doing badly by national or international standards.

Of course there are areas of deficit, but Western Australians enjoy some of the best health and health care in the world. We live longer than people in almost all other countries, and even within Australia some parts of Western Australia are notable for the longevity of their populations.

Our health professionals are as well trained and qualified as those anywhere around the world, and we rightly adopt the most stringent standards in relation to their training and practice.

Those in the system will be more aware than any others of areas in which we can do better, but above all our community should be aware and rightly proud that we have a system in which first class professionals deliver high quality health care to a community with health outcomes that would be envied in almost any other country.

The world of health and health care has changed dramatically in recent years, and especially in the last decade. Around Australia, Governments and health systems are faced with identical problems and pressures including increasing costs of labour, equipment and pharmaceutical products, the changing roles of health professionals, a

Director General's Overview

very proper emphasis on quality (and the inevitable costs and changes that this will impose on us), the needs of ageing populations and more.

The Department of Health is a vast and complex organisation, employing some 30,000 staff operating from more than 650 sites around the State. It is not a simple agency. We deliver some services ourselves; we work collaboratively with Commonwealth and local Governments; and we fund several hundred non-Government organisations, ranging in size from those such as St John Ambulance Association and the Royal Flying Doctor Service to small groups providing equally important local services.

During 2001/2002 we restructured the Department so that it is now a single unified health system. We now have a State Health Management Team, which works as a single Departmental Executive Committee. The four Metropolitan Areas have been established. Our Country Health Services have been rationalised; and an enormous amount of work has been carried out to move away from silo mentalities and towards a recognition that we must indeed work as a unified system.

During the year, the Department has recognised its responsibilities arising out of matters such as the Douglas Report on King Edward Memorial Hospital, as well as resolving some important industrial negotiations.

As the work of consolidation, always slower than one would hope, develops, my hope is that during the coming year we will be able to address further some of the high profile priorities for both Government and the community – for example coping with winter pressures, reduce waiting lists and valuing and supporting our workforce; that we will be able to demonstrate our values as a health system committed to quality, prevention and remedying disadvantage; that we will be able to focus on the medium and long term planning that are crucial if the needs of the next generation are to be well serviced; and that we will be able to engender an understanding in the community of the national and international context within which our system works. In the latter regard, negotiations on the next phase of the Australian Health Care Agreements will be of fundamental importance.

I would like to convey special appreciation to all the staff and volunteers working within the Department of Health. They know as well as anyone else the pressures we all face, but also the excellent service they provide and the commitment they display on a daily basis.

Mike Daube
DIRECTOR GENERAL

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Address and Location

Lower Great Southern Health Service

Warden Ave
ALBANY WA 6331

PO Box 252
ALBANY WA 6331

☎ (08) 9892 2222
📠 (08) 9841 8557

Mission Statement

Our Mission

To create and enhance health programs that deliver continuing improvements in the health status and wellbeing of the Lower Great Southern population.

Broad Objectives

The objectives of the Lower Great Southern Health Service are:

- To reduce the prevalence of health risk behaviours and increase the prevalence of protective behaviours to assist the community to reach and maintain the highest attainable level of health.
- To reduce the incidence and prevalence of mental health problems and the disability associated with them.
- To assess and treat people who have an illness or an injury in the shortest practicable time and at least cost within current best practice standards and practice.
- To maintain, and where practical, improve the quality of life of the chronically ill, the elderly or disabled and their carers.

Enabling Legislation

The Lower Great Southern Health Service is incorporated under the *Hospitals and Health Services Act 1927*, which provides for the establishment, maintenance and management of public hospitals, and for incidental and other purposes.

The Health Service is directed and controlled by a Board of Management constituted under Section 15 of the *Hospitals and Health Services Act 1927*.

As the Accountable Authority for the Lower Great Southern Health Service, the Board of Management is responsible to the Minister for Health, Hon. R. C. Kucera APM MLA, for the general administration of the Health Service.

The Health Service does not operate in coordination with any subsidiary, related or affiliated bodies.

Ministerial Directives

The Minister for Health did not issue any directives on Health Service operations during 2001/2002.

Submission of Annual Report

Approval was sought under the *Financial Administration and Audit Act 1985* to extend the Lower Great Southern Health Service's deadline for submission of key performance indicators and financial statements to the Auditor General to 14 October 2002.

Statement of Compliance with Public Sector Standards


In the administration of the Lower Great Southern Health Service, I have complied with the *Public Sector Standards in Human Resource Management*, the *Western Australian Public Sector Code of Ethics* and our *Code of Conduct*.

I have put in place procedures designed to ensure such compliance and have undertaken appropriate internal processes to satisfy myself the statement made above is correct.

The applications made to report a breach in standards and the corresponding outcomes for the reporting period are:

- Number of applications lodged None
- Number of material breaches found None
- Applications under review None

The Lower Great Southern Health Service has not been investigated or audited by the Office of the Public Sector Standards Commissioner for the period to 30 June 2002.



Keith Symes
GENERAL MANAGER
LOWER GREAT SOUTHERN HEALTH SERVICE
December 2002

Advertising and Sponsorship – Electoral Act 1907

The following table lists the expenditure on advertising and sponsorship made by the Lower Great Southern Health Service published in accordance with Section 175ZE of the *Electoral Act 1907*:

CLASS OF EXPENDITURE	1999/2000 \$	2000/2001 \$	2001/2002 \$
Advertising Agencies — Marketforce Productions	58,924.00	69,962.00	30,038.00
Market Research Organisations	—	—	—
Polling Organisations	—	—	—
Direct Mail Organisations	—	—	—
Media Advertising Organisations	—	—	—
TOTAL	\$58,924.00	\$69,962.00	\$30,038.00

Freedom of Information Act 1992

The Lower Great Southern Health Service received and dealt with 106 formal applications under the Freedom of Information guidelines during 2001/2002.

Formal applications are defined as requests which:

- Are in writing.
- Give enough information to enable the requested documents to be identified.
- Give an address in Australia to which notices under the *Freedom of Information Act 1992* can be sent.
- Give any other information or details required under FOI regulations.
- Are lodged at an office of the agency with any application fee required under FOI regulations.

Applications are usually received from existing or former patients wanting to read or have a copy of their medical record, while others are from lawyers, authorised next of kin or authorised agencies.

The types of documents held by the Health Service include:

- Patient medical records.
- Staff employment records.
- Department of Health reports, plans and guidelines.
- Other health-related agency reports.
- Agreements with the Department of Health.
- Statistical data and reports.
- Books relating to health planning and management.
- Books relating to the treatment of illness and disease.
- General administrative correspondence.

In accordance with Part Five of the *Freedom of Information Act 1992*, an information statement detailing the nature and types of documents held by the organisation is available from the:

Health Information Manager
Lower Great Southern Health Service
PO Box 252
ALBANY WA 6331

☎ (08) 9892 2504

Lower Great Southern Health Service

Key Operations and Achievements

- Review of staffing and restructure of services.
- Services improved with new programs.
- Equipment upgrades and replacements.
- Integration and coordination of palliative care services.
- Implementation of new primary health programs.
- Development of strategic directions and partnerships in primary and public health.
- Mental Health service reviews and new programs.
- New facility planning and redevelopments.

Review of Staffing and Restructure of Services

A review of the usage of casual nurses resulted in the establishment of a new system to enable the Health Service to predict more reliably the availability of staff. Significant changes in the operation of nursing services this year have been brought about through structural changes. These included the closure of beds in two medical wards, the creation of a Therapies Department within the inpatient area and relocation of the dialysis unit from the town centre to the Albany Regional Hospital campus. The closure of beds coincided with the opening of the Hospice on campus and the opening of a private aged care facility, Clarence Estate. Two new initiatives have been implemented and include the introduction of overnight swing beds to accommodate patients who may otherwise have been held in Emergency Department overnight.

Services Improved with New Programs

The position of Early Intervention Coordinator for the elderly and disabled has been created to address, in particular, patients awaiting placements in residential aged care facilities. Other major operational achievements include implementation of a pre-admission clinic, a stroke database, strategies to deal with aggression towards staff, introduction and construction of laminar flow units in theatre, introduction of a Drug and Alcohol Withdrawal Program and introduction of a Palliative Care Coordinator.

Equipment Upgrades and Replacements

A new LOGIQ 700 GE ultrasound unit was obtained in December 2001. A new replacement Private SKG Toshiba Asteion CT unit was installed in January 2002. Two new dedicated ultrasound examination couches were acquired in April 2002. Compliance with the *Radiation Safety Act* of all X-ray equipment was completed in April 2002.

Integration and Coordination of Palliative Care Services

The appointment of palliative care coordinators and an inter-agency palliative care management committee has improved the integration and coordination of the Lower Great Southern Palliative Care Service. This has been evident in Mount Barker, for example, with training being provided to volunteers, effective communication for shared clients and an improved working knowledge of the West Australian Rural Palliative Care Database.

Implementation of New Primary Health Programs

A number of major activities were completed during the year including implementation of the evidence-based early intervention language programs, Wilstaar and Hanen; implementation of the Building Blocks Program; an Aboriginal Health Program conducted in conjunction with the Family Futures Program; and development of a Falls Clinic for seniors with funding from the Rural and Remote Allied Health Innovative Funding program.

Development of Strategic Directions and Partnerships in Primary and Public Health

A Regional Planning Working Party was convened with the purpose of developing a process to support the development of strategic directions for the Primary and Public Health Services in the Great Southern. Strong inter-agency partnerships continue to be maintained and developed, such as the Great Southern Road Safety Coordinating Committee, which consists of key government and non-government agencies. The Lower Great Southern Community Needs Survey to identify community health needs was completed. This will direct planning for service delivery.

Mental Health Service Reviews and New Programs

The Great Southern Mental Health Service has undergone a consolidation period over the past twelve months with two major service-wide reviews. An in-depth review was held in conjunction with the Lower Great Southern Health Service organisation-wide survey and a specific clinical review was facilitated by the Office the Chief Psychiatrist. In both reviews the Health Service was found to be functioning at an effective level. The Mental Health Service, in partnership with Southern Age Care Inc. and the Great Southern Division of General Practice, has secured funding to provide a Primary Mental Health Service. A counselling team focuses upon building resilience by promoting positive mental health education and training to health care workers and the community, and support to people to manage emotional trauma in times of crisis. The establishment of ECT services in Albany Regional Hospital during the year was another highlight. The treatment is provided for inpatients and outpatients.

New Facility Planning and Redevelopments

A New Hospital Working Party was formed by the Denmark Shire in July 2001 in response to a community meeting to progress and lobby for a new health care facility for Denmark. Aurora Consultants were appointed by the Department of Health in May 2002 to plan the proposed new Denmark Health Service multipurpose facility. Renovation work is due to commence in July 2002. A new two-bay Accident and Emergency Department was constructed at Jerramungup and a new nurses office and a combined child health, immunisation and Well Women's Clinic room were also built. A new emergency ambulance entrance outside the new emergency room is in progress. The children's room and play area mural was completed as a Community Mental Health and Art Project. The practical completion certificate for the Plantagenet Hospital Redevelopment Stage 1, Banksia Lodge, was issued on 16 July 2001. This project provided a new, purpose-built, 16-bed permanent care facility which incorporates a palliative care suite.

Achievements and Highlights

Major Capital Projects

Projects Completed during the Year

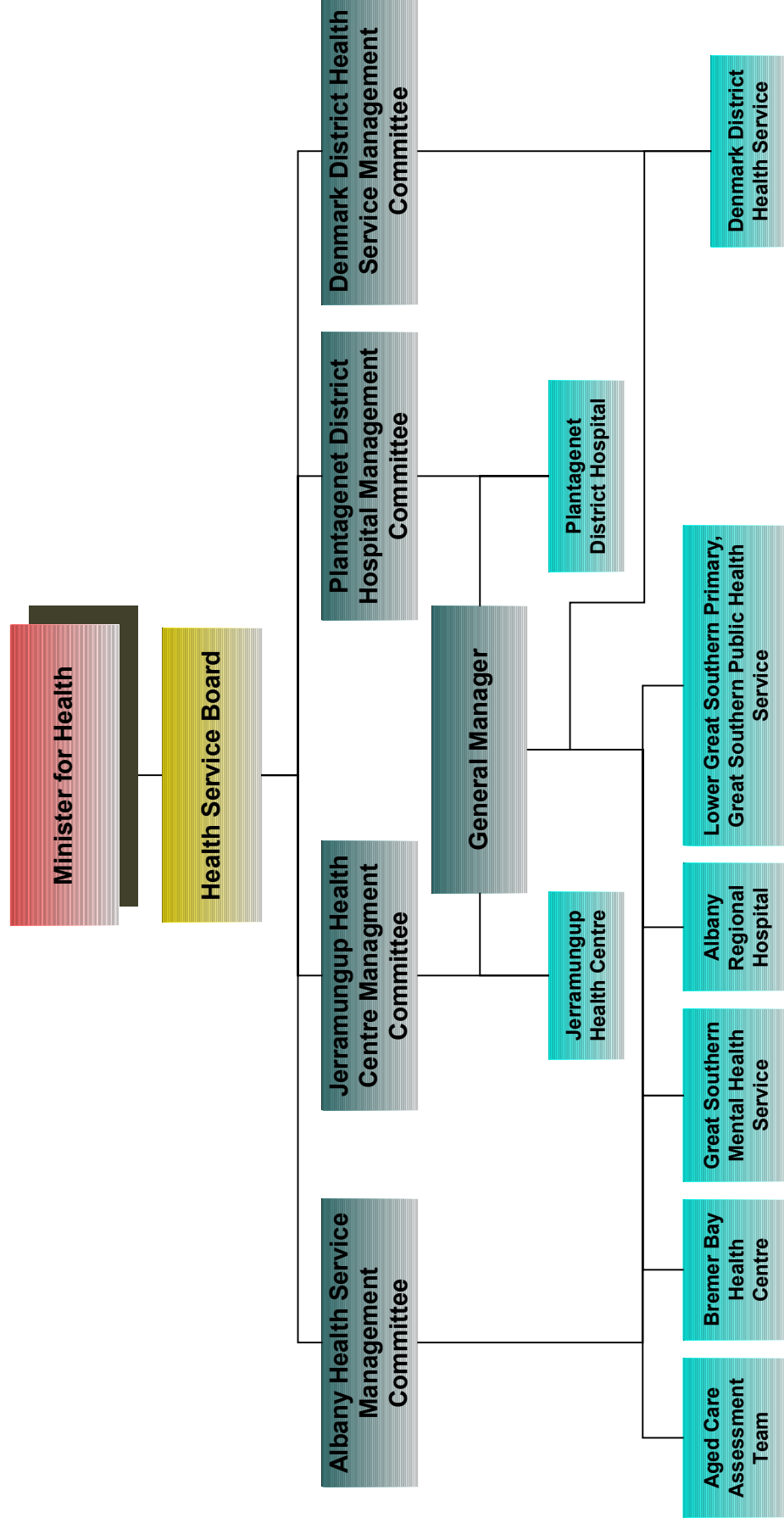
PROJECT DESCRIPTION	Actual Total Cost	Estimated Total Cost
Banksia Lodge, Plantagenet District Hospital	\$2,123,921.00	\$2,109,678.00
Theatre, Sterilisers and Laundry Equipment Upgrade, Albany Regional Hospital	\$626,534.00	\$626,534.00
Jerramungup Health Centre Upgrade	\$69,117.00	\$65,000.00

Projects in Progress

PROJECT DESCRIPTION	Expected Year of Completion	Estimated Cost to Complete	Estimated Total Cost
Renal Dialysis Unit	2002/2003	\$320,000.00	\$320,000.00

Management Structure

Organisational Chart



Accountable Authority

The Lower Great Southern Health Service Board represents the Accountable Authority for the Health Service. The board is comprised of the following members:

Name	Position	Term of Office Expires
Marjorie Sharp	Chairperson	30 June 2002
Graham Carthew	Deputy Chairperson	30 June 2002
Edward Argyle	Member	30 June 2002
Glenyse Garnett	Member	30 September 2002
Margaret Peachey	Member	30 September 2002
Betty Thomas	Member	30 June 2002
Gordon Mangan	Member	30 September 2002
Warren York	Member	30 September 2002

Note: The Governor in Executive Council approved the amalgamation of several hospital boards including the Lower Great Southern Health Service Board to form one board, with the assigned name WA Country Health Service, with effect from 1 July 2002. Notice to this effect was published in the Government Gazette on 28 June 2002.

Senior Officers

The senior officers of the Lower Great Southern Health Service Board and their areas of responsibility are listed below:

Area of Responsibility	Title	Name	Basis of Appointment
Health Service Corporate Management	General Manager	Keith Symes	Permanent
	Finance and IT Manager	Graham Smithson	Permanent
	Human Resource Manager	Shauna Dale	Permanent
	Health Information Manager	Katherine Ivey	Permanent
	Quality Management Coordinator	Frank Lethorn	Contract
	Chief Medical Imaging Technologist	Luke Meyer	Permanent
	Facilities and Support Services Manager	Ken Parker	Permanent
	Regional Pharmacist	Trish Parry	Permanent
	Aged Care Assessment Team Coordinator	Sally Rose	Permanent
Albany Hospital Nursing Services	Director of Nursing	Doug Gilchrist	Permanent
Mental Health Services	Manager	Richard Menasse	Permanent
Denmark District Health Service	Director of Nursing/Health Service Manager	Sue Roberts	Permanent
Jerramungup Health Centre	Nurse Manager	Cherie Carter	Permanent
	Administrator	Bev Brooks	Permanent
Plantagenet District Hospital	Director of Nursing	Ruth York	Permanent

Pecuniary Interests

Members of the Lower Great Southern Health Service Board have declared no pecuniary interests other than those reported in the Financial Statements section of this report.

Demography

The Lower Great Southern Health Service delivers services to communities covered by the following local authorities:

- City of Albany
- Shire of Cranbrook
- Shire of Denmark
- Shire of Jerramungup
- Shire of Plantagenet

The following table shows population figures for each local authority within the Lower Great Southern region:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
City of Albany	28,181	31,214	32,210
Shire of Cranbrook	1,160	1,053	1,178
Shire of Denmark	3,899	4,656	5,651
Shire of Jerramungup	1,335	1,235	1,497
Shire of Plantagenet	4,297	4,677	4,300

*Data sources:

Australian Bureau of Statistics 1996, *Estimated Resident Population by Age and Sex in Statistical Local Areas, WA*, Cat. No. 3203.5.

ABS 2001, *Population Estimates by Age, Sex and Statistical Local Area, WA*, Cat. No. 3235.5.

Ministry of Planning 2000, *Population Projections by Age, Sex and Local Government Area, WA*.

Available Services

The following is a list of health services and facilities available to the community:

Direct Patient Services

Accident and Emergency
Acute Medical
Acute Surgical
Extended Care Services
Gynaecology
Obstetrics
Orthopaedics
Paediatrics
Psychiatric Services
Same Day Surgery

Community Services

Child Development
Home Care
Home Nursing
Meals on Wheels
Primary Health Care

Medical Support Services

Audiology
Dietetics
Medical Imaging
Occupational Therapy
Pharmacy
Physiotherapy
Podiatry
Social Work
Speech Pathology

Other Support Services

Health Promotion
Hotel Services
Medical Records

Disability Services

Our Policy

The Lower Great Southern Health Service is committed to ensuring all people with disabilities can access the facilities provided by and within the Health Service.

Programs and Initiatives

The Health Service has aimed to improve its disability services plan during 2001/2002 according to objectives outlined in the *Disability Services Act 1993*. This goal has been achieved through programs and initiatives run on behalf of the following five key outcome areas:

Outcome 1: Existing services are adapted to ensure they meet the needs of people with disabilities.

- The Health Service is collaborating with the Disability Services Commission to improve services to people with disabilities.
- Commonwealth Government funding was obtained to provide services tailored specifically to the needs of carers of young people with severe or profound disabilities.
- At Albany Regional Hospital televisions have been obtained which can display subtitles so that people with hearing difficulties can better view TV programs.
- An audio link has been fitted to the Seminar Room on the Albany Health Campus to enable people with hearing difficulties to access programs, services, workshops and other activities.

- The Therapy for Children with Disabilities Program has developed the Working with Opportunities approach to working with children with disabilities. This provides an integrated family-centred approach.

Outcome 2: Access to buildings and facilities is improved.

- An ongoing program of upgrading buildings and facilities is in place.
- Recent upgrades include the installation of automatic doors into the ward areas at Albany Regional Hospital and plans have been approved to install an additional bathroom at Denmark District Health Service.
- A new body viewing area has been constructed. This means that people no longer need to negotiate stairs or use the lift to access the mortuary.

Outcome 3: Information about services is provided in formats which meet the communication requirements of people with disabilities.

- Health Service information is available in alternative formats upon request.

Outcome 4: Advice and services are delivered by staff who are aware of and understand the needs of people with disabilities.

- A comprehensive staff orientation program is in place which incorporates customer service and disabilities services requirements

Outcome 5: Opportunities are provided for people with disabilities to participate in public consultations, grievance mechanisms and decision-making processes.

- An effective customer interface is in place through regular consumer meetings, community and customer surveys and an open and genuine customer feedback mechanism.

Future Direction

The Health Service will continue to review and amend its policies, practices and procedures to identify possible barriers experienced by people with disabilities.

Cultural Diversity and Language Services

Our Policy

The Lower Great Southern Health Service strives to ensure there is no discrimination against members of the public based upon race, ethnicity, religion, language or culture.

Programs and Initiatives

The Health Service operates in conjunction with the *Western Australian Government Language Services Policy* and has the following strategies and plans in place to assist people who experience cultural barriers or communication difficulties while accessing the Health Service's facilities:

- The Health Service recognises that people from culturally and linguistically diverse backgrounds may need access to language services to optimise the provision of health services.
- When required, the Health Service ensures that its clients and patients have access to qualified interpreters and translators.
- The Telephone Interpreter Service is used as needed.
- The availability of these services is advertised by the Health Service.

Youth Services

Our Policy

The Lower Great Southern Health Service acknowledges the rights and special needs of youth, and endeavours to provide appropriate services, supportive environments and opportunities for young people.

The Health Service is committed to the following objectives as outlined in *Action: A State Government Plan for Young People, 2000–2003*:

- Promoting a positive image of young people.
- Promoting the broad social health, safety and wellbeing of young people.
- Better preparing young people for work and adult life.
- Encouraging employment opportunities for young people.
- Promoting the development of personal and leadership skills.
- Encouraging young people to take on roles and responsibilities, which lead to active adult citizenship.

