Esperance Health Service

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 Esperance 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

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

Esperance Health Service
Hicks St
ESPERANCE WA 6450

PO Box 339
ESPERANCE WA 6450

☎ *(08) 9071 9222*
℻ *(08) 9071 9200*

The Esperance Health Service is also made up of the following health care units:

Esperance District Hospital
Hicks St
ESPERANCE WA 6450

☎ *(08) 9071 9222*

Esperance Community Health Centre
Forrest St
ESPERANCE WA 6450

☎ *(08) 9071 2499*

South East Coastal Community Mental Health
Forrest St
ESPERANCE WA 6450

☎ *(08) 9071 7677*

Mission Statement

Our Mission
To work together with our local community to achieve the best possible health for all.

Broad Objectives

The objectives of the Esperance Health Service are:

- To provide accessible health care to those who require it.
- To provide health services according to recognised standards of quality, and in a way that is acceptable to members of the public.

Enabling Legislation

The Esperance 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 Esperance 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 Esperance 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 Esperance 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.

Such processes include:

- Making relevant policies and procedures available for all existing employees to access. New employees receive this information as part of the staff induction process.
- Directly linking managerial job descriptions and performance reviews to the public sector standards and *Code of Ethics* to ensure work practices comply and are in accordance with the established Human Resource Management plan.
- Conducting routine internal checks to ensure the Health Service's working systems are appropriate to and compliant with regulatory standards.
- Adopting a staff and visiting services codes of conduct in October 1997. Regular reviews are undertaken, with the codes incorporated into employee performance appraisals and staff orientation programs.

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

Bronwen Scott
ACTING REGIONAL DIRECTOR
GOLDFIELDS SOUTH-EAST HEALTH REGION
December 2002

Advertising and Sponsorship — Electoral Act 1907

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

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies — Esperance Holdings	353.00	300.00	–
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations	–	–	–
Media Advertising Organisations	–	–	–
TOTAL	**$353.00**	**$300.00**	**$0.00**

Freedom of Information Act 1992

The Esperance Health Service received and dealt with 13 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:

FOI Coordinator
Esperance Health Service
Hicks St
ESPERANCE WA 6450

☎ *(08) 9071 9222*

Esperance Health Service

Key Operations and Achievements

- Improving and introducing new visiting specialist services to the area.
- Increasing the use of telehealth services.
- Appointing a primary health manager.
- Initiating a cardiac rehabilitation program.
- Improving mental health services by employing an extra staff member and increasing the use of telepsychiatry.
- Implementing competency-based nursing skill checklists and questionnaires.
- Establishing a midwifery booking-in clinic.

Improvements to Visiting Specialist Services

The Health Service has continued to work with visiting specialists to provide a range of consulting and procedural services to meet community needs.

The paediatric diabetic service has continued to operate during 2001/2002 and is working well. Medical Specialist Outreach Assistance Program funding has provided opportunities for the Health Service to expand existing visiting specialist services, and to introduce some new services such as ear, nose and throat and urology for 2002/2003.

Increasing Use of Telehealth Services

Telehealth use continues to grow as staff, doctors and patients become more comfortable with alternative service delivery models. Speech pathology workshops have proven successful when provided via telehealth services from Esperance to teachers in Norseman and Varley, which are 200kms and 270kms away respectively. Direct patient consultations conducted by allied health staff using telehealth technology have also proven successful.

Appointing a Primary Health Manager

A primary health manager was appointed by the Health Service in February 2002 to develop programs supporting the New Vision New Direction study. This study aims to provide a strategic direction for nursing while recognising the changing patterns of patient care, and valuing the role of the nurse and the nursing profession.

The primary health manager has also helped to refocus the work patterns of existing nursing and allied health staff from individual to group activities that target early intervention. This managerial position has already led to positive changes such as the development of new speech and early childhood programs.

Initiating a Cardiac Rehabilitation Program

The Eastern Goldfields Medical Division of General Practice has initiated a cardiac rehabilitation program. The registered nurse responsible for coordinating this program liaises closely with local GPs, and works from the Esperance District Hospital.