Programs and Initiatives

The Health Service has run numerous programs targeting youth groups and introduced a number of innovations such as:

- Pilot of the Resourceful Adolescent Program at Mount Barker Senior High School.
- All Year 11 students in Albany completed the St John First Aid Certificate.
- Safe Sex Camp for At-Risk girls.
- Participation in Annual Asthma WA Camp.
- In partnership with the Department of Education, the piloting of an Early Childhood Screen for children attending pre-primary schools to identify children at risk.
- Implementation of the Asthma Friendly Schools initiative was completed.
- The Fruit and Water Policy in Schools Pilot Project was the winner of the Excellence in Health Promotion Award in the over \$5,000 category and the North Albany Senior High School Mental Health Promotion Program was winner in the Excellence in Health Promotion Award under \$5,000.
- Nursing student placements for clinical practice from the universities have increased over this financial year. Ten students have been placed at Denmark during 2001/2002. Work experience students and a structured workplace learning program through the local high school have also been supported by the Health Service.

Employee Profile

The following table shows the number of full-time equivalent staff employed by the Lower Great Southern Health Service:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	249.19	261.28	249.71
Administration and Clerical*	68.47	76.72	78.51
Medical Support*	55.37	56.78	57.78
Hotel Services*	113.00	107.38	105.28
Maintenance	24.99	26.30	24.99
Medical (salaried)	1.71	2.08	2.12
Other	—	—	—
TOTAL	512.73	530.54	518.39

*Note these categories include the following:

- **Administration and Clerical** — health project officers, ward clerks, receptionists and clerical staff.
- **Medical Support** — physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers.
- **Hotel Services** — cleaners, caterers and patient service assistants.

Recruitment Practices

The policy on recruitment, selection and appointment has been updated to reflect the changes to the *Public Sector Standards in Human Resource Management*.

Advertising has been modified to attract a wider range of applicants and initiatives such as attraction allowances for hard-to-fill positions, such as medical imaging have been successful.

Potential applicants are provided with a comprehensive package of information on the organisation and the surrounding area of Albany, Denmark and Mount Barker.

Exit interviews are being implemented to provide feedback on organisational performance and issues which may assist in staff retention.

The majority of job description forms have been updated and are now sent to all new employees. Selection criteria are reviewed to enable positions to be filled by a variety of suitably qualified professionals. This has assisted in attracting staff to a variety of difficult-to-recruit areas.

Staff Development

Core in-service this year has included task-specific manual handling, which has been tailored to the specific needs of different areas. These sessions are time consuming, but the feedback from the attendees has been extremely positive.

The Corporate Day, which includes all core in-service topics, has proved popular with all areas of the health service.

Well-attended lunchtime seminars and programs included Women's Hormones and Health, Cerebral Artery Gas Embolism, Defuse Diabetes and ECT – The Shocking Truth.

The Staff Training and Development Unit has an ongoing commitment to Telehealth, Westlink and Clinical Information Access Online in order to improve staff access to information. Telehealth and CIAO have been used for a variety of activities from meetings to clinical seminars.

Significant training programs this year have included the following:

- Continence Resource Nurses Course.
- Beyond Burnout — be happy in work and life.
- Advanced Life Support Course.
- Run Crash Run — management strategies for amphetamine use.
- Staff Interviews — practicals.
- CIMS/AIMS training.
- Difficult Behaviours.
- Time Management.
- Foodsafe Plus.
- The Acutely Ill Patient.
- Getting off the Grog.
- Presentation of VRE.
- Physical Assessment for Enrolled Nurses.
- Palliative Care Study Day.
- Acute Cardiac Seminar.
- Telehealth Paediatric Emergency Assessment.
- Perinatal Loss — seminar and workshop.
- Wound Management Study Day

Industrial Relations Issues

The development of Enterprise Bargaining Agreements has been undertaken centrally and wages outcomes are based on Government guidelines. New agreements have been reached in 2001/2002 for support services staff, medical officers and salaried officers. Locally, there has been no industrial action.

The major event in the industrial relations area was the successful transition of employees and residents from the Spencer Lodge Aged Care facility to the private sector in March 2002. Employees of the Health Service were provided with information sessions to prepare them for interviews with the new employer and a transition package was developed as an incentive to transfer to the private sector. All but eight employees transferred to the private sector. Those who have remained with the Health Service are undertaking retraining or have been successfully redeployed.

Workers' Compensation and Rehabilitation

The following table shows the number of workers' compensation claims made through the Lower Great Southern Health Service:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	13	23	8
Administration and Clerical*	1	1	2
Medical Support*	1	1	1
Hotel Services*	15	15	13
Maintenance	2	2	5
Medical (salaried)	0	0	0
Other	0	1	0
TOTAL	32	43	29

*Note these categories include the following:

- **Administration and Clerical** — health project officers, ward clerks, receptionists and clerical staff.
- **Medical Support** — physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers.
- **Hotel Services** — cleaners, caterers and patient service assistants.

Equity and Diversity Outcomes

Our Policy

The ability of an organisation to provide high quality health services to the general public is closely related to workforce diversity. That diversity needs to be tapped for planning, decision-making and service delivery.

The Lower Great Southern Health Service aims to achieve equity and diversity in the workplace by eliminating any discrimination in employment based upon grounds of sex, marital status, pregnancy, family status, race, religious or political conviction, or age, and by promoting equal opportunity for all people.

Programs and Initiatives

The Health Service aims to promote equal opportunity for all persons, according to the *Equal Opportunity Act 1984*. This goal is achieved through activities and programs run on behalf of the following outcomes:

Outcome 1 – The organisation values EEO and diversity, and the work environment is free from racial and sexual harassment.

- All new staff are advised of requirements for necessary equal employment opportunity behaviour at orientation. Cultural awareness is provided by Family Futures at corporate orientation.
- All job description forms have been updated to include the requirement that all employees comply with and demonstrate a positive commitment to the highest achievement level in equal employment opportunity, occupational safety and health, public sector standards, *Code of Conduct*, *Code of Ethics*, quality improvement, performance management, customer focus, the *Disability Services Act* and confidentiality.
- The Health Service *Code of Conduct* includes a statement on equity and equal opportunity.

Outcome 2 – Workplaces are free from employment practices that are biased or discriminate unlawfully against employees or potential employees.

- Training in bias-free recruitment methodologies is widely provided.
- The recruitment and selection policy has been updated to ensure bias-free methods are included.
- Recruitment is monitored by the Human Resource Manager and the General Manager.

Outcome 3 – Employment programs and practices recognise and include strategies for EEO groups to achieve workforce diversity.

- A partnership has been developed with Family Futures for provision of employment via that agency.
- An Aboriginal employment strategy is being developed.

EEO Indicators

The following table indicates strategic plans or processes the Department of Health aims to have in place across the health system to achieve equity and diversity in the workplace, and the level to which the Lower Great Southern Health Service has been able to meet these goals:

Plan or Process	Level of Achievement
EEO Management Plan	Under Review
Organisational plans reflect EEO	Programs in Progress
Policies and procedures encompass EEO requirements	Implemented and Under Review
Established EEO contact officers	Under Review
Training and staff awareness programs	Implemented
Diversity	Program in Progress

Marketing

Lower Great Southern Health Service did not use any major marketing during 2001/2002.

Publications

Community awareness of the Health Service was achieved through the following activities:

- The *Recreation Directory for seniors in Albany* as part of the Stay on Your Feet Program. The directory provides information on seniors recreation activities and contact details. It is available from the Department of Sport and Recreation, Great Southern Public Health Services, Stay on Your Feet Project Officer.
- *The Diabetes Management Book*. This contains the clinical management guidelines for diabetes and aims to empower patients and increase self-efficacy. It has been translated into Bahasa Malay for use in the Central Great Southern Malay community. Diabetes educators distribute the books.
- *Lower Great Southern Community Health Survey 2000 Overview*. The purpose of this is to present the findings of the Lower Great Southern Community Health Survey to assist health professionals and Health Service management in planning, monitoring and evaluating health priorities and services within the Lower Great Southern region. A copy is available at the Albany Library.

Research and Development

The drink driving research project in the Great Southern was completed in collaboration with NFO Donovan Research.

Several major reports were completed:

- *Tobacco Control: Best Practice Strategies in a Regional Context.*
- *Lower Great Southern Community Health Survey 2000.*
- *Alcohol and tobacco Brief Intervention Project Final Report.*
- *Great Southern FRIENDS Program Final Report.*

Two journal articles were accepted for publication:

- 'Helping Hospitalised Clients Quit Smoking.'
- 'A study of Rural Nursing Practice and Barriers' in the *Australian Journal of Rural Health* (2002).

Evaluations

Evaluations have been held in the following areas:

- The Albany inpatient unit underwent a post-occupancy evaluation resulting in several recommendations to upgrade the facilities to cater for specific activities such as rehabilitation, a quiet area, consulting and administration.
- An extended aged care package is being trialed in the community in response to client and family need, due to lack of aged residential care facilities in Denmark. This has been operating since December 2001 and is currently being evaluated.
- Alcohol and Other Drugs Program Brief Intervention Project.
- Drug and Alcohol Withdrawal Project.

Risk Management

Our Policy

The Lower Great Southern Health Service aims to achieve the best possible practice in the management of all risks that threaten to adversely impact upon the Health Service itself, its patients, staff, assets, functions, objectives, operations, or upon members of the public.

Strategies and Initiatives

The Health Service has adopted a Risk Management Policy. The aim of the policy is to motivate employees to achieve best practice in Risk Management.

The major risks which could impact on the Health Service have been identified with the assistance of RiskCover and a Risk Management Consultant, Stanton Partners. The major risks are identified as:

- Clinical.
- Occupational Safety and Health (Workers Compensation).
- Public Liability (and Directors' and Officers' Liability).
- Personnel.
- Financial.
- Information Technology Management.
- Health Service Estate.
- Business Continuity (major adverse event risk).

A range of strategies has been implemented to manage the identified major risks.

In addition, as a general rule, insurance has been taken out wherever possible to offset the financial impacts of identified risks. These insurance policies are provided by RiskCover and cover buildings, clinical negligence, equipment, directors' and officers' liability, workers compensation and motor vehicles.

Future Direction

The Lower Great Southern Health Service will continue to review its risk management and quality improvement processes in keeping with the above policy.

Internal Audit Controls

The Lower Great Southern Health Service has established a system of internal controls as a means of providing reasonable assurance that assets are safeguarded, proper accounting records are maintained, and financial information is reliable.

An Audit Committee has been established to oversee the operation of internal audit functions and to ensure that management addresses any findings made by the Health Service's internal and external audit. There were no significant audit findings during the year.

Waste Paper Recycling

There is no market in the Lower Great Southern area for recycled paper and so no paper was recycled.

Pricing Policy

The Lower Great Southern Health Service raises a number of fees and charges to recover the estimated cost of providing certain services, except where a public service obligation exists.

A daily bed fee is raised against all patients other than those treated under the public health system. These fees contribute towards the cost of services required to treat patients. The only exception to this is professional medical services, which are provided privately by medical practitioners.

No fees are raised against registered public and private outpatients of the hospital.

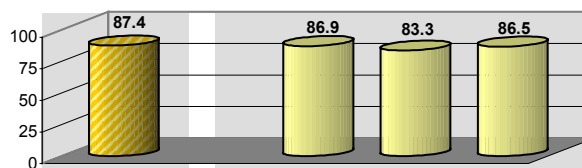
Client Satisfaction Surveys

Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey Questionnaires for various health service client groups with special forms for parents to answer on behalf of their children. The questionnaires have been standardised and have demonstrated valid and reliable results over time.

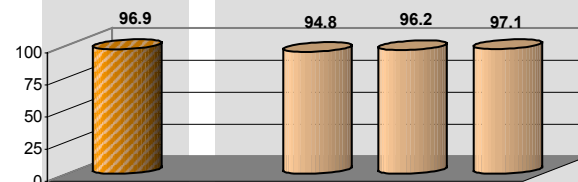
Each year a number of client groups are selected to answer questions about their experiences within the health system. The survey process is managed by the Department of Health with questionnaires being posted to patients during a specified survey period. Details of the responses to individual questions are shown below and audited aggregate results of these surveys are shown in the Key Performance Indicator section (page 49) of this report.

KPI 2.2: SAMEDAY PATIENTS — RURAL

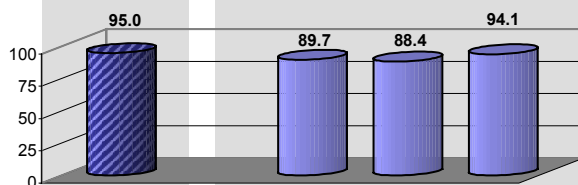
GETTING TO THE HOSPITAL



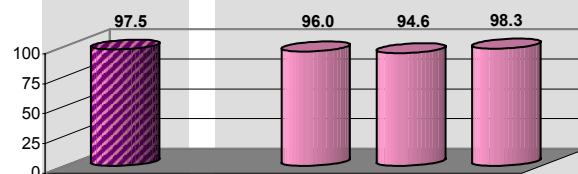
ATTENTION FROM DOCTORS AND NURSING STAFF



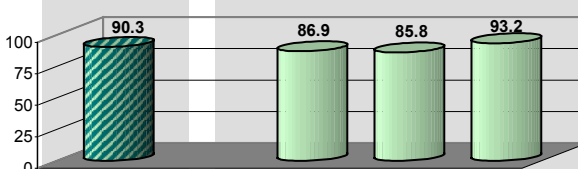
INFORMATION AND COMMUNICATION



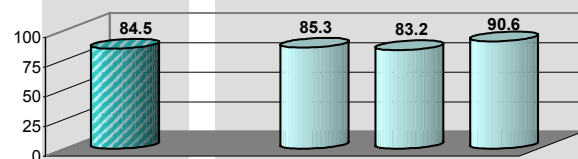
MEETING PERSONAL NEEDS



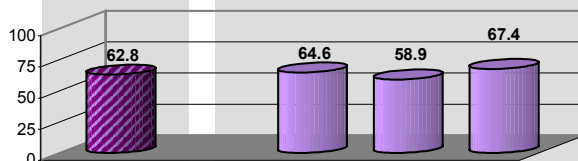
CONTINUITY OF CARE



RESIDENTIAL ASPECTS OF THE HOSPITAL



YOUR RIGHTS AS A PATIENT



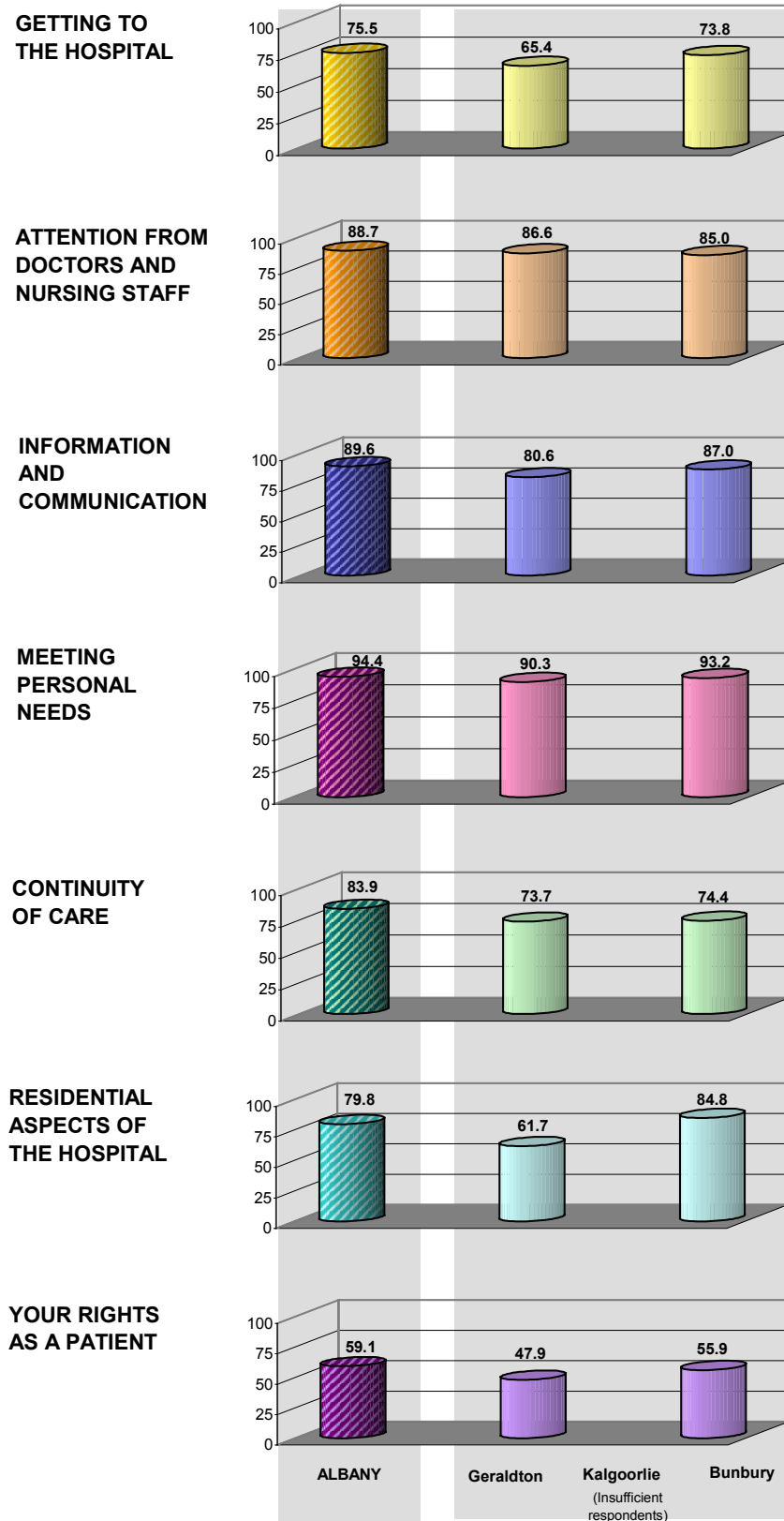
ALBANY

Geraldton

Kalgoorlie

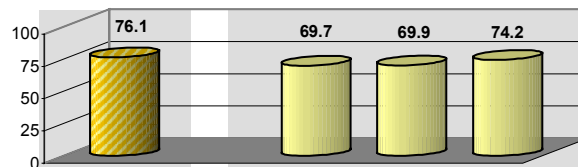
Bunbury

KPI 2.2: EMERGENCY PATIENTS — RURAL

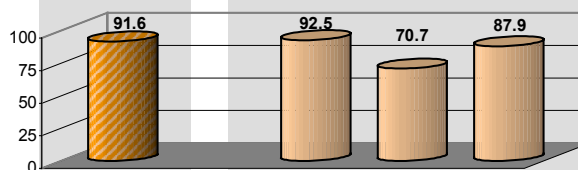


KPI 2.2: OUTPATIENTS — RURAL

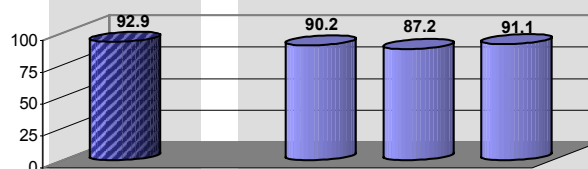
GETTING TO THE HOSPITAL



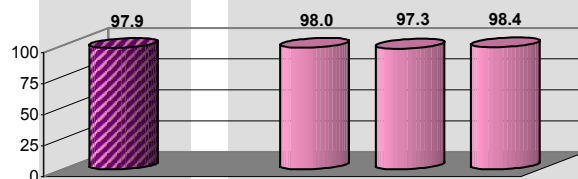
ATTENTION FROM DOCTORS AND NURSING STAFF



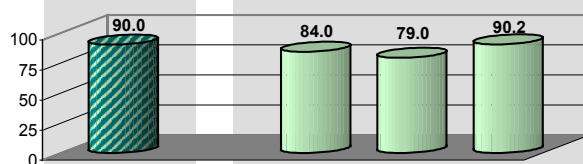
INFORMATION AND COMMUNICATION



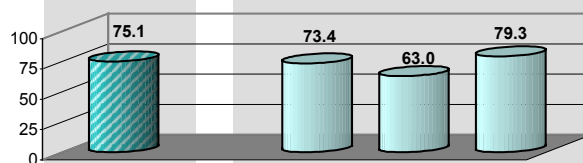
MEETING PERSONAL NEEDS



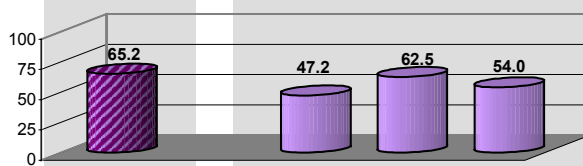
CONTINUITY OF CARE



RESIDENTIAL ASPECTS OF THE HOSPITAL



YOUR RIGHTS AS A PATIENT



ALBANY

Geraldton

Kalgoorlie

Bunbury



AUDITOR GENERAL

To the Parliament of Western Australia

**LOWER GREAT SOUTHERN HEALTH SERVICE BOARD
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002**

Scope

I have audited the key effectiveness and efficiency performance indicators of the Lower Great Southern Health Service Board for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

The Board was responsible for developing and maintaining proper records and systems for preparing and presenting performance indicators. I have conducted an audit of the key performance indicators in order to express an opinion on them to the Parliament as required by the Act. The key performance indicators reflect the progress made to date as part of the staged process to develop more enhanced measurement of the performance of the Lower Great Southern Health Service Board.

My audit was performed in accordance with section 79 of the Act to form an opinion based on a reasonable level of assurance. The audit procedures included examining, on a test basis, evidence supporting the amounts and other disclosures in the performance indicators, and assessing the relevance and appropriateness of the performance indicators in assisting users to assess the Health Service's performance. These procedures have been undertaken to form an opinion as to whether, in all material respects, the performance indicators are relevant and appropriate having regard to their purpose and fairly represent the indicated performance.

The audit opinion expressed below has been formed on the above basis taking into account the ongoing development of the key performance indicators.

Audit Opinion

In my opinion, the key effectiveness and efficiency performance indicators of the Lower Great Southern Health Service Board are relevant and appropriate for assisting users to assess the Health Service's performance and fairly represent the indicated performance for the year ended June 30, 2002.

D D R PEARSON
AUDITOR GENERAL
March 7, 2003



AUDITOR GENERAL

INTERIM REPORT

To the Parliament of Western Australia

LOWER GREAT SOUTHERN HEALTH SERVICE

Under the provisions of section 94 of the Financial Administration and Audit Act 1985, I advise that it will not be possible to complete the audit of the financial statements and performance indicators of the Lower Great Southern Health Service for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Lower Great Southern Health Service an extension to October 14, 2002 to prepare and submit performance indicators, my Office did not receive these until November 29, 2002. The indicators submitted were not of an appropriate standard and were returned for further revision. These were resubmitted to my Office on January 28, 2003 in a form adequate to enable my staff and audit contractors to undertake audit testing against the supporting documentation held at the Health Service site. Audit testing and a review of the results of that work is currently in course to enable the forming of an audit opinion.

It is anticipated that the opinions will be issued by March 31, 2003.

D D R PEARSON
AUDITOR GENERAL
February 28, 2003

Performance Indicators Certification Statement

LOWER GREAT SOUTHERN HEALTH SERVICE CERTIFICATION OF PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2002

I hereby certify that the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Lower Great Southern Health Service and fairly represent the performance of the Health Service for the financial year ending 30 June 2002.



Mike Daube
ACCOUNTABLE AUTHORITY
Director General of Health

November 2002

Key Performance Indicators

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Background

The Performance Indicators reported in the following pages address the extent to which the strategies and activities of the Health Service have contributed to the required health outcomes and outputs, viz.,

OUTCOME 1 - Improvement in health by a reduction in the incidence of preventable disease, injury, disability, premature death and the extent and impact of drug abuse.

Output 1 - Prevention and promotion services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability, premature death and the extent and impact of drug abuse.

OUTCOME 2 - Restoration of the health of people with acute illness.

Output 2 - Diagnosis and treatment services aim to improve the health of Western Australians by restoring the health of people with acute illness.

OUTCOME 3 - Improvement in the quality of life for people with chronic illness and disability.

Output 3 - Continuing care services are provided to improve the quality of life for those who need continuing care.

The different service activities, which relate to the components of the outcome, are outlined below.

Output 1: Prevention and Promotion

- Community and Public health services
- Mental health services
- Drug abuse strategy coordination, treatment and prevention services

Output 2: Diagnosis and Treatment

- Hospital services (emergency, outpatient & in-patient)
- Nursing posts
- Community health services (post discharge care)
- Mental health services

Output 3: Continuing Care

- Services for frail aged and disabled people (eg, Aged Care Assessments, in-patient respite, outpatient services for chronic pain and disability, Nursing Home Type hospital care)
- Services for the terminally ill (eg, in-patient palliative care)
- Mental health services

There are some services, such as Community Health, which address all three of the outputs. Current information systems do not easily allow the distinction to be made between the three and this is therefore an important area for future development. To assure consistency in reporting and evaluation the Health Service has, during the year, continued to develop clear guidelines for the collection and interpretation of data for performance reporting. Whilst steps have been taken to minimise inconsistencies, some still exist.

General Approach

One of the aims of the Health Service has been to deliver activity, equitably distributed to, and accessible by, all sectors of the community.

For most of those performance indicators of health service delivery which target the

- reduction of the incidence of preventable disease, injury, disability and premature death and
 - the improvement of the quality of life of people with chronic illness and disability,
- the graphs used indicate performance for those who live in each catchment area irrespective of where service is provided and whether service is delivered in private or public hospitals.

For most services restoring the health of those with acute illness, performance is graphed according to where the service has been provided, irrespective of where people live and only includes service delivered by the public sector.

The indicators for these intervention strategies are the first step in a staged process leading to more comprehensive and meaningful measurement and reporting of performance in the above. Further indicators are being developed to assist in measurement, management and reporting.

Comparative Results

In certain cases results for other Health Services are assessed as being helpful in illustrating the performance of the Health Service being principally reported, ie the subject matter of the Report.

In the labelling of graphs, the technique has been used in which the results of the principally reported Health Service is always placed first (on the left), using UPPER CASE lettering.

After leaving a space, those results for comparative Health Services are shown to the right of this and use Lower Case identification to differentiate clearly between principal and comparative Health Services.

Output Measures

The four output measures are of quantity, quality, timeliness and cost. These are direct measures of performance, but are not to be confused with Key Performance Indicators of Efficiency and Effectiveness.

Quantity measures describe outputs in terms of how much, or how many are performed and require a unit of measurement to be defined.

Quality measures usually reflect service standards based on customer needs. The dimensions of quality as an output measure include: accuracy; completeness; accessibility; continuity; and a customer acceptability of the output.

Timeliness measures provide parameters for how often, or within what time frame, outputs will be produced.

Cost measures reflect the full accrual cost to an agency of producing each output.

Hospitals and Health Services are required to report output measures of quantity, quality, timeliness and cost together with a comparison between actual and target performance.

Assessing the Performance of the Health Service

It is not only the KPIs and Output Measures which readers of this report should examine when assessing the performance of the Health Service. The Key Performance Indicators, Financial Statements and Hospitals/Health Services reports, all provide information relevant to assessment of Health Service performance for 2001/02.

Glossary of Terms

Performance Indicator – *information about output performance or outcome achievement, usually expressed as a unit, index or ratio.*

Efficiency Indicator – *a performance indicator that relates an output to the level of resource input required to produce it.*

Effectiveness Indicator – *a performance indicator which provides information on the extent to which a government desired outcome has been achieved through the funding and production of an agreed output.*

MEDIAN WAITING TIMES FOR COMMUNITY AND ALLIED HEALTH SERVICES (HOSPITAL AND COMMUNITY BASED)

KPI 1.1

Timely and easy access to health services is effective in reducing the incidence of preventable diseases and premature death by providing clinically appropriate treatment of illness and injury.

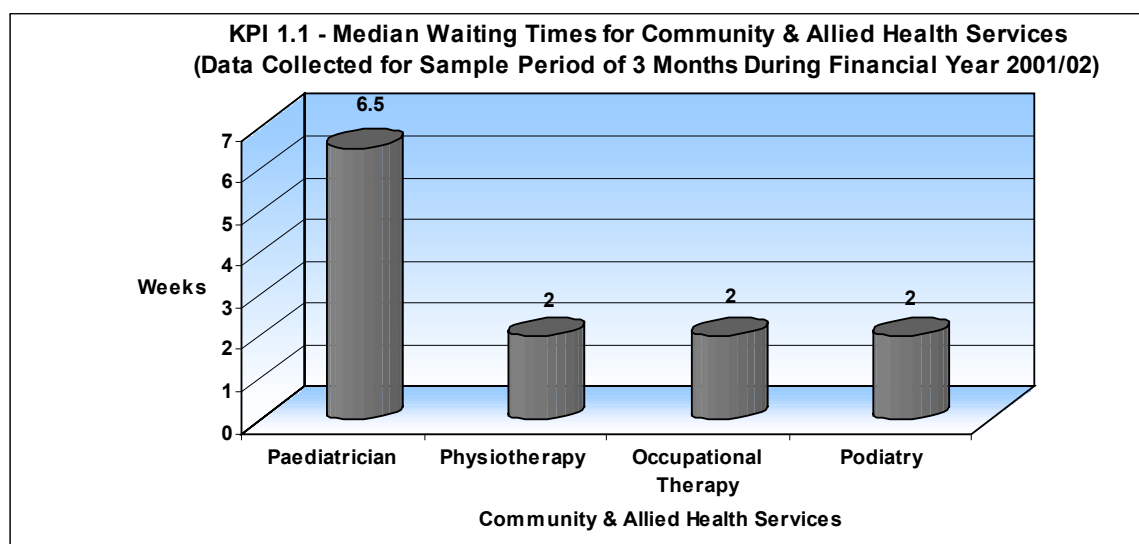
Access to health services are provided on the basis of clinical need but situations where clients are waiting longer than the average may reflect sub-optimal practices or under-resourcing within the organisation.

This indicator measures the median (middlemost) waiting time in weeks that clients waited from the date of referral or initial presentation for their first occasion of service. It must be noted that the time waiting for first available appointment in each of the specialties may differ. This indicator highlights different waiting times for different specialties.

Availability of practitioners for rural Health Services vary significantly from year to year and are in some situations available for some parts of the year and not able to be provided continuously; all of which make comparisons from one year to another of limited value.

Different Health Services for which peer comparisons are appropriate for other Output 1 Indicators operate such a different range and mix of clinics that comparisons here are of limited value.

The waiting times are considered appropriate given the available resources.



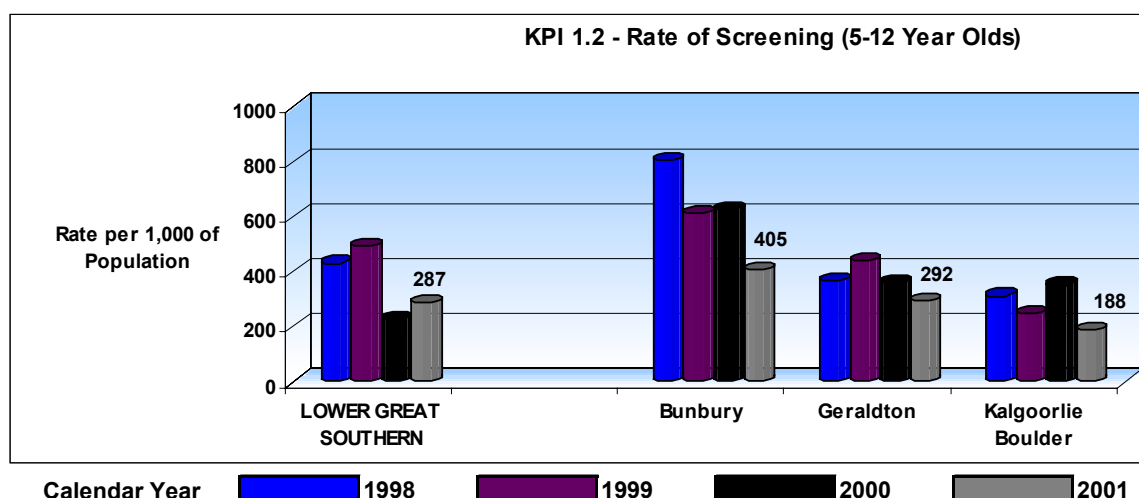
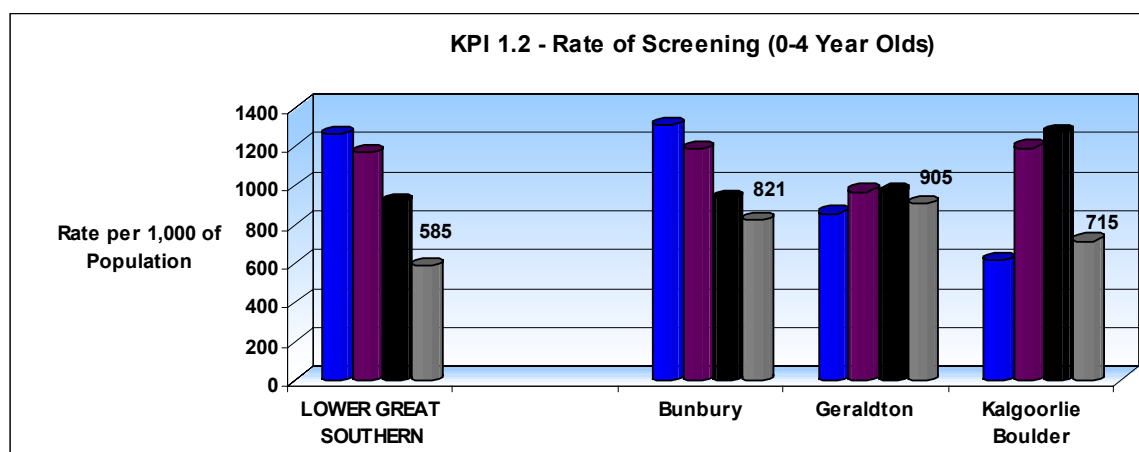
RATE OF SCREENING IN CHILDREN

KPI 1.2

The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good health when they become ill, but also help to maintain a state of 'wellness' that allows them to develop to their full potential. The State promotes a program of health monitoring at specific intervals in the period from birth to adolescence in accordance with the National Health and Medical Research Council's (NH&MRC) Minimum Screening Schedule.

The consequences of any illness or disability not detected by routine screening programs for children are more likely to be permanently disabling or even contribute to their premature death. This indicator measures the rate of NH&MRC screening, by 0-4 and 5-12 year age groups of the resident child population in the catchment for the health service.

Note: A rate in excess of 1,000 per thousand can occur due to the same child attending more than once a year.



RATE OF CHILDHOOD IMMUNISATION

KPI 1.5

Vaccine preventable diseases are associated with considerable morbidity and mortality, and vaccination is effective in reducing the incidence of these diseases in the community. Through this adoption of the National Immunisation Schedule, health system effectiveness in providing vaccination coverage at key milestones (12 and 24 months of age) can be assessed.

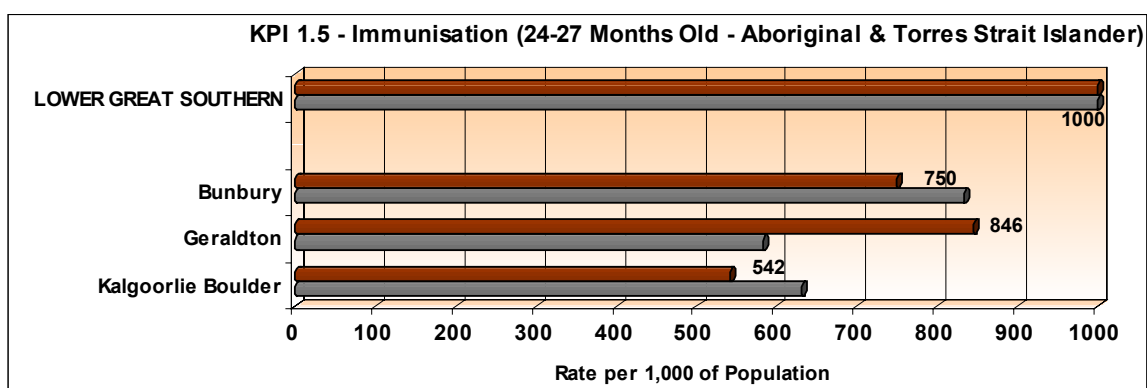
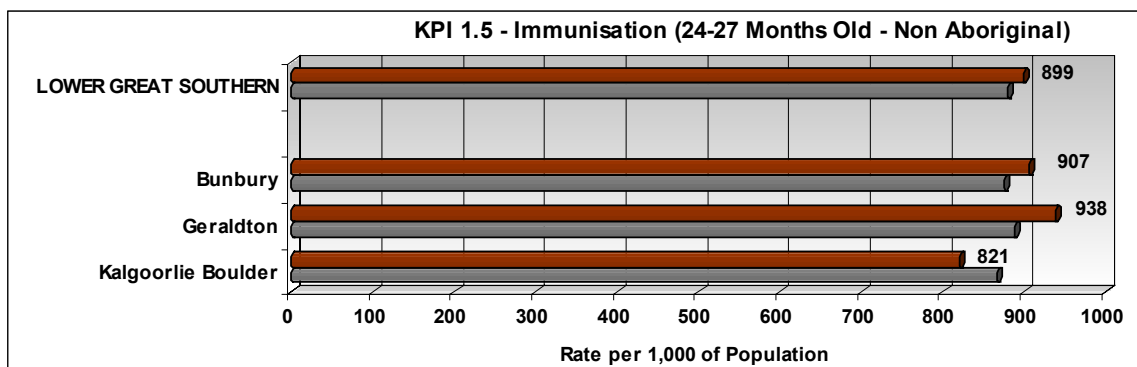
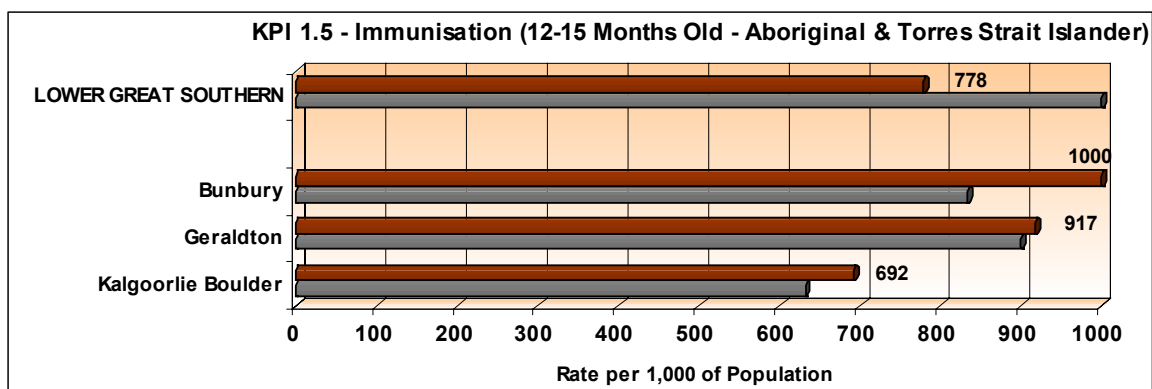
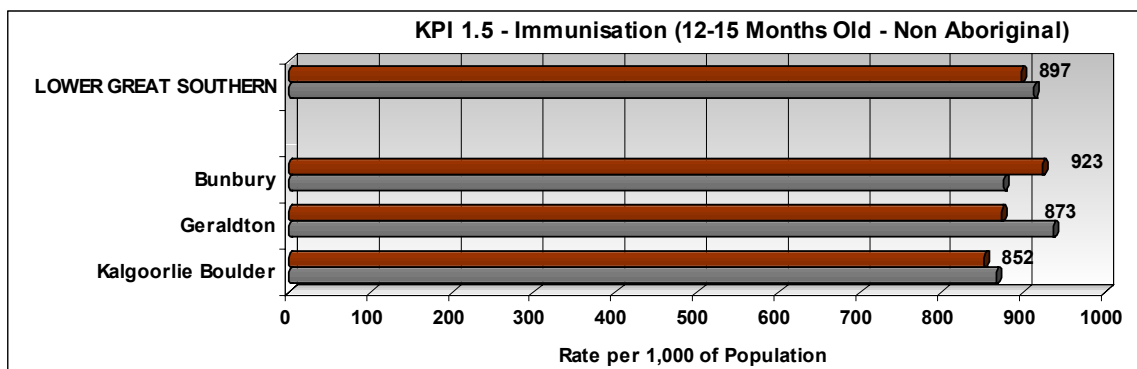
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the children shown even up to the calendar year 2002. The data shown for calendar year 2002 is from the first six months of the 2001/02 financial year and is therefore appropriate for this Report.

Key Performance Indicators



Calendar Year

2001

2002

RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE

KPI 1.13

The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill but also to maintain a state of 'wellness' that allows them to develop to full potential.

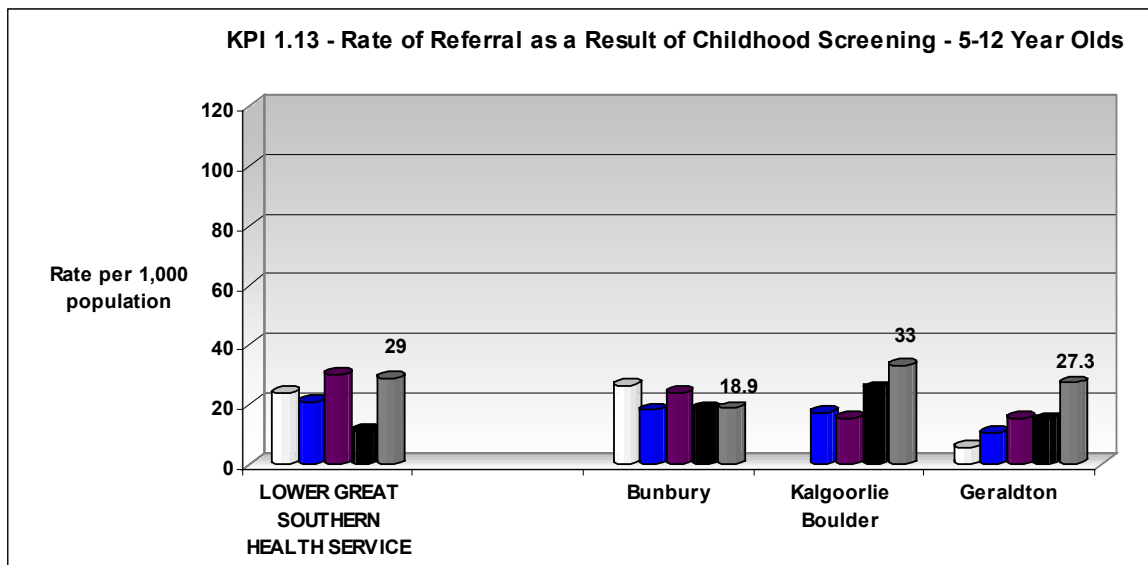
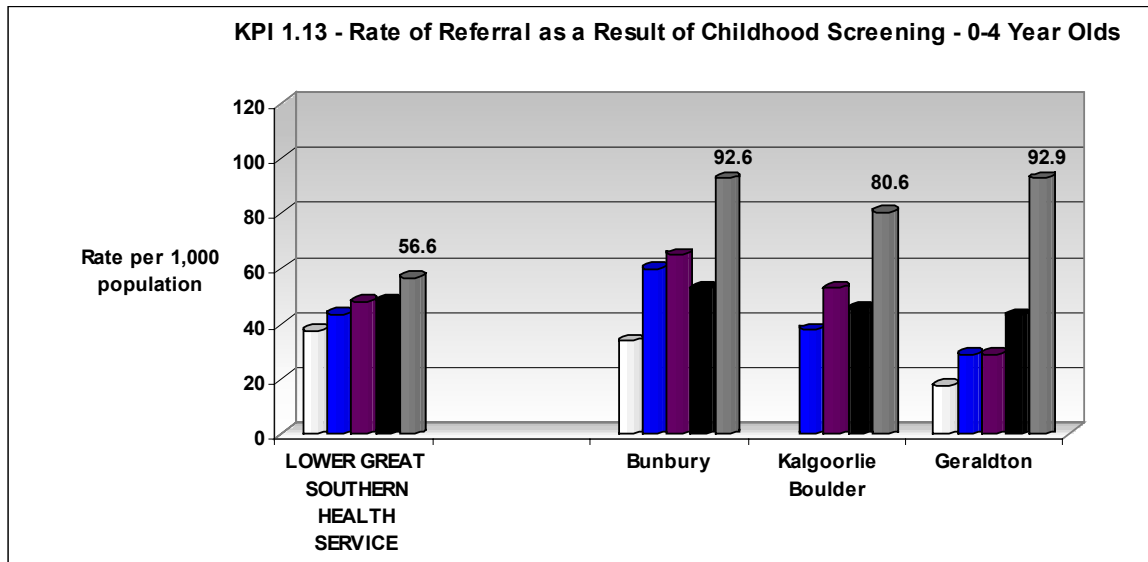
The State promotes a program of health monitoring at specific intervals in the period from birth to adolescence in accordance with the National Health and Medical Research Council's (NH&MRC) Minimum Screening Schedule. This program includes appropriate referral for children needing further assessment and treatment. Timely referral can improve health outcomes for children in preventing disease or disability in later years.