Expanding Mental Health Services

The South East Coastal Mental Health service has expanded the Child and Adolescent Mental Health Program by employing a level 3/5 mental health professional. This has allowed the Health Service to improve the provision of mental health services to the Norseman and Ravensthorpe communities. Telepsychiatry has been used for follow-up visits and consultations with child and adult psychiatrists.

A community mental health liaison position has also been developed for the Esperance District Hospital. This position will be used to coordinate Special Care Unit staffing and education, and the development of education programs and protocols between services.

Progressing Competency-Based Nursing Skills Assessments

Esperance District Hospital nursing staff are progressing the introduction of competency-based nursing skills assessments. Competency-based skill checklists and questionnaires have been successfully implemented in the Operating Room and Emergency Department for a range of nursing skills such as resuscitation and defibrillation, and for endoscopy clinics.

Establishing a Midwifery Booking-In Clinic

Patient-focused services continue to be a priority at the Esperance Health Service. It was determined that a formalised booking-in procedure was required to meet the needs of mothers — especially new mothers — and to allow a hospital midwife time to commence patient education. This appraisal was made following a service review with feedback received from both mothers and midwives.

A midwifery booking-in clinic was established in January 2002 as a result. Each mother is now scheduled for a 45-minute appointment. This allows time for a midwife to discuss a range of issues and options with the expectant mother. The antenatal psychosocial assessment tool is currently completed to ascertain mothers who are at risk of suffering postnatal depression.

Major Capital Projects

Projects Completed during the Year

The Esperance Health Service did not complete any major capital projects during 2001/2002.