This indicator measures the rate of referral after NH&MRC screening, by 0-4 and 5-12 year age groups of the resident child population in the catchment for the health service.

Changes in rate of referral is reflective of changed screening practices to focus on those most at risk.

Key Performance Indicators

The increased rates of referral are a result of improved identification of high risk children through better focus of resources using the Best Beginning program and the location of a child health nurse with the Family Futures Program.



Calendar Year
1997 1998 1999 2000 2001

RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE

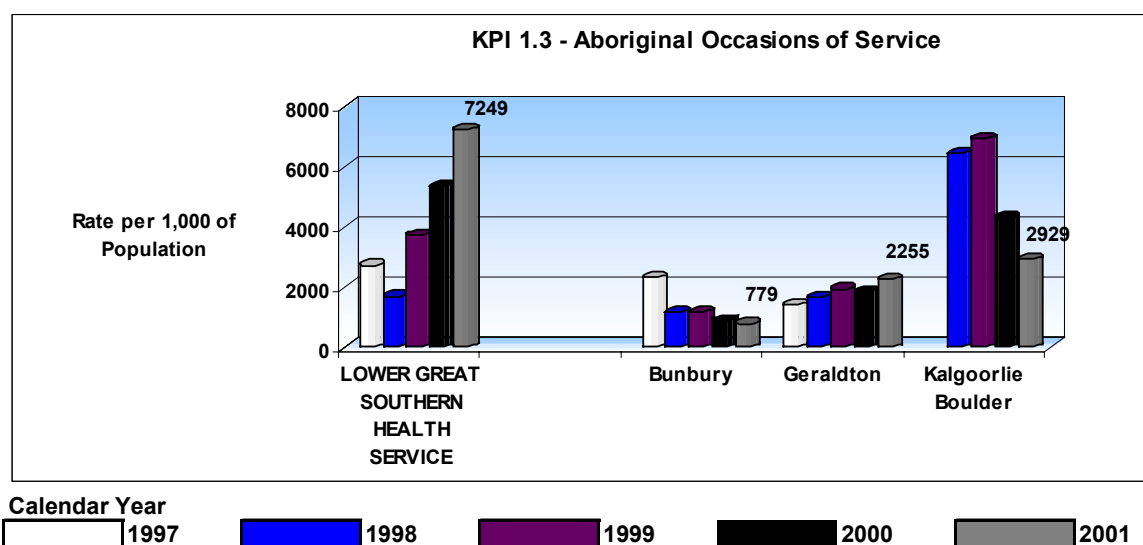
KPI 1.3

The lower level of health experienced by Aboriginal people has been of ongoing concern not just to the local community but to the world at large. National and State policies focus attention and resources on the area in an attempt to bring the health of Aboriginal people to a state that is comparable to the rest of Australia.

It is assumed that with poorer health, Aboriginal people will need to access health services at least as frequently as non-Aboriginal people. However, it must be noted that cultural differences which make them reluctant or unable to access available services and the inconsistent reporting of Aboriginality could mean that the number of services credited to the population may display inconsistent patterns.

A rate in excess of 1,000 will occur due to individuals visiting more than once in a year.

The rates of service provision to Aboriginal people have increased due to the establishment of specific targeted services.



HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS

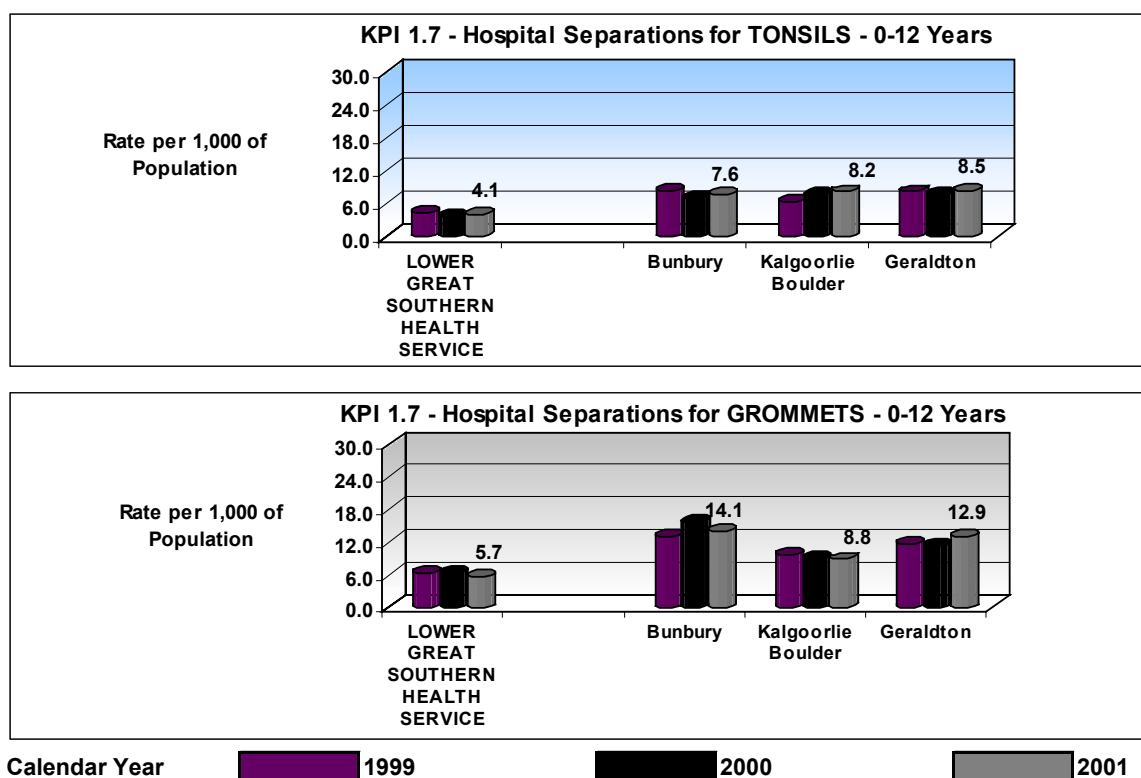
KPI 1.7

Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

Successful management and treatment of children with chronic infections by community health staff could be anticipated to reduce the level of surgical intervention. As the success of this intervention program cannot be measured directly, an indirect measure of its success can be estimated by determining the rate of hospitalisation for these procedures.

Comparison of the rate of hospitalisation for tonsillectomies and grommet insertions with other comparable areas can help identify those areas where improvements in primary care could be necessary.

Both of the conditions for which these procedures are performed, are ones which have a high number of patients treated either in hospital or the community. It would be expected that hospital admissions would decrease as performances and quality of service in the many different health areas increases.



HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN

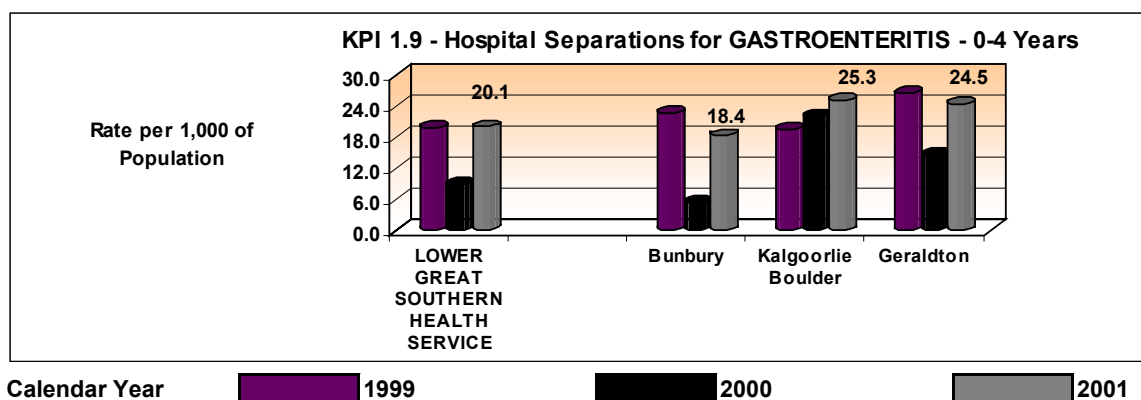
KPI 1.9

Public health and environmental health programs are aimed at maintaining safe water and sewerage disposal systems, and establishing and enforcing effective food processing and handling practices.

Effective delivery of these programs reduces the rate of transmissible disease like gastroenteritis, of which severe cases can result in hospitalisation.

An indirect measure of the success of community and public health prevention strategies is the rate of hospitalisation due to gastroenteritis. Improved primary management will reflect a decrease in the number of admissions for this condition.

Comparison of the rate of hospitalisation for gastroenteritis with other comparable areas can help identify those areas where improvements in primary care could be necessary.



HOSPITAL SEPARATIONS FOR RESPIRATORY CONDITIONS

KPI 1.10

Respiratory illness is one of the most common reasons for hospital admission in children and young adults. Improved primary health and community health strategies, such as health monitoring, education and risk prevention can assist in reducing the incidence and prevalence of conditions such as acute asthma, acute bronchitis, bronchiolitis and croup.

Improved primary management will reflect a decrease in the number of admissions for these conditions. Comparison of the rate of hospitalisation for respiratory illness with other comparable areas can help identify those areas where improvements in primary care could be necessary.

Bronchiolitis

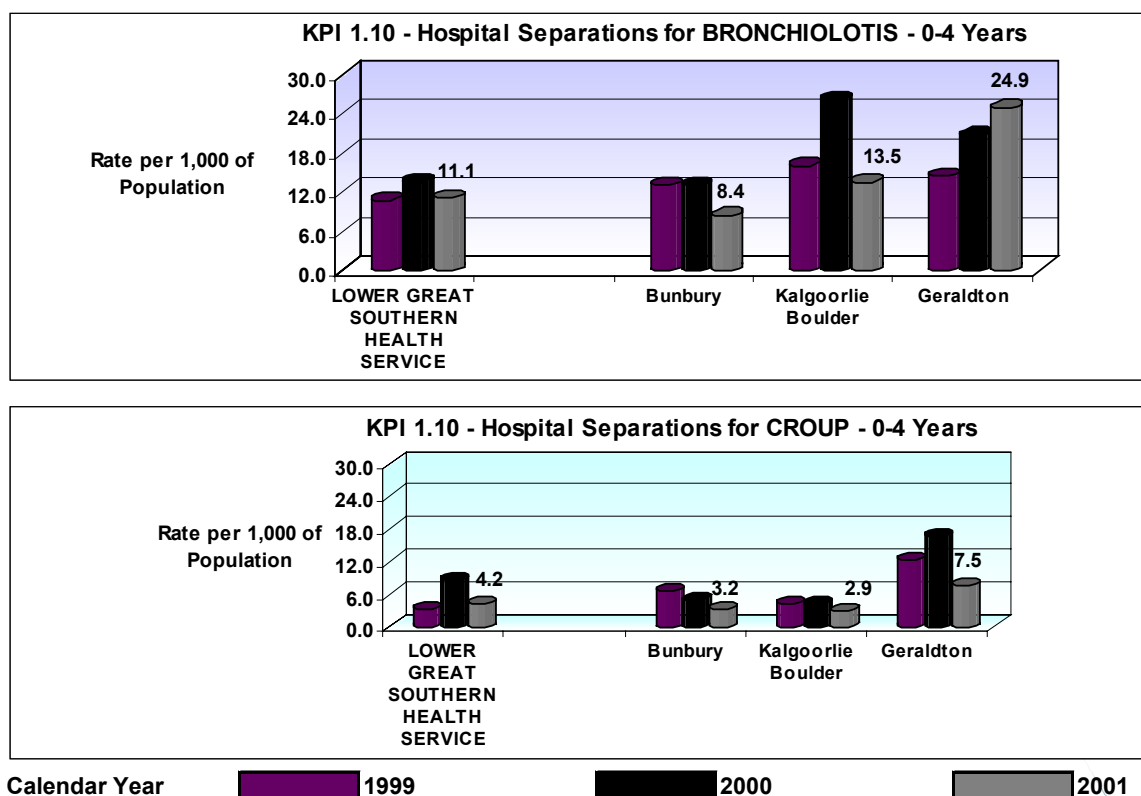
The graph shows individuals aged 0-4. Of those individuals aged 5-12, only two were hospitalised this year, a rate of 0.4 per thousand and of those individuals aged 13-18, none were hospitalised.

Croup

The graph shows individuals aged 0-4. Of those individuals aged 5-12, 6 were hospitalised this year, a rate of 1.1 per thousand and of those aged 13-18, none were hospitalised.

Acute Bronchitis

Only 2 individuals aged 0-4 at a rate of 0.7 per thousand were hospitalised this year, with no individuals being admitted aged 5-12 or 13-18.



HOSPITAL ADMISSIONS FOR ASTHMA

KPI 3.7

Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

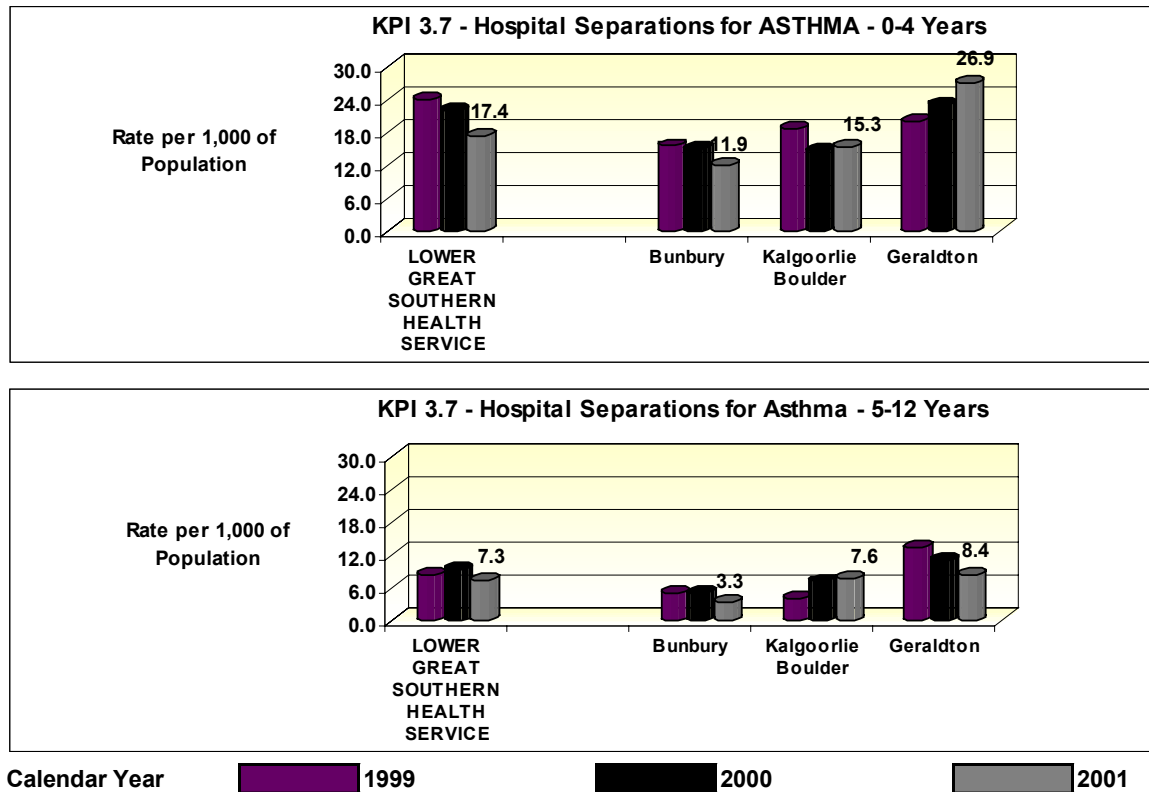
The number of patients who are admitted to hospital per 1,000 population for treatment of Asthma may be an indication of improved primary care or community health strategies - for example, health education.

It is important to note however, that other factors - such as allergic and climatic responses for example - may influence the number of people hospitalised with Asthma. This condition is one which has a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for Asthma may decrease as performance and quality of service increases thus indicating an improvement in the quality of life of people with a chronic illness.

The graphs show individuals aged 0-4 and 5-12. 25 individuals aged 13-18 at a rate of 6.5 per thousand were hospitalised this year, with 20 individuals being admitted aged 19-34 at a rate of 2.6 per thousand and 45 individuals aged 35 years and over at a rate of 1.9 per thousand.

Key Performance Indicators

Most notable in the period under review is the improvement in the separation rate for children aged 0-4 and 5-12 indicative of the effectiveness of the asthma program in the district.



COST PER OCCASION OF SERVICE OF COMMUNITY HEALTH SERVICE

KPI 1.14

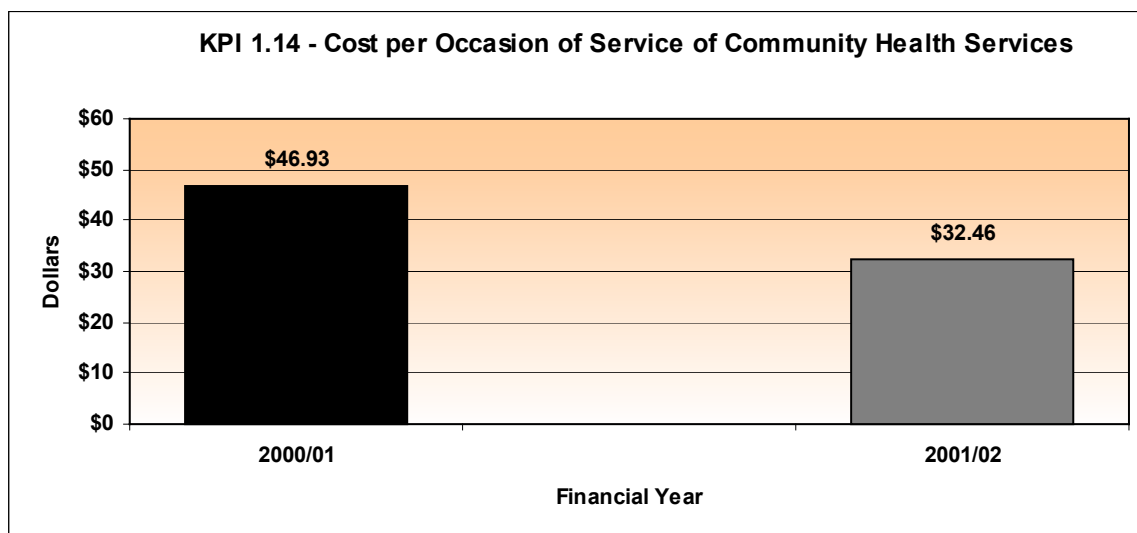
Community health occasions of service measure the provision of primary and community health services undertaken by a range of health service professionals in a community setting, with a focus on improving the overall health of the State population. Child health nursing, clinical psychology, occupational and speech therapy are some examples of the types of community-based services provided under this Indicator. It provides a measure of, on average, how cost effective these activities are over time.

A wide range of interventions by practitioners from many specialties are used, singularly and in combination, to effect changes in the health of individuals, their families and their communities. These interventions are quantified as occasions of service but can cover a wide range of services in terms of time and complexity.

This indicator measures the average cost of an occasion of service for the particular use of programs that each health service provides. Given what has been said above, it is only useful for broad comparisons of trends and must be considered in conjunction with an understanding of current program delivery priorities.

NOTE:

- This is the first year that this indicator has been reported. It is expected that over time the collection of Community Health data and the reporting of this indicator will become more refined.
- The figures used to calculate the cost per community occasion of service were based on 6 months (July to December 2001) expenditure and activity data.



CLIENT SATISFACTION

KPI 2.2

This indicator is a measurement of how clients have rated the personal care and the way services are provided by hospitals and other health services.

Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if patients' perception of health service provision are favourable they will be more likely to seek timely help, assistance or treatment.

The Lower Great Southern Health Service reports an overall satisfaction score of 88 for same-day patients, 82 for emergency patients and 84 for outpatients for this financial year with standard errors of 0.81, 1.16 and 1.55 respectively on a 95% confidence interval. The estimated populations of individuals surveyed were 1126 Same-Day patients, 14703 Emergency Services patients and 4703 Outpatients.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	NUMBER SENT	NUMBER RETURNED	RESPONSE RATE
Same-day Patients	184	93	51%
Same-day Patients – Mode of Administration Data	65	56	86%
Emergency Patients – Hospital Administered	391	130	33%
Outpatients - Hospital Administered	244	82	34%

ELECTIVE SURGERY WAITING TIMES FOR PUBLIC PATIENTS

KPI 2.14

Access to health services must be provided on the basis of clinical need and if an organisation has large numbers of patients waiting for long periods of time for elective surgery, this may reflect sub-optimal practices, the non-availability of specialist staff or a lack of resources.

All patients who are referred for elective surgery must be classified by senior medical staff into one of the three following admission categories:

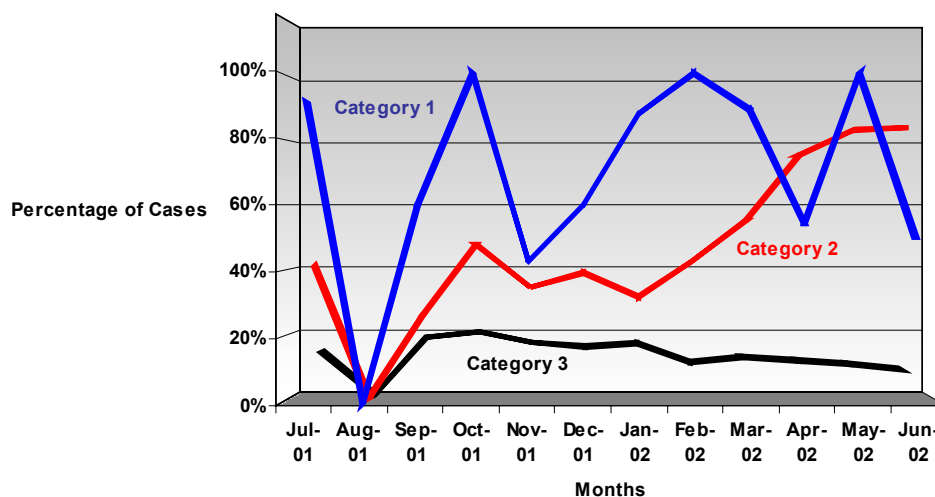
Category 1	Urgent	Admission desired within 30 days
Category 2	Semi-Urgent	Admission desired within 90 days
Category 3	Routine	Admission desirable within 365 days

This indicator measures the percentage of cases on an elective surgery waiting list which were not admitted within the appropriate time frame based on an assessment of their clinical need.