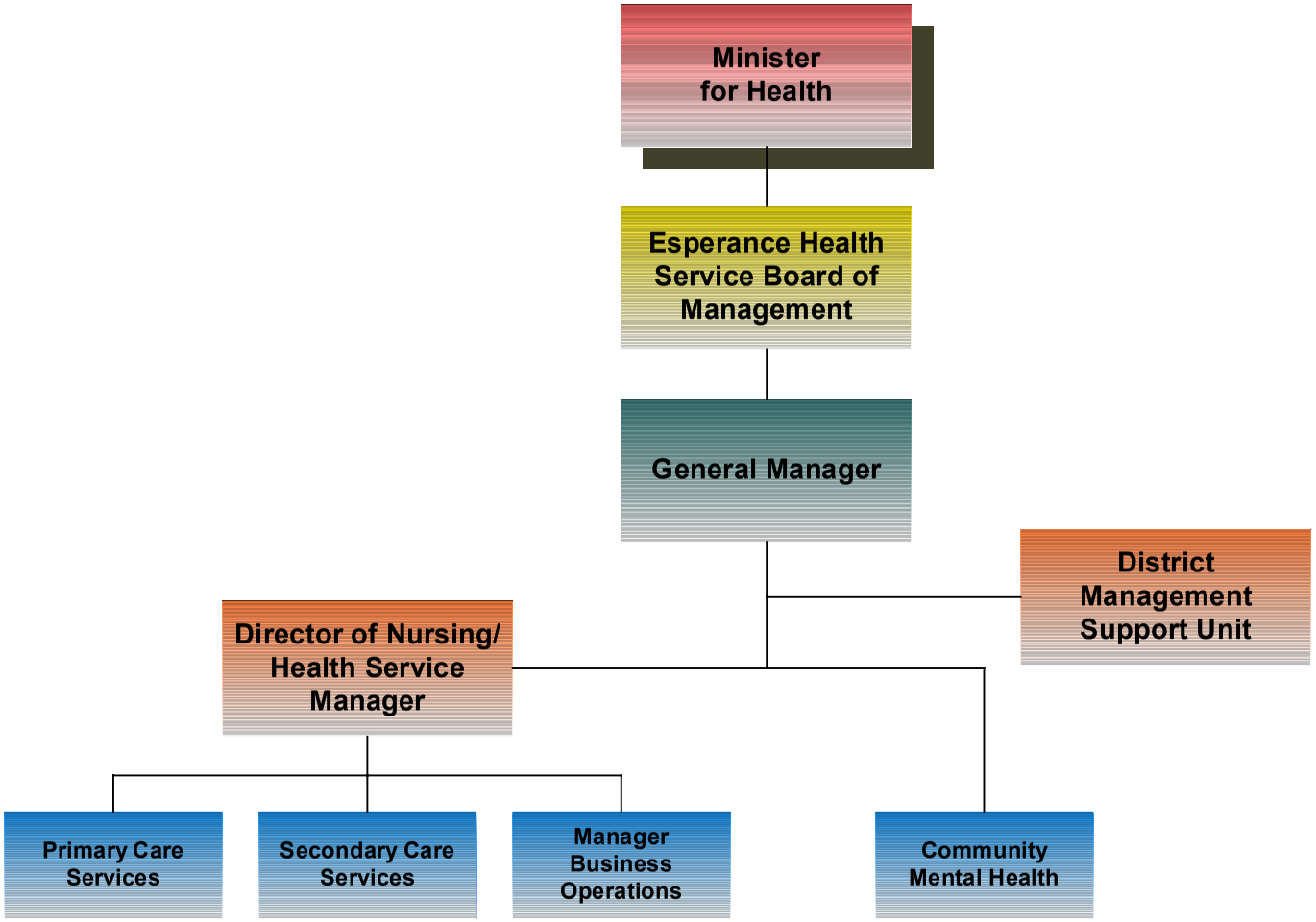
Projects in Progress

PROJECT DESCRIPTION	Expected Year of Completion	Estimated Cost to Complete	Estimated Total Cost
Esperance District Hospital Kitchen Upgrade	2003	$100,000.00	$180,000.00

The replacement of exhaust hoods, air conditioning and cooking equipment has been completed at the Esperance District Hospital during 2001/2002. A replacement of the Hospital's floor is scheduled for 2002/2003.

Management Structure

Organisational Chart



Accountable Authority

The Esperance Health Service Board of Management represents the Accountable Authority for the Health Service. The board is comprised of the following members:

Name	Position	Term of Office Expires
Thuriyya Ibrahim	Chairperson	30 December 2002
Melvin Bell	Member	30 September 2002
Anthony Bright	Member	30 December 2002
Alva Courtis	Member	30 December 2002
Steven Florisson	Member	30 December 2002
Malcolm Heasman	Member	30 September 2002
Sue Rollands	Member	30 September 2002
Rosemary Shaddick	Member	30 September 2002
Debbie Syme	Member	30 September 2002

Note: The Governor in Executive Council approved the amalgamation of several hospital boards including the Esperance 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 Esperance Health Service and their areas of responsibility are listed below:

Area of Responsibility	Title	Name	Basis of Appointment
District Health Service Management	General Manager	Mark Edgar	Permanent
Nursing and Corporate Services	Health Service Manager/Director of Nursing	Sherryl Wolfenden	Permanent
Medical Services	Chairman, Medical Advisory Committee	Dr Graham Jacobs	12-month Contract

The Health Service Manager is directly responsible for all clinical and non-clinical Department of Health employees operating within the Esperance Shire boundary, excluding those from the South East Coastal Mental Health Service.

Pecuniary Interests

Members of the Esperance Health Service Board of Management and senior officers of the Health Service have declared no pecuniary interests other than those reported in the Financial Statements section of this report.

Demography

The Esperance Health Service delivers services to communities covered by the following local authorities:

- Dundas Shire
- Esperance Shire
- Ravensthorpe Shire

The following table shows population figures for each local authority covered by the Health Service:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Dundas Shire	1,652	1,247	1,700
Esperance Shire	12,316	13,319	15,499
Ravensthorpe Shire	1,435	1,523	2,102

*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*.

Use of the Esperance Health Service continues to increase due to a steady growth in the local population, rising community interest in healthier lifestyles and continuing promotion of Esperance as a popular tourist destination.

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
Gastroenterology
Gynaecological
Mental Health Services
Obstetrics
Ophthalmology
Orthopaedics
Paediatric
Respite Care
Same Day Surgery
Terminal Patient Support

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

Community Services
Child Development
Home Care
Meals on Wheels
Primary Health Care
School Health Care

Other Support Services
Health Promotion
Hotel Services
Medical Records

Specialist Services
None

Other Services
None

Disability Services

Our Policy
The Esperance 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 continues to make appropriate changes to existing facilities as funds become available.
- Any workplace changes are made with careful consideration of the disability services plan in mind.

Outcome 2: Access to buildings and facilities is improved.

- Ongoing reviews are conducted to ensure access to buildings is appropriate for people with disabilities. This includes providing external lighting, displaying signs and improving means of entry to buildings.

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

- Every effort is made by Health Service staff to provide information in accessible formats for people with disabilities.

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

- Contact officers employed at the Health Service have been trained to distribute information and assist staff with any issues encountered in the workplace. This role includes a responsibility to provide help for people with disabilities who are employed at the Health Service.

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

- The Health Service encourages issues to be brought to our attention to ensure areas of concern for people with disabilities are improved. This goal is achieved by maintaining appropriate representation on community-based committees and at inter-agency meetings.

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 Esperance 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 may experience cultural barriers or communication difficulties while accessing the service's facilities:

- The Health Service has access to a telephone interpreter service when it is required. In most cases, it is usually either merchant seamen or tourists who require the use of an interpreter.
- An Aboriginal health worker is employed by the Health Service, and acts as a liaison with the Indigenous community.

Youth Services

Our Policy
The Esperance 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 the following:

- The Community Mental Health Team employs a youth counsellor for the South East Coastal region. This counselling service is targeted towards young people aged from 15 to 25 who are at risk of serious emotional disturbance, or who display self-harming or other troubling behaviour.
- A registered nurse is employed at the Esperance Senior High School, and works closely with the Health Service's youth counsellor on many programs including health promotion activities.
- An early intervention mental health program targeted towards young people was run during 2001/2002. The program aimed to reduce the prevalence of mental health problems among youth, and to prevent the development of more serious mental health disorders.

The Health Service also provides a broad range of community services that incorporate youth needs. These services include counselling sessions for individuals, education and information sessions for groups, and referrals to treatment services where appropriate.

Employee Profile

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	43.09	48.89	49.00
Administration and Clerical*	17.21	18.34	22.54
Medical Support*	12.72	14.99	15.59
Hotel Services*	23.56	23.52	22.43
Maintenance	5.20	6.03	6.03
Medical (salaried)	–	–	–
Other	–	–	–
TOTAL	**101.78**	**111.77**	**115.59**

*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 Esperance Health Service's turnover of staff has seen a slight increase over the past few years. New positions funded through the Commonwealth Regional Health Strategy are being created and filled.

A dedicated human resources officer was employed in July 2001 for the first time in the history of the Health Service.

Staff Development

Staff development has been achieved during 2001/2002 in the following ways:

- Fifty-seven staff attended a range of in-house and external development programs for a combined total of 200 days.
- Nursing, allied health and clerical staff undertook general up-skilling through specific staff development courses.
- Catering services became accredited in hazard analysis and critical control point principles and practices.
- Staff were made familiar with the New Vision New Direction study in the area of community and public health. This study aims to provide a strategic direction for nursing while recognising the changing patterns of patient care, and valuing the role of the nurse and the nursing profession.
- All community health staff successfully completed requirements to retain their immunisation skills.
- In-house programs for staff have covered topics such as suicide prevention and ways of dealing with difficult people.

Regular presentations televised through the Westlink network are being accessed, especially by nursing staff. These presentations are considered particularly relevant to those working in the area of general nursing care. Greater use of telehealth facilities is also being made throughout the Health Service.

The ongoing generosity of a local family and donations from organisations in the area are used to cover many of the registration costs for courses Health Service staff attend.

Industrial Relations Issues

No new industrial relations issues needed the Health Service's attention during 2001/2002. The Health Service Manager continued to represent the Department of Health on the Career Structure Working Party as part of the 2001 nurses enterprise bargaining agreement.