The visiting frequency of some surgeons results in fluctuating rates and the high number of people waiting for surgery in category 3.

Note: No data was available for 31 August 2001

KPI 2.14 - Elective Surgery Waiting Times for Public Patients



EMERGENCY DEPARTMENT WAITING TIMES

KPI 2.18

Access to health services must be provided on the basis of clinical need and if a hospital has large numbers of patients waiting longer than the accepted standards, or transfers a significant percentage of those patients to another facility, it may be that there are “gaps” in its ability to provide emergency services. This may reflect sub-optimal practices, under-resourcing and/or poor recognition of the need for hospital and community services.

In smaller rural communities in Western Australia, medical services are predominantly provided by solo or small group medical practices. In these areas standards for availability and provision of services applicable to larger towns and cities may not be met due to the heavy demand for services and due to periods of time when the GP is not in the town.

Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

When patients first enter an Emergency Department, they are assessed by nursing staff and allocated a triage code between 1 and 5 that indicates their urgency. This code provides an indication of how quickly patients should be reviewed by medical staff. In rural areas however, where a medical practitioner is not available (eg; GP out of town etc), timely review by Nursing staff should be measured (and clearly documented in the explanatory notes).

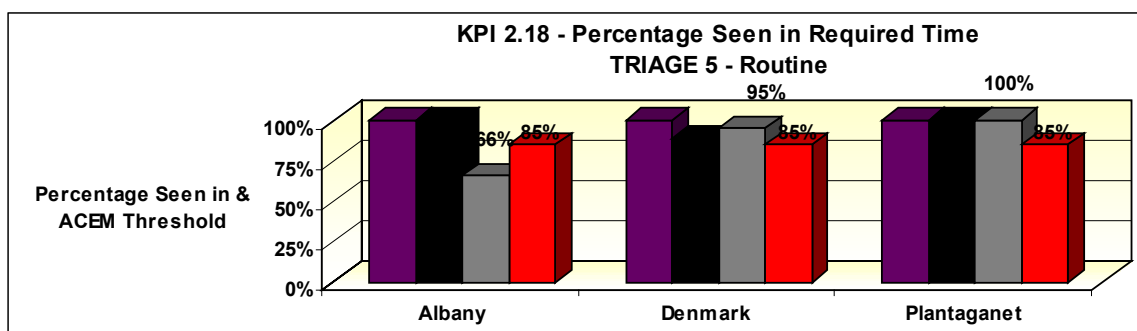
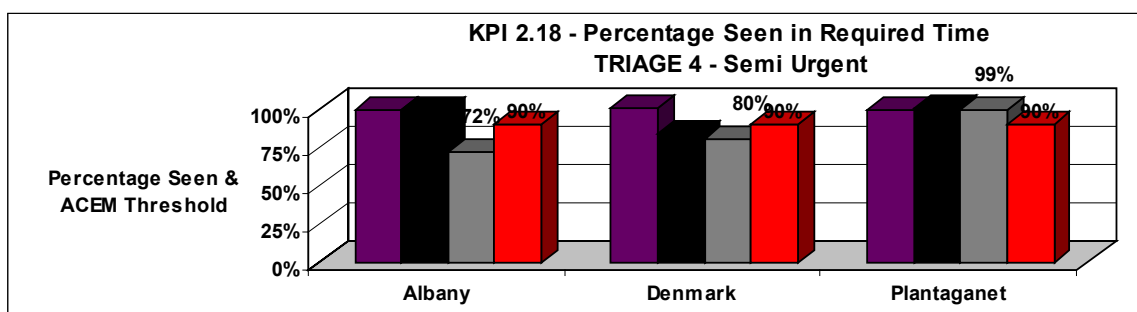
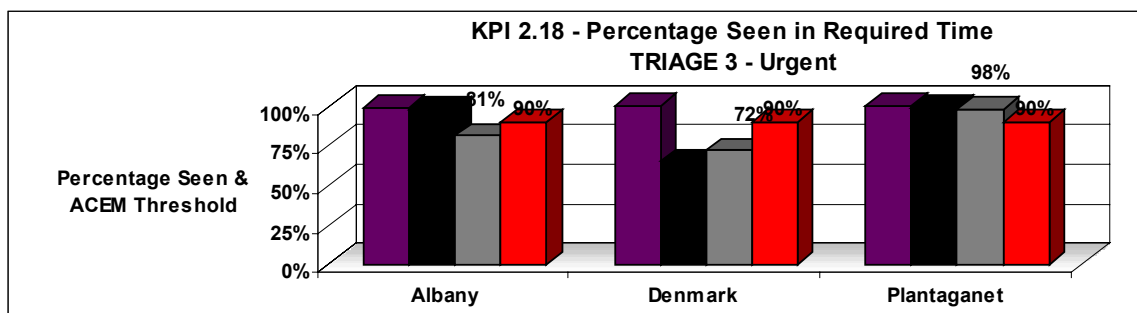
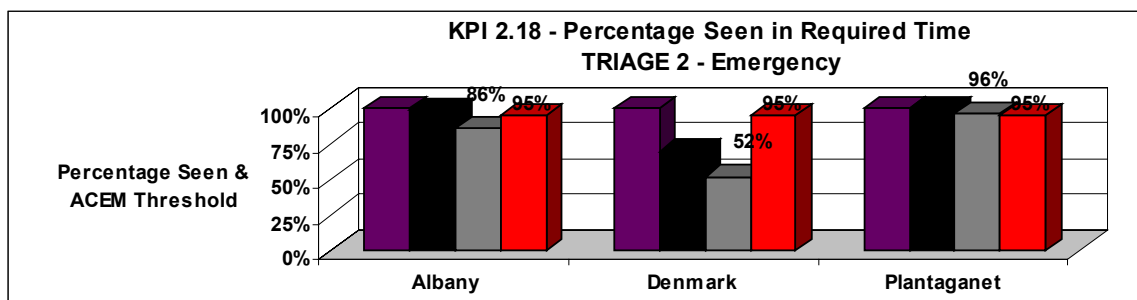
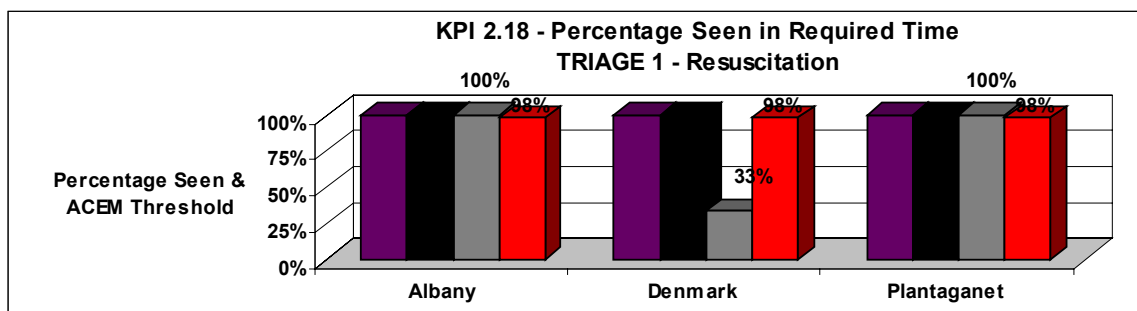
Data relevant to this indicator should be linked to data on the transfer of patients to other health care units, for example, larger hospitals and tertiary metropolitan centres.

This indicator assesses what percentage of patients in each triage category were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) – in rural areas, this may include for example, telephone advice given by GP.

TRIAGE CATEGORY	TYPE OF PATIENT	REQUIRED TIME TO BE FIRST SEEN (By Practitioner)	ACEM THRESHOLD FOR PERCENTAGE SEEN WITHIN REQUIRED TIME
Triage 1	Resuscitation	Immediately	98%
Triage 2	Emergency	Within 10 Minutes	95%
Triage 3	Urgent	Within 30 Minutes	90%
Triage 4	Semi-Urgent	Within 60 Minutes	90%
Triage 5	Non-Urgent	Within 120 Minutes	85%

Despite below threshold performance in some areas for doctor attendance, active intervention is being undertaken by trained and experienced nursing staff in accordance with treatment protocols.

Key Performance Indicators



Financial Year

1999/00

2000/01

2001/02

ACEM Threshold Percentage of Each Triage Category

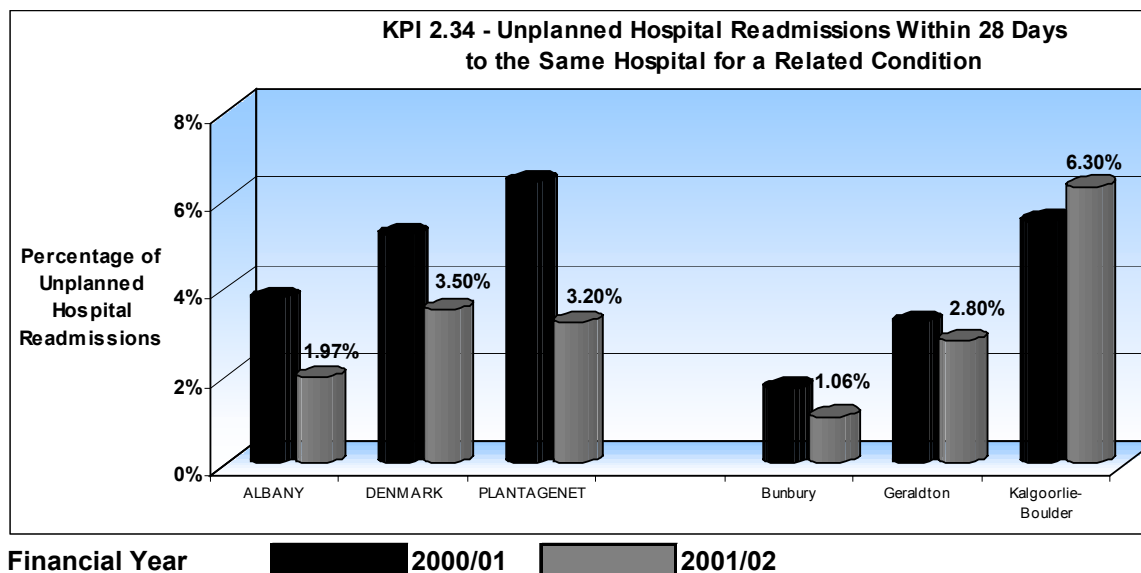
UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR A RELATED CONDITION

KPI 2.34

Good medical and/or surgical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

A low unplanned readmission rate suggests that good clinical practice is in operation. Although there are some conditions which may require numerous admissions to enable the best level of care to be given, in most of these cases readmission to hospital would be planned.

Results this year show significant improvement over previous year's results.



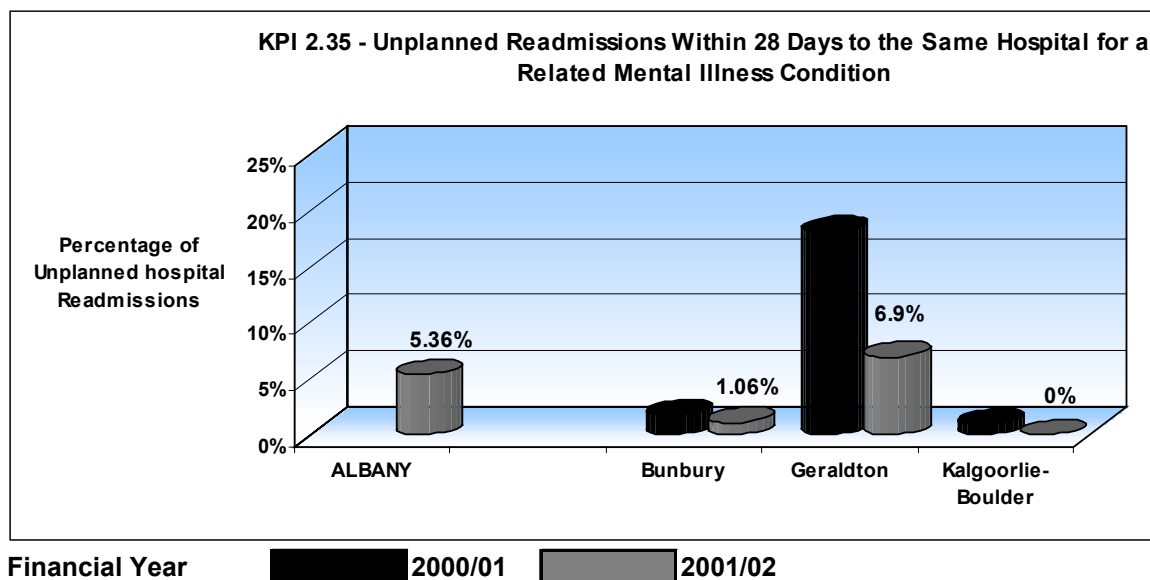
UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR TREATMENT AND CARE FOR A RELATED MENTAL HEALTH ILLNESS

KPI 2.35

Readmissions to hospital within 28 days is an indicator of the effectiveness of hospital treatment and discharge planning, but may also reflect post-discharge treatment and care. The treatment and care needs of different age groups may be quite different. Readmission rates for these different age groups may provide a measure of the effectiveness of services in addressing these needs.

A low unplanned readmission rate suggests that good clinical practice is in operation. Although there are some conditions, which may require numerous admissions to enable the best level of care to be given, in most of these cases readmission to hospital would be planned.

No comparative year data is available for this performance indicator.



POST-OPERATIVE PULMONARY EMBOLISMS

KPI 2.38

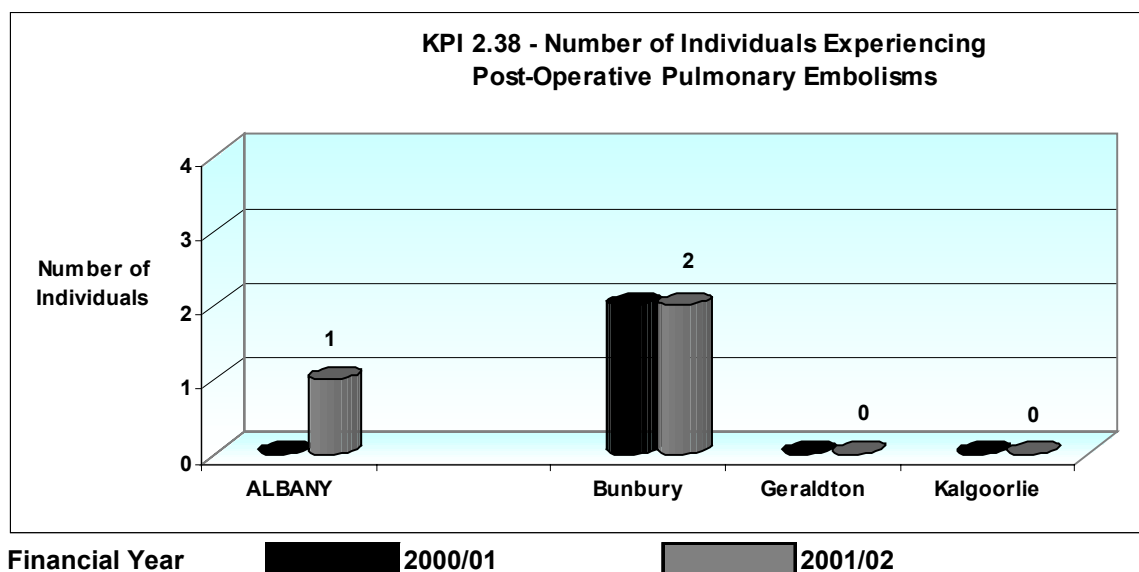
Patients post-operatively can develop a blood clot in the deep veins of the leg. This can travel to the lungs and cause circulatory problems. This is known as a Pulmonary Embolism. This is the main preventable cause of death in fit people undergoing elective surgery.

Hospital staff can take special precautions to decrease the risk of this happening. A low percentage of cases developing Pulmonary Embolism post-operatively suggests that the appropriate precautions have been taken.

This indicator measures the percentage rate of patients who underwent surgery and subsequently developed pulmonary embolism. By monitoring the incidence of post-operative Pulmonary Embolism occurring, a hospital can ensure clinical protocols which minimise such risks are in place and are working.

The monitoring of post-operative complications is important in ensuring the optimum recovery rate for people with acute illness.

The results show only one case of post operative pulmonary embolism in a relatively small number of sample cases and it is therefore not statistically significant.



AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS

KPI 2.71

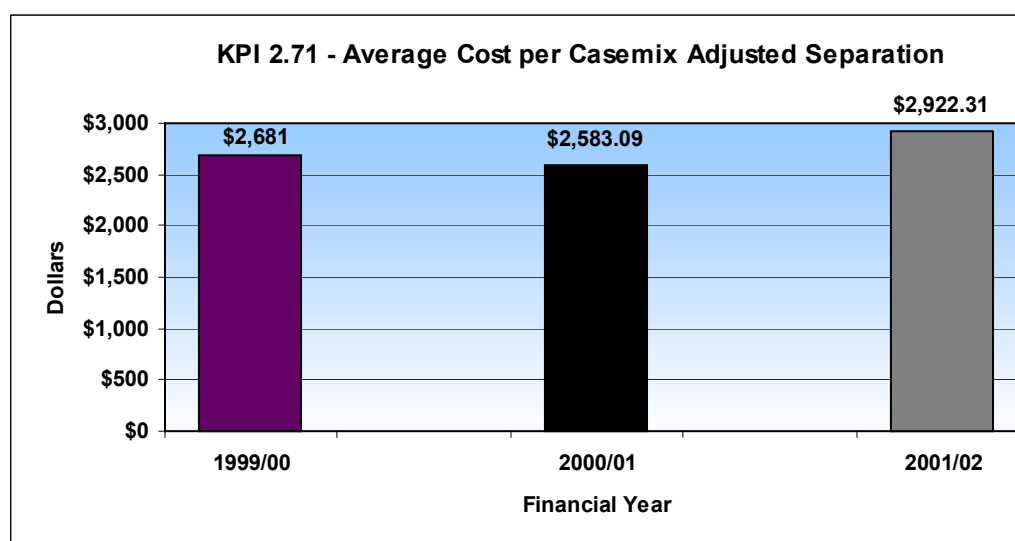
The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provision and the use of resources. Hence the number of separations in a hospital may be adjusted from an actual number of 50,000 to 60,000 by a casemix index of 1.2 to reflect that very complex services have been provided. In Australia, hospitals utilise the Australian Diagnostic Related Groups (AN-DRGs) Version 4.2 to which cost weights are allocated. In Western Australia, cost weight allocations utilise scaled central episodes.

The use of a casemix index together with expenditure data allows a reasonable comparison between hospitals on the efficient use of resources in providing inpatient services.

This indicator measures the average cost of a casemix-adjusted separation.

The average cost per case-mix adjusted separation is an average of Albany, Denmark and Plantagenet hospital's performance.

Increased cost due to employee award increases, staff increases in mental health and the multi-purpose service, hospital relocation and palliative care services. In addition the capital user charge has been incorrectly applied to operating costs.



AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE

KPI 2.86

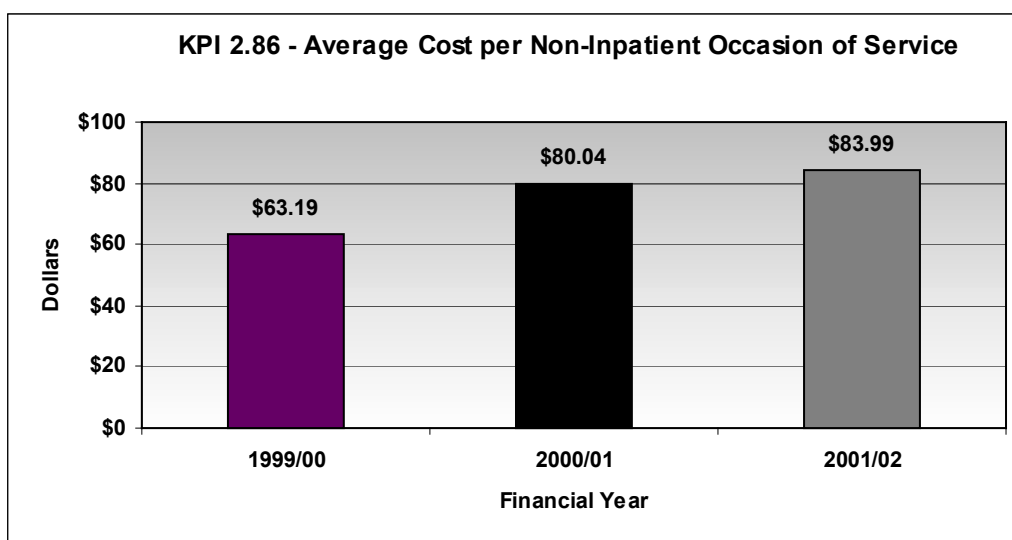
The effective use of hospital resources can help minimise the overall costs of providing health care or can provide for more patients to be treated for the same cost.

Excessive costs in providing non-inpatient services compared to other hospitals may indicate the inefficient use of resources.

This indicator measures the average cost per non-inpatient occasion of service.

Costs have increased due to employee award increases. The capital user charge has also been incorrectly applied to operating costs.

The average cost per non-inpatient occasion of service is an average of Albany, Denmark and Plantagenet hospitals' performance.



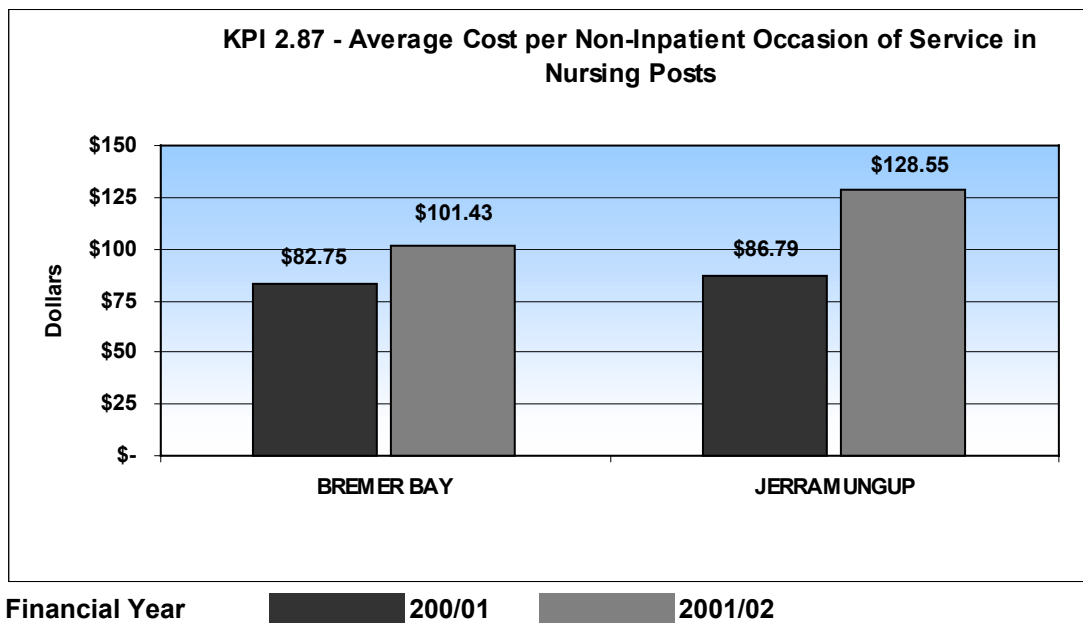
AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE IN NURSING POSTS

KPI 2.87

The effective use of Nursing Post resources can help minimise the overall costs of providing health care or can provide for more patients to be treated for the same cost.

Excessive costs in providing non-inpatient services compared to other nursing posts may indicate the inefficient use of resources.

This indicator measures the average cost per non-inpatient occasion of service.



KPI 3.7 : Hospital separations for Asthma

Hospitalisation for acute Asthma is part of managing chronic conditions. The indicator has been moved to Output 1 from Output 3 in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

**NUMBER OF AGED CARE ASSESSMENT TEAM (ACAT) ASSESSMENTS
WITHIN TARGETED AGE GROUPS PER 1,000 POPULATION
NUMBER OF FIRST ACAT ASSESSMENTS WITHIN TARGETED AGE
GROUPS PER 1,000 POPULATION**

**KPI 3.2
3.3**

People within the targeted age groups (see below) are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living. A range of services are available to people requiring support to improve or maintain their optimal quality of life. There are supports available to people living in their own homes as well as supported accommodation options.

Aged Care Assessment Teams ('ACAT') assess the support needs of people who may require services to improve or maintain their quality of life. Appropriate coverage of the 'at risk' population is a measure of ensuring that the needs of this population are adequately assessed and the plans for the provision of required levels of support are developed.

This indicator measures the extent to which people within the targeted age groups are assessed by Aged Care Assessment Teams. This is a measure of the extent to which elderly people's support needs are assessed and, where required, Care Plans developed to ensure that they receive the support they require. Care Plans aim to maintain elderly people in their own homes and communities for as long as possible.

Results are reported for the whole population aged 70+ years and for Aboriginal and Torres Strait Islander people aged 50-69 years.

The total number of assessments performed are shown in the first graph, with the number of first assessments performed shown in the second graph.*

Note: 2001 is the latest year of available data.

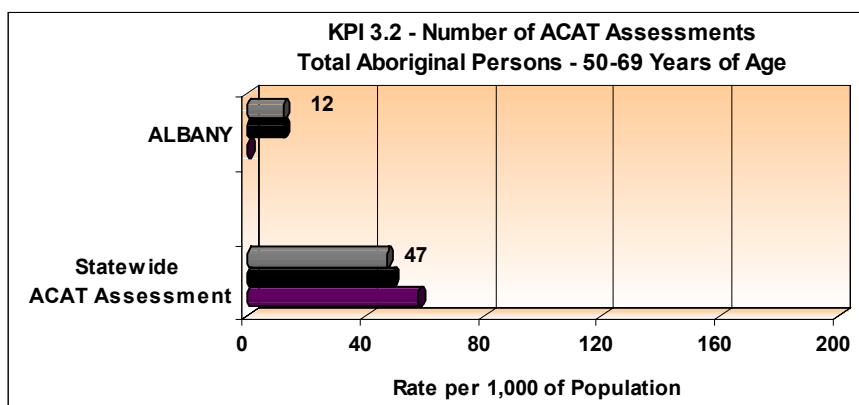
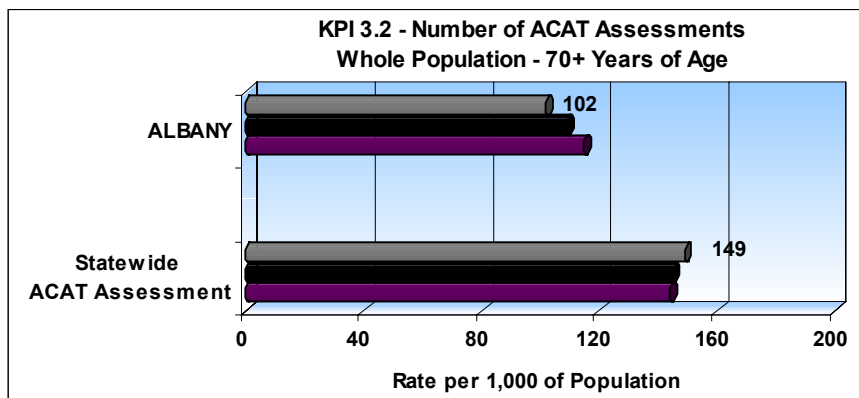
***Notes:**

Estimate of the target population (ie, 70+ years) is obtained from the Estimated Resident Population report released by the ABS for the appropriate year (Catalogue No. 3203.5).

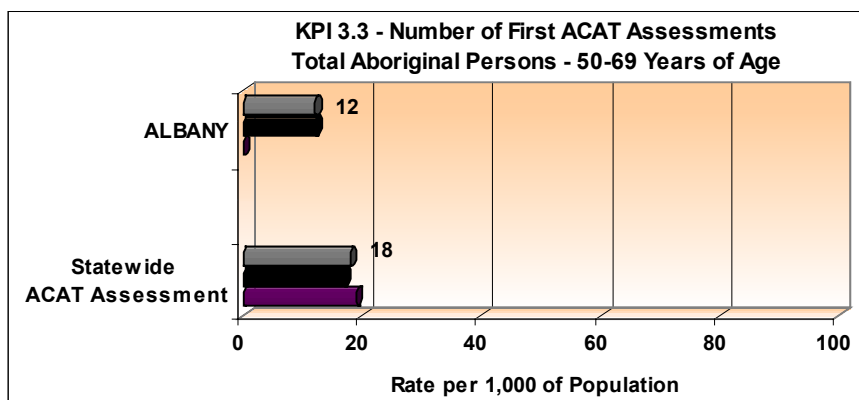
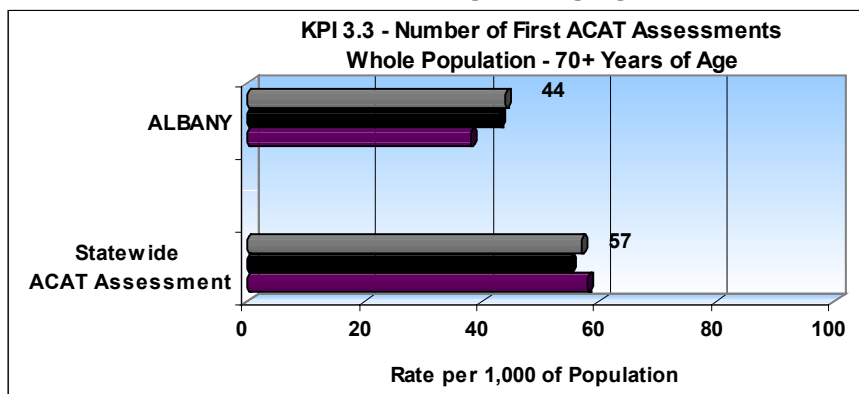
Estimate of the number of Aboriginal and Torres Strait Islander people aged 50-69 years is obtained from Epidemiology & Analytical Services, Health Information Centre.

Key Performance Indicators

ACAT assessments within targeted age groups



FIRST ACAT assessments within targeted age groups



Calendar Year

1999

2000

2001

NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUPS ADMITTED AS A NURSING HOME TYPE PATIENT	KPI 3.5
AVERAGE COST PER NURSING HOME TYPE PATIENT BED DAY	KPI 3.10

Number of Individuals Admitted as a Nursing Home Type Patient

Some people with chronic illness and disability who are not able to be cared for at home even with regular respite care and/or with the support services provided by Home and Community Care (HACC), may need long-term residential care. This care is provided in an acute hospital where beds/funds have been allocated for this type of long-term residential care.

A Nursing Home Type Patient (NHTP) is an individual who because of a need for 24-hour medical and nursing supervision and/or services, requires long-term residential care. The aim of the services and care is not only to allow the individual to maintain the greatest possible level of independence at the best possible level of health that can be practically achieved, but that these services and care are provided in a home-like environment.

This indicator measures the extent to which people within the targeted age groups are admitted as a Nursing Home Type Patient. The number of individuals within the targeted age group, i.e. over 70 years for non Aboriginal patients and over 50 years for Aboriginal patients, is measured against the total population in the catchment area. This shows the proportion of the eligible population that receives Nursing Home Type care in the Health Service.

There were 38 Nursing Home Type Patients admissions at Albany Regional Hospital in 2001/02, with an average of 6 bed days. In Denmark District Hospital there were 3 Nursing Home Type Patients admitted during the year, with an average of 3.7 bed days. At Plantagenet District Hospital there were 9 Nursing Home Type Patients admitted with an average of 11.7 bed days.

The majority of Nursing Home Type Patients are not admitted to public hospitals in the Lower Great Southern area. The majority of these patients are admitted to residential aged care facilities and therefore the results would not be indicative of the true number of these patients who need long term residential care.

Average Cost per Nursing Home Type Patient Bed Day

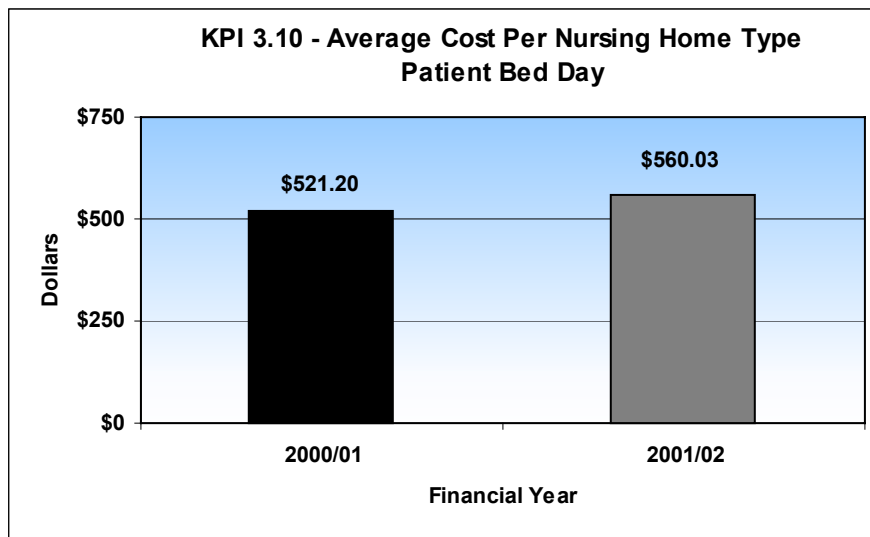
A Nursing Home Type Patient (NHTP) is an individual who because of a need for 24-hour medical and nursing supervision and/or services, requires long-term residential care. This indicator measures the cost per Nursing Home Type Patient bed day.

The effective use of hospital resources can help to minimise the overall cost of providing health care or can provide for more patients to be treated at the same cost. Higher costs in providing care for Nursing Home Type Patients compared to providing the same service in another health service may indicate the inefficient use of resources.

There were increased bed days for this financial year due to redevelopment of Banksia Lodge at Plantagenet Hospital and difficulty in placing care awaiting placement patients into Nursing Homes.

Key Performance Indicators

NB: This is the first year this KPI has been reported. Over time, the indicator will be refined so that there is clearer differentiation between the cost of the different care types treated within hospitals.

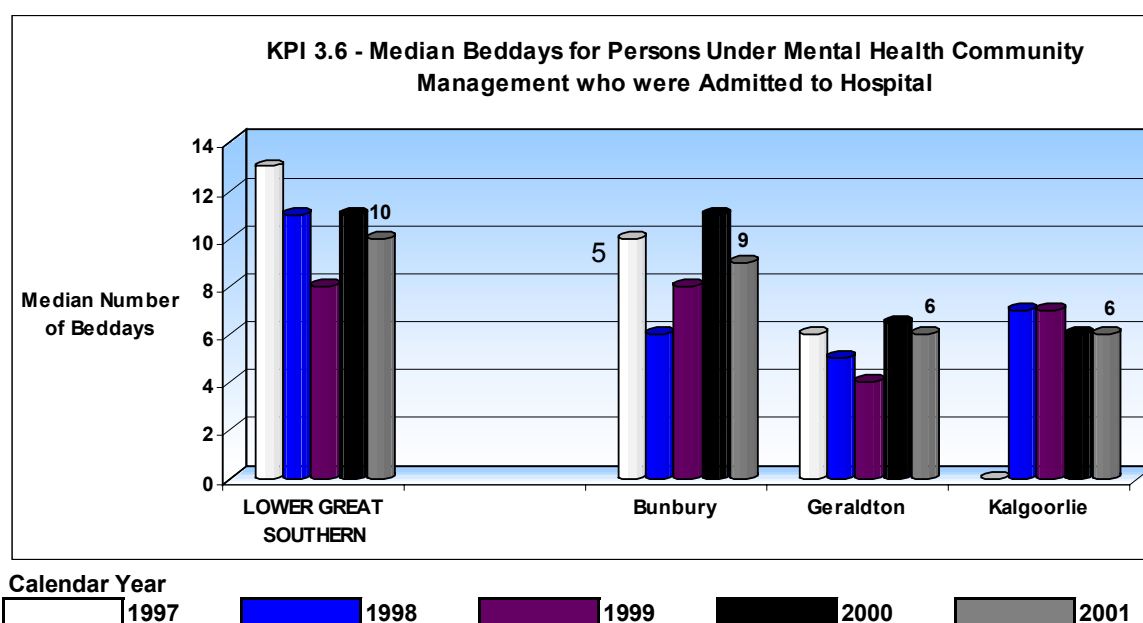


MEDIAN BED-DAYS FOR PERSONS UNDER MENTAL HEALTH COMMUNITY MANAGEMENT WHO WERE ADMITTED TO HOSPITAL

KPI 3.6

The aim of community management of people with mental illness is to provide the treatment and support required to prevent the recurrence of an acute episode of a severity requiring hospitalisation. This indicator shows the extent to which community mental health services have achieved this aim, by measuring the number of bed-days of people under Mental Health community management. This indicator consists of all overnight admissions to public psychiatric inpatient facilities.

Inpatient admissions include those from acute public hospitals, approved psychiatric hospitals and Elderly Mental Health Services. Day cases at all hospitals are excluded.



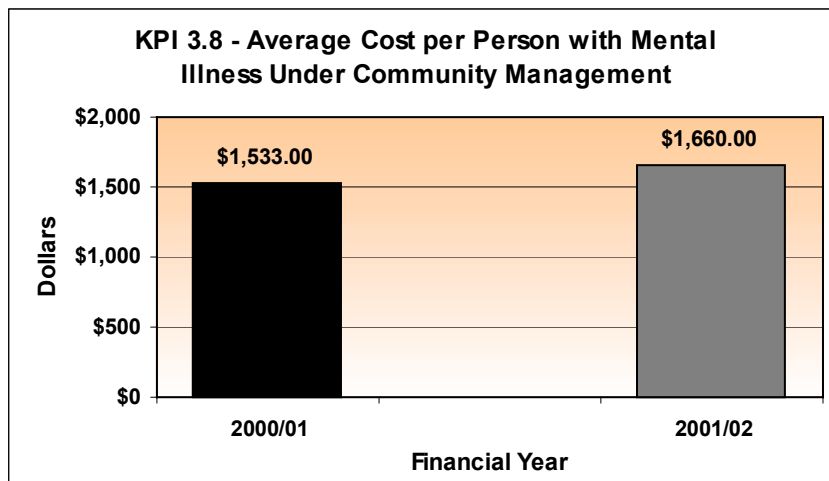
AVERAGE COST PER PERSON WITH MENTAL ILLNESS UNDER COMMUNITY MANAGEMENT

KPI 3.8

The majority of services provided by community mental health services are for people in an acute phase of a mental health problem or who are receiving post-acute care. This indicator gives a measure of the cost effectiveness of treatment for public psychiatric patients under community management.

The figures for this indicator are obtained by dividing the combined gross accrued cost of community based services by the total number of persons who received at least one occasion of service during the period.

Increased costs are a result of employee award increase, increase in the number of mental health staff and the employment of a Consultant Psychiatrist.



NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE

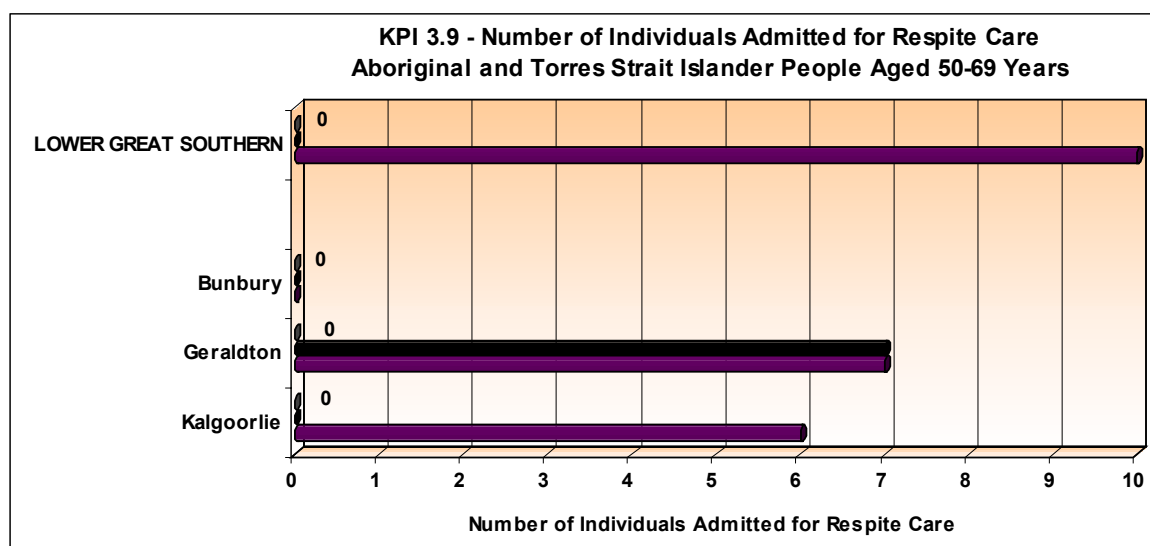
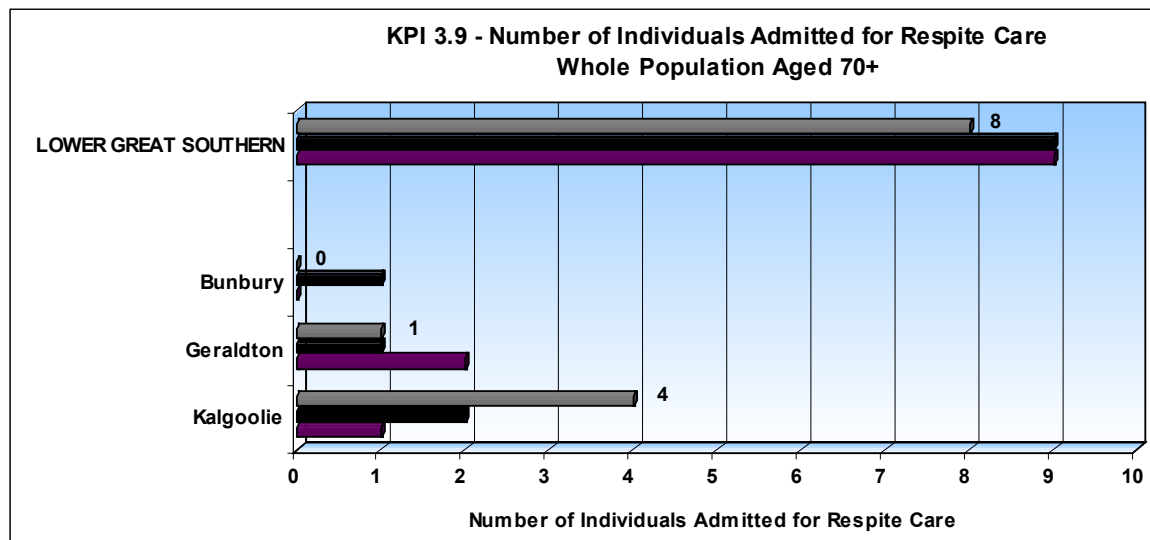
KPI 3.9

Some people with chronic illness and disability are cared for at home or in a family member's home with the support of local community services including Home & Community Care (HACC). To enable the carer to have a break from the continual carer role, short-term care may be provided in country facilities. This short-term (or Respite) care may be provided on a planned (and sometimes on an emergency) basis for day(s) or night(s) to enable the carer to have a break. Without access to this type of service more people with chronic illness may require permanent Nursing Home Type Care earlier.

The number of individuals within the targeted age group, ie. over 70 years for non Aboriginal patients and over 50 years for Aboriginal patients, is measured against the total population in the catchment area. This shows the proportion of the eligible population that receives Respite Care in the Health Service.

Key Performance Indicators

This indicator counts respite patients in acute hospitals and Multi-Purpose Services (MPS) only. Significant respite care is provided in the community and in residential aged care facilities.



Financial Year 1999/00 2000/01 2001/02



AUDITOR GENERAL

To the Parliament of Western Australia

LOWER GREAT SOUTHERN HEALTH SERVICE BOARD FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the accounts and financial statements of the Lower Great Southern Health Service Board for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

The Board was responsible for keeping proper accounts and maintaining adequate systems of internal control, preparing and presenting the financial statements, and complying with the Act and other relevant written law. The primary responsibility for the detection, investigation and prevention of irregularities rests with the Board.

My audit was performed in accordance with section 79 of the Act to form an opinion based on a reasonable level of assurance. The audit procedures included examining, on a test basis, the controls exercised by the Board to ensure financial regularity in accordance with legislative provisions, evidence to provide reasonable assurance that the amounts and other disclosures in the financial statements are free of material misstatement and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions so as to present a view which is consistent with my understanding of the Board's financial position, its financial performance and its cash flows.

The audit opinion expressed below has been formed on the above basis.

Lower Great Southern Health Service Board
Financial Statements for the year ended June 30, 2002

Audit Opinion

In my opinion,

- (i) the controls exercised by the Lower Great Southern Health Service Board provide reasonable assurance that the receipt, expenditure and investment of moneys and the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions; and
- (ii) the Statement of Financial Performance, Statement of Financial Position, Statement of Cash Flows, and the Notes to and forming part of the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Board at June 30, 2002 and its financial performance and its cash flows for the year then ended.

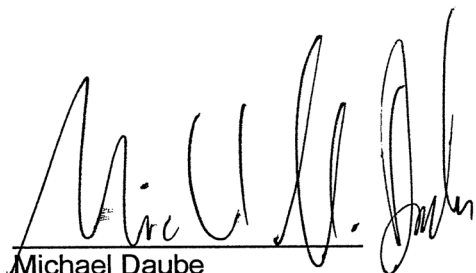


D D R PEARSON
AUDITOR GENERAL
March 7, 2003

CERTIFICATION OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2002

The accompanying financial statements of the Lower Great Southern Health Service have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002 and the financial position as at 30 June 2002.

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



Michael Daube
Director General of Health
Accountable Authority for
Lower Great Southern
Health Service

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Lower Great Southern
Health Service

30 August 2002

Statement of Financial Performance

For the year ended 30 June 2002

	Note	2001/02 \$	2000/01 \$
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses		25,096,482	22,864,397
Fees for visiting medical practitioners		3,644,925	3,717,703
Superannuation expense		2,106,621	2,035,227
Patient support costs	3	5,500,422	4,972,991
Patient transport costs		758,832	709,514
Borrowing costs expense		60,890	70,776
Repairs, maintenance and consumable equipment expense		1,097,182	1,482,874
Depreciation expense	4	1,322,842	1,219,342
Net loss on disposal of non-current assets	5	35,461	79,592
Capital user charge	6	1,873,065	0
Other expenses from ordinary activities	7	1,935,290	1,935,951
Total cost of services		43,432,012	39,088,367
Revenues from Ordinary Activities			
Patient charges	8	2,162,873	2,089,683
Commonwealth grants and contributions	9	1,096,409	1,584,910
Donations revenue	10	91,828	138,406
Interest revenue		4,443	16,543
Other revenues from ordinary activities	11	1,682,734	1,492,064
Total revenues from ordinary activities		5,038,287	5,321,606
NET COST OF SERVICES		38,393,725	33,766,761
Revenues from Government			
Output appropriations	12	39,253,624	29,390,324
Capital appropriations	12	0	2,793,979
Assets assumed / (transferred)	13	(1,894,068)	(380,764)
Liabilities assumed by the Treasurer	14	7,130	1,838,035
Resources received free of charge	15	19,500	25,000
Total revenues from government		37,386,186	33,666,574
Change in net assets		(1,007,539)	(100,187)
Total changes in equity other than those resulting from transactions with WA State Government as owners		(1,007,539)	(100,187)

The Statement of Financial Performance should be read in conjunction with the notes to the financial statements.

Statement of Financial Position

As at 30th June 2002

	Note	2001/02 \$	2000/01 \$
CURRENT ASSETS			
Cash assets	16	1,330,057	217,198
Restricted cash assets	17	72,225	102,675
Receivables	18	705,782	691,634
Inventories	20	326,975	347,322
Prepayments		19,451	3,060
Total current assets		2,454,490	1,361,889
NON-CURRENT ASSETS			
Amounts receivable for outputs	19	1,279,700	0
Property, plant and equipment	21	27,573,143	27,219,935
Construction works in progress		9,304	1,853,665
Other financial assets	22	5,930	5,838
Total non-current assets		28,868,077	29,079,438
Total assets		31,322,567	30,441,327
CURRENT LIABILITIES			
Payables		1,251,365	1,785,974
Interest-bearing liabilities	23	42,906	40,625
Accrued salaries	24	904,950	402,797
Provisions	25	3,170,925	3,027,374
Total current liabilities		5,370,146	5,256,770
NON-CURRENT LIABILITIES			
Interest-bearing liabilities	23	1,040,472	1,084,715
Provisions	25	2,643,080	2,407,864
Total non-current liabilities		3,683,552	3,492,579
Total liabilities		9,053,698	8,749,349
Net Assets		22,268,869	21,691,978
EQUITY			
Contributed equity	26	22,420,088	20,835,658
Asset revaluation reserve	27	265,000	265,000
Accumulated surplus / (deficiency)	28	(416,219)	591,320
Total Equity		22,268,869	21,691,978

The Statement of Financial Position should be read in conjunction with the notes to the financial statements.

Statement of Cash Flows

For the year ended 30 June 2002

	Note	2001/02 \$ Inflows (Outflows)	2000/01 \$ Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT			
Output appropriations	29(c)	36,043,194	29,278,834
Capital contributions (2000/01 appropriation)	29(c)	598,796	79,166
Net cash provided by Government		<u>36,641,990</u>	<u>29,358,000</u>
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(15,417,648)	(12,360,562)
Employee costs		(24,309,549)	(22,447,952)
GST payments on purchases		(1,170,193)	(972,045)
Receipts			
Receipts from customers		2,172,091	2,065,374
Commonwealth grants and contributions		1,068,146	1,584,910
Donations		56,439	122,216
Interest received		6,723	15,815
GST receipts on sales		144,431	103,026
GST receipts from taxation authority		982,944	842,459
Other receipts		1,545,974	1,556,931
Net cash (used in) / provided by operating activities	29(b)	<u>(34,920,642)</u>	<u>(29,489,828)</u>
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	21	(639,484)	(671,055)
Proceeds from sale of non-current assets	5	545	22,040
Net cash (used in) / provided by investing activities		<u>(638,939)</u>	<u>(649,015)</u>
Net increase / (decrease) in cash held		1,082,409	(780,843)
Cash assets at the beginning of the reporting period		319,873	1,481,480
Cash assets transferred to / from the Health Service	13	0	(380,764)
Cash assets at the end of the reporting period	29(a)	<u><u>1,402,282</u></u>	<u><u>319,873</u></u>

The Statement of Cash Flows should be read in conjunction with the notes to the financial statements.

Notes to the Financial Statements

For the year ended 30 June 2002

Note 1 SIGNIFICANT ACCOUNTING POLICIES

The following accounting policies have been adopted in the preparation of the financial statements. Unless otherwise stated these policies are consistent with those adopted in the previous year.

(a) General Statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with Australian Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, and Urgent Issues Group (UIG) Consensus Views as applied by the Treasurer's Instructions. Several of these are modified by the Treasurer's Instructions to vary application, disclosure, format and wording. The Financial Administration and Audit Act and the Treasurer's Instructions are legislative provisions governing the preparation of financial statements and take precedence over Australian Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, and UIG Consensus Views. The modifications are intended to fulfil the requirements of general application to the public sector, together with the need for greater disclosure and also to satisfy accountability requirements.

If any such modification has a material or significant financial effect upon the reported results, details of that modification and where practicable, the resulting financial effect are disclosed in individual notes to these financial statements.

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, except for certain assets and liabilities which, as noted, are measured at valuation.

(b) Output Appropriations

Output Appropriations are recognised as revenues in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of appropriated funds at the time those funds are deposited into the Health Service's bank account or credited to the holding account held at the Department of Treasury and Finance.

(c) Contributed Equity

Under UIG 38 "Contributions by Owners Made to Wholly-Owned Public Sector Entities", transfers in the nature of equity contributions must be designated by the Government (owners) as contributions by owners (at the time of, or prior to transfer) before such transfers can be recognised as equity contributions in the financial statements. Capital contributions (appropriations) have been designated as contributions by owners and have been credited directly to Contributed Equity in the Statement of Financial Position. All other transfers have been recognised in the Statement of Financial Performance. Prior to the current reporting period, capital appropriations were recognised as revenue in the Statement of Financial Performance. Capital appropriations which are repayable to the Treasurer are recognised as liabilities.

(d) Acquisition of Assets

The cost method of accounting is used for all acquisitions of assets. Cost is measured as the fair value of the assets given up or liabilities undertaken at the date of acquisition plus incidental costs directly attributable to the acquisition.

Assets acquired at no cost or for nominal consideration, are initially recognised at their fair value at the date of acquisition.

(e) Valuation of Non-Current Assets

The Health Service has applied the transitional provisions in AASB 1041 "Revaluation of Non-Current Assets" for land and buildings, and as a consequence assets are reported at cost, valuation and fair value. Fair value is the amount for which an asset could be exchanged, between knowledgeable, willing parties in an arm's length transaction.

i) Land and Non-Clinical Buildings

The revaluations of land and non-clinical buildings have been undertaken by the Valuer General's Office in Western Australia, on the following bases:

Land (clinical site)	Market value for Current use
Land (non-clinical site)	Market value for Highest and best use
Buildings (non-clinical)	Market value for Highest and best use

Recent valuations on this basis are equivalent to fair value.

Notes to the Financial Statements

For the year ended 30 June 2002

ii) Clinical Buildings

The valuations of clinical buildings (eg hospitals) have been carried out at five yearly intervals by the Department of Health in conjunction with the Department of Housing and Works using "as constructed" drawings. The clinical buildings are valued at "Replacement Capital Value", which is defined as the cost to replace buildings constructed at current building costs with current materials on a greenfield site. All building costs are Perth based and include elements of electrical, mechanical and plumbing services. Loose and free standing furniture and equipment together with specialised medical equipment are excluded from this valuation. Buildings are depreciated using weighted average age to determine the net carrying values. Recent valuations on this basis are equivalent to fair value.

(f) Depreciation of Non-current Assets

All non-current assets having a limited useful life are systematically depreciated over their useful lives in a manner that reflects the consumption of their future economic benefits.

Depreciation is calculated on the reducing balance basis, using rates which are reviewed annually. Useful lives for each class of depreciable assets are:

Buildings	50 years
Computer equipment	5 to 10 years
Furniture and fittings	10 to 50 years
Motor vehicles	4 to 10 years
Other mobile plant	10 years
Other plant and equipment	4 to 20 years

(g) Leases

The Health Service has entered into a number of operating lease arrangements for the rent of buildings and equipment where the lessors effectively retain all of the risks and benefits incident to ownership of the items held under the operating leases. Equal instalments of the lease payments are charged to the Statement of Financial Performance over the lease term as this is representative of the pattern of benefits to be derived from the leased items.

The Health Service has no contractual obligations under finance leases.

(h) Cash

For the purpose of the Statement of Cash Flows, cash includes cash assets and restricted cash assets. These include short-term deposits that are readily convertible to cash on hand and are subject to insignificant risk of changes in value.

(i) Receivables

Receivables are recognised at the amounts receivable as they are due for settlement no more than 30 days from the date of recognition.

Collectability of receivables is reviewed on an ongoing basis. Debts which are known to be uncollectable are written off. A provision for doubtful debts is raised where some doubts as to collection exists.

(j) Inventories

Inventories are valued on a weighted average cost basis at the lower of cost and net realisable value.

(k) Payables

Payables, including accruals not yet billed, are recognised when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. Payables are generally settled within 30 days.

(l) Accrued Salaries

Accrued salaries represent the amount due to staff but unpaid at the end of the financial year, as the end of the last pay period for that financial year does not coincide with the end of the financial year. The Health Service considers the carrying amount approximates net fair value.

(m) Interest-bearing liabilities

Interest-bearing liabilities are recognised at an amount equal to the net proceeds received. Borrowing costs expense is recognised on a time proportionate basis.

Notes to the Financial Statements

For the year ended 30 June 2002

(n) Provisions

Employee Entitlements

i) Annual and Long Service Leave

The liability for annual leave represents the amount which the Health Service has a present obligation to pay resulting from employees' services up to the reporting date. The liability has been calculated on current remuneration rates and includes related on-costs.

The liability for long service leave is recognised, and is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given, when assessing expected future payments, to expected future wage and salary levels including related on-costs, experience of employee departures and periods of service. Expected future payments are discounted using interest rates on national government securities to obtain the estimated future cash outflows.

The methods of measurement of the liabilities are consistent with the requirements of Australian Accounting Standard AAS 30 "Accounting for Employee Entitlements".

ii) Superannuation

Staff may contribute to the Pension Scheme, a defined benefits pension scheme now closed to new members, or to the Gold State Superannuation Scheme, a defined benefit lump sum scheme now also closed to new members. All staff who do not contribute to either of these schemes become non-contributory members of the West State Superannuation Scheme, an accumulation fund complying with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. All of these schemes are administered by the Government Employees Superannuation Board (GESB).

The liability for future payments under the Pension Scheme are provided for at reporting date.

The unfunded employer's liability in respect of the pre-transfer benefit for employees who transferred from the Pension Scheme to the Gold State Superannuation Scheme is assumed by the Treasurer. A revenue "Liabilities assumed by the Treasurer" equivalent to the change in this unfunded liability is recognised in the Statement of Financial Performance.

From 1 July 2001 employer contributions were paid to the GESB in respect of the Gold State Superannuation Scheme and West State Superannuation Scheme. Prior to 1 July 2001, the unfunded liability in respect of these schemes was assumed by the Treasurer. An amount equivalent to the employer contributions which would have been paid to the Gold State Superannuation Scheme and the West State Superannuation Scheme if the Health Service had made concurrent employer contributions to those schemes, was included in superannuation expense. This amount was also included in the revenue item "Liabilities assumed by the Treasurer".

The note disclosure required by paragraph 51(e) of AAS30 (being the employer's share of the difference between employees' accrued superannuation benefits and the attributable net market value of plan assets) has not been provided. State scheme deficiencies are recognised by the State in its whole of government reporting. The GESB's records are not structured to provide the information for the Health Service. Accordingly, deriving the information for the Health Service is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

(o) Revenue Recognition

Revenue from the sale of goods, disposal of other assets and the rendering of services, is recognised when the Health Service has passed control of the goods or other assets or has delivered the services to the customer.

(p) Grants and Other Contributions Revenue

Grants, donations, gifts and other non-reciprocal contributions are recognised as revenue when the Health Service obtains control over the assets comprising the contributions. Control is normally obtained upon their receipt.

Contributions are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

(q) Resources Received Free of Charge or For Nominal Value

Resources received free of charge or for nominal value which can be reliably measured are recognised as revenues and as assets or expenses as appropriate at fair value.

(r) Comparative Figures

Comparative figures are, where appropriate, reclassified so as to be comparable with the figures presented in the current reporting period.

Notes to the Financial Statements

For the year ended 30 June 2002

Note 2 Administered trust accounts	2001/02 \$	2000/01 \$
Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.		
a) The Health Service administers a trust account for the purpose of holding patients' private moneys.		
A summary of the transactions for this trust account is as follows:		
Opening Balance	15,118	10,716
Add Receipts		
- Patient Deposits	87,185	88,334
- Interest	3	23
	<u>102,306</u>	<u>99,073</u>
Less Payments		
- Patient Withdrawals	92,845	83,946
- Interest / Charges	0	9
Closing Balance	<u>9,461</u>	<u>15,118</u>
b) Other trust accounts		
Accommodation Bonds Account		
Opening Balance	150,802	43,729
Add Receipts		
- Deposits	94,902	112,850
- Interest	6,959	6,044
	<u>252,663</u>	<u>162,623</u>
Less Payments		
- Withdrawals	51,921	6,500
- Interest / Charges	2	5,321
Closing Balance	<u>200,740</u>	<u>150,802</u>
Note 3 Patient support costs		
Medical supplies and services	2,242,479	2,106,947
Domestic charges	537,632	545,932
Fuel, light and power	699,928	659,630
Food supplies	482,375	466,351
Purchase of external services	<u>1,538,008</u>	<u>1,194,131</u>
	<u>5,500,422</u>	<u>4,972,991</u>
Note 4 Depreciation expense		
Buildings	737,364	706,099
Computer equipment and software	151,078	136,293
Furniture and fittings	82,455	59,209
Motor vehicles	7,019	5,959
Other mobile plant	871	1,024
Other plant and equipment	<u>344,055</u>	<u>310,758</u>
	<u>1,322,842</u>	<u>1,219,342</u>
Note 5 Net profit / (loss) on disposal of non-current assets		
a) Proceeds from sale of non-current assets		
Proceeds were received for the sale of non-current assets during the reporting period as follows:		
Received as cash by the Health Service	545	22,040
Gross proceeds from sale of non-current assets	<u>545</u>	<u>22,040</u>
b) Profit / (Loss) on disposal of non-current assets:		
Computer equipment and software	(5,686)	(17,088)
Furniture and fittings	(10,491)	(31,395)
Motor vehicles	0	3,066
Other plant and equipment	<u>(19,284)</u>	<u>(34,175)</u>
	<u>(35,461)</u>	<u>(79,592)</u>

Notes to the Financial Statements

For the year ended 30 June 2002

Note 6 Capital user charge	2001/02 \$	2000/01 \$
	<u>1,873,065</u>	<u>0</u>

A capital user charge rate of 8% has been set by the Government for 2001/02 and represents the opportunity cost of capital invested in the net assets of the Health Service used in the provision of outputs. The charge is calculated on the net assets adjusted to take account of exempt assets. Payments are made to the Department of Treasury and Finance on a quarterly basis by the Department of Health on behalf of the Health Service.

Note 7 Other expenses from ordinary activities

Workers compensation insurance	480,366	345,334
Other employee expenses	292,393	329,452
Motor vehicle expenses	189,285	201,867
Insurance	113,934	95,186
Communications	283,667	256,704
Printing and stationery	204,795	192,623
Rental of property	16,452	19,292
Audit fees - external	29,356	44,284
Bad and doubtful debts expense	4,335	15,604
Advertising	58,496	86,076
Freight	96,320	98,560
Other	165,891	250,969
	<u>1,935,290</u>	<u>1,935,951</u>

Note 8 Patient charges

Inpatient charges	2,126,359	2,065,451
Outpatient charges	<u>36,514</u>	<u>24,232</u>
	<u>2,162,873</u>	<u>2,089,683</u>

Note 9 Commonwealth grants and contributions

Grant for nursing homes	1,096,409	1,559,836
Grant from Commonwealth Department of Veterans' affairs to assist Spencer Lodge accreditation process.	0	25,074
	<u>1,096,409</u>	<u>1,584,910</u>

Note 10 Donations revenue

General public contributions	56,493	138,406
Specific contribution from Home & Community Care, Wickepin, for motor vehicle	15,000	0
Specific contribution from SKG Radiology for computer software	<u>20,335</u>	<u>0</u>
	<u>91,828</u>	<u>138,406</u>

Note 11 Other revenues from ordinary activities

Rent from properties	25,775	37,105
Boarders' accommodation	136	224
Recoveries	211,233	173,395
Use of hospital facilities	921,408	747,755
Other	<u>524,182</u>	<u>533,585</u>
	<u>1,682,734</u>	<u>1,492,064</u>

Note 12 Government appropriations

Output appropriations (I)	39,253,624	29,390,324
Capital appropriations (II)	0	2,793,979
	<u>39,253,624</u>	<u>32,184,303</u>

(I) Output appropriations are accrual amounts as from 1 July 2001, reflecting the full price paid for outputs purchased by the Government. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the estimated depreciation expense for the year and any agreed increase in leave liability during the year.

(II) Capital appropriations were revenue in 2000/01 (year ended 30 June 2001). From 1 July 2001, capital appropriations, termed Capital Contributions, have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

Notes to the Financial Statements

For the year ended 30 June 2002

	2001/02 \$	2000/01 \$
Note 13 Assets assumed / (transferred)		
The following assets have been assumed from / (transferred to) other government agencies during the year:		
- Land and buildings	(1,894,068)	0
- Cash transferred to Kalgoorlie - Boulder Health Service for Rural General Managers Council.	0	(380,764)
Total assets assumed / (transferred)	<u>(1,894,068)</u>	<u>(380,764)</u>
Note 14 Liabilities assumed by the Treasurer		
Superannuation	<u>7,130</u>	<u>1,838,035</u>
The change in funding arrangement for the Gold State Superannuation Scheme and the West State Superannuation Scheme has resulted in the decrease in "Liabilities assumed by Treasurer". (Refer note 1 (n)(ii)).		
Note 15 Resources received free of charge		
Resources received free of charge has been determined on the basis of the following estimates provided by agencies.		
Office of the Auditor General		
- Audit services	<u>19,500</u>	<u>25,000</u>
Where assets or services have been received free of charge or for nominal consideration, the Health Service recognises revenues equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable.		
Note 16 Cash assets		
Cash on hand	10,520	8,158
Cash at bank - general	1,134,515	54,363
Cash at bank - donations	185,022	154,677
	<u>1,330,057</u>	<u>217,198</u>
Note 17 Restricted cash assets		
Cash assets held for specific purposes		
Cash at bank	<u>72,225</u>	<u>102,675</u>
A restriction is imposed on the above cash resources by way of various monies being donated to be spent in purchasing specific items for Albany Regional Hospital \$32,338 and Banksia Lodge \$39,887.		
Note 18 Receivables		
Patient fee debtors	218,532	229,107
GST receivable	77,534	90,002
Other receivables	410,248	377,862
	<u>706,314</u>	<u>696,971</u>
Less: Provision for doubtful debts	<u>(532)</u>	<u>(5,337)</u>
	<u>705,782</u>	<u>691,634</u>
Note 19 Amounts receivable for outputs		
Non-current	<u>1,279,700</u>	<u>0</u>
This asset represents the non-cash component of output appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.		
Note 20 Inventories		
Supply stores - at cost	148,820	169,096
Pharmaceutical stores - at cost	124,689	125,804
Engineering stores - at cost	53,466	52,422
	<u>326,975</u>	<u>347,322</u>

Notes to the Financial Statements

For the year ended 30 June 2002

Note 21 Property, plant and equipment	2001/02 \$	2000/01 \$
Land		
At cost (i)	386,891	483,891
At fair value (ii)	95,000	355,000
	<u>481,891</u>	<u>838,891</u>
Buildings		
<u>Clinical:</u>		
At cost (i)	3,835,265	1,081,347
Accumulated depreciation	(116,620)	(32,893)
	<u>3,718,645</u>	<u>1,048,454</u>
At valuation - 30 June 1999 (iii)	45,878,025	49,255,000
At valuation - 30 June 1998 (iii)	890,000	890,000
Accumulated depreciation	(27,441,360)	(28,692,036)
	<u>19,326,665</u>	<u>21,452,964</u>
<u>Non-Clinical:</u>		
At cost (i)	442,345	497,345
Accumulated depreciation	(32,998)	(23,592)
	<u>409,347</u>	<u>473,753</u>
Computer equipment and software		
At cost	880,939	698,759
Accumulated depreciation	(406,839)	(264,786)
	<u>474,100</u>	<u>433,973</u>
Furniture and fittings		
At cost	1,003,646	673,366
Accumulated depreciation	(185,392)	(106,169)
	<u>818,254</u>	<u>567,197</u>
Motor vehicles		
At cost	33,125	18,125
Accumulated depreciation	(16,544)	(9,525)
	<u>16,581</u>	<u>8,600</u>
Other mobile plant		
At cost	7,179	7,179
Accumulated depreciation	(2,246)	(1,375)
	<u>4,933</u>	<u>5,804</u>
Other plant and equipment		
At cost	3,263,850	2,999,158
Accumulated depreciation	(941,123)	(608,859)
	<u>2,322,727</u>	<u>2,390,299</u>
Total of property, plant and equipment	<u>27,573,143</u>	<u>27,219,935</u>

Land and buildings

- (i) Land, clinical buildings and non-clinical buildings that are yet to be revalued are carried at their cost of acquisition.
- (ii) Land, clinical buildings and non-clinical buildings have been subject to a recent revaluation and are carried at their fair value.
- (iii) Land, clinical buildings and non-clinical buildings are yet to be revalued at fair value.

Payments for non-current assets

Payments were made for purchases of non-current assets during the reporting period as follows:

Paid as cash by the Health Service from output appropriations	476,498	671,055
Paid as cash by the Health Service from capital contributions	131,546	0
Paid as cash by the Health Service from other funding sources	31,440	0
Paid by the Department of Health	<u>2,912,958</u>	<u>2,581,190</u>
Gross payments for purchases of non-current assets	<u>3,552,442</u>	<u>3,252,245</u>

Notes to the Financial Statements

For the year ended 30 June 2002

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the current financial year are set out below.

	2001/02 \$	
Land		
Carrying amount at start of year	838,891	
Additions	0	
Disposals	(357,000)	
Carrying amount at end of year	<u>481,891</u>	
Buildings		
Carrying amount at start of year	22,975,171	
Additions	2,753,918	
Disposals	(1,537,068)	
Depreciation	(737,364)	
Carrying amount at end of year	<u>23,454,657</u>	
Computer equipment and software		
Carrying amount at start of year	433,973	
Additions	196,891	
Disposals	(5,686)	
Depreciation	(151,078)	
Carrying amount at end of year	<u>474,100</u>	
Furniture and fittings		
Carrying amount at start of year	567,197	
Additions	344,003	
Disposals	(10,491)	
Depreciation	(82,455)	
Carrying amount at end of year	<u>818,254</u>	
Motor vehicles		
Carrying amount at start of year	8,600	
Additions	15,000	
Disposals	0	
Depreciation	(7,019)	
Carrying amount at end of year	<u>16,581</u>	
Other mobile plant		
Carrying amount at start of year	5,804	
Additions	0	
Disposals	0	
Depreciation	(871)	
Carrying amount at end of year	<u>4,933</u>	
Other plant and equipment		
Carrying amount at start of year	2,390,299	
Additions	296,312	
Disposals	(19,829)	
Depreciation	(344,055)	
Carrying amount at end of year	<u>2,322,727</u>	

Note	22	Other financial assets	2001/02 \$	2000/01 \$
		Shares in Mount Barker Co-operative Limited at Cost.	<u>5,930</u>	<u>5,838</u>

Note 23 Interest-bearing liabilities

a) Western Australian Treasury Corporation (WATC) loans

Balance at beginning of year	1,125,340	1,166,054
Less repayments this year	<u>(41,962)</u>	<u>(40,714)</u>
Balance at end of year	<u>1,083,378</u>	<u>1,125,340</u>
Amount repayable within the next 12 months	42,906	40,625
Amount repayable after 12 months	<u>1,040,472</u>	<u>1,084,715</u>
Balance at end of year	<u>1,083,378</u>	<u>1,125,340</u>

The debt is held in a portfolio of loans managed by the Department of Health. Repayments of the debt are made by the Department of Health on behalf of the Health Service.

Notes to the Financial Statements

For the year ended 30 June 2002

Note 23 Interest-bearing liabilities - continued	2001/02 \$	2000/01 \$
Total interest-bearing liabilities:		
Balance at beginning of year	1,125,340	1,166,054
Less repayments this year	<u>(41,962)</u>	<u>(40,714)</u>
Balance at end of year	<u>1,083,378</u>	<u>1,125,340</u>
Amount repayable within the next 12 months	42,906	40,625
Amount repayable after 12 months	<u>1,040,472</u>	<u>1,084,715</u>
Balance at end of year	<u>1,083,378</u>	<u>1,125,340</u>
Note 24 Accrued salaries		
Amounts owing for:	<u>904,950</u>	<u>402,797</u>
7 days from 24 June to 30 June 2002		
(2001: 6 days from 25 June to 30 June 2001)		
Nursing, Hotel Services and Doctors -		
Backdated arrears from 1 April to 30 June 2002		
Voluntary Severance Scheme termination payments due 30 June 2002		
Spencer Lodge staff termination payments due 30 June 2002		
Note 25 Provisions		
Current liabilities:		
Annual leave	2,332,128	2,193,731
Long service leave	681,857	733,699
Superannuation	<u>156,940</u>	<u>99,944</u>
	<u>3,170,925</u>	<u>3,027,374</u>
Non-current liabilities:		
Long service leave	1,346,638	1,136,774
Superannuation	<u>1,296,442</u>	<u>1,271,090</u>
	<u>2,643,080</u>	<u>2,407,864</u>
Total employee entitlements	<u>5,814,005</u>	<u>5,435,238</u>
The superannuation liability has been established from data supplied by the Government Employees Superannuation Board.		
The Health Service considers the carrying amount of employee entitlements approximates the net fair value.		
Note 26 Contributed equity		
Balance at beginning of the year	20,835,658	20,835,658
Capital contributions (i)	<u>1,584,430</u>	<u>0</u>
Balance at end of the year	<u>22,420,088</u>	<u>20,835,658</u>
(i) From 1 July 2001, capital appropriations, termed Capital Contributions, have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.		
Note 27 Asset revaluation reserve		
Balance at beginning of the year	265,000	265,000
Net revaluation increments / (decrements)	<u>0</u>	<u>0</u>
Balance at end of the year	<u>265,000</u>	<u>265,000</u>
(i) Revaluation increments and decrements are offset against one another within the same class of non-current assets.		
(ii) Any net increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement previously recognised as an expense.		
(iii) Any net decrement is recognised as an expense in the Statement of Financial Performance, except to the extent that any decrement reverses a revaluation increment previously credited to the asset revaluation reserve.		

Notes to the Financial Statements

For the year ended 30 June 2002

		2001/02	2000/01
		\$	\$
Note 28	Accumulated surplus / (deficiency)		
	Balance at beginning of the year	591,320	691,507
	Change in net assets	(1,007,539)	(100,187)
	Balance at end of the year	(416,219)	591,320
Note 29	Notes to the statement of cash flows		
a)	Reconciliation of cash		
	Cash assets at the end of the reporting period as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:		
	Cash assets (Refer note 16)	1,330,057	217,198
	Restricted cash assets (Refer note 17)	72,225	102,675
		<u>1,402,282</u>	<u>319,873</u>
b)	Reconciliation of net cash flows used in operating activities to net cost of services		
	Net cash used in operating activities (Statement of Cash Flows)	(34,920,642)	(29,489,828)
	Increase / (decrease) in assets:		
	GST receivable	(12,468)	88,816
	Other receivables	21,811	123,396
	Inventories	(20,347)	23,947
	Prepayments	16,391	(4,480)
	Decrease / (increase) in liabilities:		
	Doubtful debts provision	4,805	(4,531)
	Payables	534,609	(625,850)
	Accrued salaries	(502,153)	(71,402)
	Provisions	(378,767)	(456,876)
	Non-cash items:		
	Depreciation expense	(1,322,842)	(1,219,342)
	Profit / (loss) from disposal of non-current assets	(35,461)	(79,592)
	Interest paid by Department of Health	(60,890)	(70,776)
	Capital user charge paid by Department of Health	(1,873,065)	0
	Other expenses paid by Department of Health	0	(138,623)
	Donation of non-current assets	35,335	0
	Superannuation liabilities assumed by the Treasurer	(7,130)	(1,838,035)
	Resources received free of charge	(19,500)	(25,000)
	Other	146,589	21,415
	Net cost of services (Statement of Financial Performance)	<u>(38,393,725)</u>	<u>(33,766,761)</u>
c)	Notional cash flows		
	Output appropriations as per Statement of Financial Performance	39,253,624	29,390,324
	Capital appropriations as per Statement of Financial Performance	0	2,793,979
	Capital appropriations credited directly to Contributed Equity	1,584,430	0
		<u>40,838,054</u>	<u>32,184,303</u>
	Less notional cash flows:		
	Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
	Interest paid to WA Treasury Corporation	(60,890)	(70,776)
	Repayment of interest-bearing liabilities to WA Treasury Corporation	(41,962)	(40,714)
	Capital user charge	(1,873,065)	0
	Capital subsidy	(943,673)	(2,718,038)
	Other non cash adjustments to output appropriations	3,226	3,225
		<u>(2,916,364)</u>	<u>(2,826,303)</u>
	Less non-cash component of output appropriations (Refer Note 19)	(1,279,700)	0
	Net cash provided by Government as per Statement of Cash Flows	<u>36,641,990</u>	<u>29,358,000</u>

Notes to the Financial Statements

For the year ended 30 June 2002

Note 30 Revenue, public and other property written off or presented as gifts	2001/02 \$	2000/01 \$
a) Revenue and debts written off.	20,100	12,711
b) Public and other property written off.	20,516	17,467

All of the amounts above were written off under the authority of the Accountable Authority.

Note 31 Remuneration of members of the accountable authority and senior officers

Remuneration of members of the Accountable Authority

The number of members of the Accountable Authority, whose total of fees, salaries, superannuation and other benefits for the reporting period, fall within the following bands are:

2001/02	2000/01
0	0
\$	\$
0	0

The total remuneration of the members of the Accountable Authority is:

The superannuation included here represents the superannuation expense incurred by the Health Service in respect of members of the Accountable Authority.

Remuneration of senior officers

The number of Senior Officers (other than members of the Accountable Authority), whose total of fees, salaries, superannuation and other benefits for the reporting period, fall within the following bands are:

	2001/02	2000/01
\$10,001 - \$20,000	0	1
\$20,001 - \$30,000	1	0
\$30,001 - \$40,000	0	0
\$40,001 - \$50,000	0	1
\$50,001 - \$60,000	1	1
\$60,001 - \$70,000	2	0
\$70,001 - \$80,000	0	2
\$80,001 - \$90,000	1	0
\$90,001 - \$100,000	1	1
\$100,001 - \$110,000	0	0
\$110,001 - \$120,000	0	0
\$120,001 - \$130,000	0	0
\$130,001 - \$140,000	1	1
Total	7	7
	\$	\$
	514,208	492,651

The total remuneration of senior officers is:

The superannuation included here represents the superannuation expense incurred by the Health Service in respect of Senior Officers (other than members of the Accountable Authority).

Numbers of Senior Officers presently employed who are members of the Pension Scheme:

	2001/02	2000/01
Members of the Accountable Authority	0	0
Senior officers other than members of the Accountable Authority	0	0
	0	0

Notes to the Financial Statements

For the year ended 30 June 2002

Note 32 Explanatory statement

a) **Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.**

Details and reasons for significant variations between actual results and the corresponding items of the preceding year are detailed below. Significant variations are considered to be those greater than 10% or \$1,950,000.

	2001/02 \$	2000/01 \$	Variation \$
Employee expenses	25,096,482	22,864,397	2,232,085
Other Goods & Services	18,335,530	16,223,970	2,111,560
Total Cost of Services	43,432,012	39,088,367	4,343,645
Revenues from ordinary activities	5,038,287	5,321,606	(283,319)
Net Cost of Services	38,393,725	33,766,761	4,626,964
(i) Employee expenses	25,096,482	22,864,397	2,232,085
Increase as a result of award pay increases; staff increases in Mental Health Service and Denmark Multi Purpose Service; and cost of voluntary redundancies.			
(ii) Other Goods and Services			
Patient Support Costs	5,500,422	4,972,991	527,431
Purchase of external services increased as a result of payments for laboratory services, hospice relocation and palliative care services.			
Capital user charge	1,873,065	0	1,873,065
Capital user charge applied to the Health Service set by the Government for 2001/2002.			

b) **Significant variations between estimates and actual results for the financial year.**

Section 42 of the Financial Administration and Audit Act requires the Health Service to prepare annual budget estimates. Details and reasons for significant variations between these estimates and actual results are detailed below. Significant variations are considered to be those greater than 10% of budget or \$1,950,000.

	2001/02 Actual \$	2001/02 Estimate \$	Variation \$
Employee expenses	25,096,482	23,172,000	1,924,482
Other Goods & Services	18,335,530	16,171,000	2,164,530
Total Cost of Services	43,432,012	39,343,000	4,089,012
Revenues from ordinary activities	5,038,287	4,378,000	660,287
Net Cost of Services	38,393,725	34,965,000	3,428,725
(i) Employee expenses	25,096,482	23,172,000	1,924,482
Increase as a result of award pay increases; staff increases in Mental Health Service and Denmark Multi Purpose Service; and cost of voluntary redundancies.			
(ii) Other Goods and Services			
Capital user charge	1,873,065	0	1,873,065
Capital user charge applied to the Health Service set by the Government for 2001/2002.			
(iii) Revenues from ordinary activities	5,038,287	4,378,000	660,287

Increased patient charges as a result of increased private patients, nursing home type patients and delay in closure of Spencer Lodge nursing home.

Increased Commonwealth nursing home benefits as a result of delay in closure of Spencer Lodge nursing home.

Increased revenue from new radiology service contract.
Cardio Vascular Disease program funding received from Great Southern Division of General Practice previously received as an appropriation.

Notes to the Financial Statements

For the year ended 30 June 2002

Note 33 Commitments for Expenditure	2001/02 \$	2000/01 \$
a) Capital expenditure commitments		
Capital expenditure commitments contracted for at reporting date are payable:		
Within one year	<u>252,696</u>	<u>387,717</u>
b) Operating lease commitments:		
Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	298,431	262,162
Later than one year, and not later than five years	<u>175,114</u>	<u>197,593</u>
	<u>473,545</u>	<u>459,755</u>

These commitments are all inclusive of GST.

Note 34 Contingent liabilities

At the reporting date, the Health Service is not aware of any contingent liabilities.

Note 35 Events occurring after reporting date

The Lower Great Southern Health Service Board will cease to exist as a legal entity as at 1 July 2002. The health service will be amalgamated with other health services to form the WA Country Health Service on 1 July 2002. The amalgamation was gazetted on 28 June 2002.

Note 36 Related bodies

A related body is a body which receives more than half its funding and resources from the Health Service and is subject to operational control by the Health Service. Related bodies are generally government agencies which have no financial administration responsibilities.

The Health Service had no related bodies during the reporting period.

Note 37 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service and is not subject to operational control by the Health Service. Affiliated bodies are generally non-government agencies, such as charitable, welfare and community interest groups which receive financial support from government.

The Health Service had no affiliated bodies during the reporting period.

Notes to the Financial Statements

For the year ended 30 June 2002

Note 38 Financial instruments

a) Interest rate risk exposure

The following table details the Health Service's exposure to interest rate risk as at the reporting date:

	Weighted average effective interest rate %	Variable interest rate \$000	Less than 1 year \$000	Fixed interest rate maturities 1 to 5 years \$000	Over 5 years \$000	Non interest bearing \$000	Total \$000
As at 30th June 2002							
Financial Assets							
Cash assets	1.2%	229	0	0	0	1,101	1,330
Restricted cash assets	0.3%	72	0	0	0	0	72
Receivables		0	0	0	0	706	706
		301	0	0	0	1,807	2,108
Financial Liabilities							
Payables		0	0	0	0	1,251	1,251
Interest-bearing liabilities							
- W A Treasury Corporation	5.7%	0	43	1,040	0	0	1,083
		0	43	1,040	0	1,251	2,334
Net financial assets / (liabilities)		301	(43)	(1,040)	0	556	(226)
As at 30th June 2001							
Financial Assets							
Cash assets	0.5%	164	0	0	0	53	217
Restricted cash assets	0.5%	103	0	0	0	0	103
Receivables		0	0	0	0	692	692
		267	0	0	0	745	1,012
Financial Liabilities							
Payables		0	0	0	0	1,786	1,786
Interest-bearing liabilities							
- W A Treasury Corporation	5.7%	0	40	1,085	0	0	1,125
		0	40	1,085	0	1,786	2,911
Net financial assets / (liabilities)		267	(40)	(1,085)	0	(1,041)	(1,899)

b) Credit risk exposure

All financial assets are unsecured. Amounts owing by other government agencies are guaranteed and therefore no credit risk exists in respect of those amounts. In respect of other financial assets, the carrying amounts represent the Health Service's maximum exposure to credit risk in relation to those assets.

c) Net fair values

The carrying amount of financial assets and financial liabilities recorded in the financial statements are not materially different from their net fair values, determined in accordance with the accounting policies disclosed in note 1 to the financial statements.

Notes to the Financial Statements

For the year ended 30 June 2002

Note 39 Output information

COST OF SERVICES

Expenses from Ordinary Activities

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01
	\$000	\$000	\$000	\$000	\$000	\$000	\$000	\$000
Employee expenses	2,660	2,431	20,322	18,310	2,115	2,123	25,097	22,864
Fees for visiting medical practitioners	0	0	3,645	3,718	0	0	3,645	3,718
Superannuation expense	207	199	1,753	1,681	147	155	2,107	2,035
Patient support costs	412	481	4,016	3,610	1,072	882	5,500	4,973
Patient transport costs	0	0	757	707	2	2	759	709
Borrowing costs expense	0	0	61	71	0	0	61	71
Repairs, maintenance and consumable equipment expense	221	187	807	1,227	69	69	1,097	1,483
Depreciation expense	47	49	1,213	1,088	63	82	1,323	1,219
Net loss on disposal of non-current assets	8	5	21	75	6	0	35	80
Capital user charge	0	0	1,749	0	124	0	1,873	0
Other expenses from ordinary activities	277	344	1,563	1,466	95	126	1,935	1,936
Total cost of services	3,832	3,696	35,907	31,953	3,693	3,439	43,432	39,088

Revenues from Ordinary Activities

Patient charges	10	4	1,753	1,566	400	519	2,163	2,089
Commonwealth grants and contributions	0	0	0	0	1,096	1,585	1,096	1,585
Donations revenue	0	3	92	134	0	1	92	138
Interest revenue	0	0	4	17	0	0	4	17
Other revenues from ordinary activities	466	411	1,159	1,035	58	46	1,683	1,492
Total revenues from ordinary activities	476	418	3,008	2,752	1,554	2,151	5,038	5,321

NET COST OF SERVICES

Revenues from Government

Output appropriations	3,803	2,998	34,483	25,276	968	1,117	39,254	29,391
Capital appropriations	0	0	0	2,794	0	0	0	2,794
Assets assumed / (transferred)	0	0	(1,894)	(381)	0	0	(1,894)	(381)
Liabilities assumed by the Treasurer	0	200	7	1,484	0	154	7	1,838
Resources received free of charge	0	0	19	25	0	0	19	25
Total revenues from government	3,803	3,198	32,615	29,198	968	1,271	37,386	33,667
Change in net assets	447	(80)	(284)	(3)	(1,171)	(17)	(1,008)	(100)

Notes to the Financial Statements

For the year ended 30 June 2002

Note 39 Output information (continued)

Output groups as defined in the budget papers are as follows:

Prevention and Promotion

Prevention and promotion services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability and premature death. Services provided in this output include community health services; screening services; communicable disease management; health regulation and control; and community information and education.

*** Community Health Services**

Community health services include a range of community based services with the focus on improving the overall health of Western Australians. This is achieved by developing health promotion and prevention activities, supporting early child development, enhancing and ensuring universal access to community services, building capacity and assessing determinants of health as they relate to inequality.

*** Screening Services**

Screening services assist in the early identification and intervention of disease or conditions that can lead to long-term disability or premature death.

*** Communicable Disease Management**

Communicable disease management includes a range of strategies which aim to reduce the incidence and effects of communicable diseases.

*** Health Regulation and Control**

Health regulation and control is used to prevent and/or reduce the risk of disease, injury or premature death in those areas where health risk factors can be managed.

*** Community Information and Education**

A key strategy to prevent disease, injury or premature death is the provision of community information and education. The purpose of these services is to promote a healthy lifestyle and educate Western Australians about appropriate preventive health behaviours.

Diagnosis and Treatment

The objective for the diagnosis and treatment services is to improve the health of Western Australians by restoring the health of people with acute illness. The services provided to diagnose and treat patients include emergency services; ambulatory or outpatient services and services for those people who are admitted to hospitals. Services provided in this output include admitted care, ambulatory care and emergency services.

*** Admitted Care**

The types of services admitted patients may receive include obstetric care, services to cure illness or provide definitive treatment of injury, surgery, relief of symptoms or a reduction of severity of injury or illness (excluding palliative care), protection against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions, and diagnostic or therapeutic procedures.

*** Ambulatory Care**

Ambulatory care includes same day procedures, outpatient attendance, pre-admission assessments and home-based treatment and care. With these services patients do not undergo the formal hospital admission process.

*** Emergency Services**

Emergency services are provided to treat people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either, not available from their General Practitioner, or for which their General Practitioner has referred them for treatment. Emergency departments provide a range of services from immediate resuscitation to urgent medical advice. An emergency department patient may subsequently undergo a formal admission process and would then be classified as an admitted patient, or be treated and discharged directly from the Emergency department without admission.

Continuing Care

Services provided to improve the quality of life for those who need continuing care. Services provided in this output include home care and residential services.

*** Home Care**

Community based care and support to maintain and enhance, as far as possible, people's quality of life (eg home nursing, home help, transport service, home maintenance, delivered meals, respite care); care and support for terminally ill people and their families and carers (eg hospice services and palliative care); and care and support for people with long term disabilities to ensure an optimal quality of life.

*** Residential Care**

Residential aged care services are for people assessed as being no longer able to live in their own home (eg nursing home services, nursing home type services in public hospitals and hostel services).