Workers' Compensation and Rehabilitation

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	0	0	1
Administration and Clerical*	1	1	0
Medical Support*	0	0	0
Hotel Services*	3	0	1
Maintenance	0	0	0
Medical (salaried)	0	0	0
Other	0	0	0
TOTAL	**4**	**1**	**2**

*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.

The Occupational Safety and Health Committee — with the full endorsement of the Esperance Health Service Executive — conducts regular OSH audits and review policies to improve safety. Rehabilitation specialists have been contracted to conduct workplace assessments with positive results received by the Health Service. Lost time injuries have been negligible during 2001/2002.

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 Esperance 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.

- EEO legislation is explained and covered at the Health Service's corporate induction days with relevant material on equal opportunity and diversity given to all new staff.
- Occupational Safety and Health representatives are proactive in keeping the workplace free from racial and sexual harassment, and are available to any staff who may wish to report issues.

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

- The *Public Sector Standards in Human Resource Management* is strictly adhered to by the Health Service and all HR personnel. This has resulted in no breaches being lodged as part of the recruitment, selection and appointment process.

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

- The Health Service encourages physically or mentally challenged students to use the organisation for work experience.
- People from different ethnic and cultural backgrounds represent part of the staff employment base.
- Human Resource personnel are currently engaged in developing a workforce development plan for the future.

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 Esperance Health Service has been able to meet these goals:

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

Marketing

Community awareness of the Esperance Health Service's facilities was raised through the following marketing activities:

- Continuing the use and distribution of pamphlets.
- Promoting the organisation through local media outlets and service clubs as opportunities arise.
- Conducting tours of the Health Service for school children and community-related groups.
- Conducting inter-agency activities such as being a member of other community committees.

Publications

The Esperance Health Service produced no external publications during 2001/2002.

Research and Development

Significant progress was made during 2001/2002 on the following two research projects:

The Suicide Research Project
The Esperance Health Service completed the *Prevention of Suicidal Behaviours in the South East Coastal Health Region — Research and Evaluation Report* during 2001/2002. The report has been forwarded to the organisation's Mental Health Division, with copies available through the Office of Mental Health.

Two papers have been submitted for publication based on the Suicide Research Project. These are:

- The *Esperance Primary Prevention Suicide Project*, which was submitted to the Australian and New Zealand Journal of Psychiatry.
- The *Esperance Secondary Prevention Suicide Project*, which was submitted to the Australian Journal of Remote and Rural Medicine.

These papers are also available from the Office of Mental Health or the community mental health offices.

The Community Partnerships Project
The completed report, *Collaboration Between Rural Mental Health Services, Community Health Services and Community Services: A Qualitative Study*, is available from the Office of Mental Health and the South East Coastal Mental Health Service.

Many of the report's recommendations have been implemented. One of these key recommendations was for improved communication between the mental health service and other community health and welfare agencies. Definitions were clarified covering the role and boundaries of the mental health service, and inclusion and exclusion criteria. Feedback mechanisms and referral processes were clearly defined and documentation audits of clinical files were implemented.

A presentation on report outcomes was presented at the Pathways to Care conference held in Albany in June 2002.

Evaluations

The Esperance Health Service carried out no major evaluations during 2001/2002.

Risk Management

Our Policy

The Esperance 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

Successful risk management strategies in operation during 2001/2002 include the following:

- The Health Service makes all planning and operational decisions after careful consideration of the range of possible risks that can impact on the organisation.
- Funding was continued to support the employment of a risk management project officer. This project brief will finish in September 2002.
- A risk management committee — chaired by the South East Coastal Health Service General Manager — continued to work on recommendations made by the risk management project officer.

Future Direction

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

Internal Audit Controls

The Esperance 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. There were no significant audit findings identified during 2001/2002. An Esperance Health Service Board of Management audit committee oversees the operation of internal audit functions, and ensures management addresses any findings arising from internal and external audit reports.

There were no significant audit findings identified during 2001/2002.

Waste Paper Recycling

The Health Service does not have the capacity to recycle waste paper other than for use as notepaper or as compost for the hospital grounds.

No records were kept of the amount of waste paper recycled during 2001/2002 as a result.

The Shire of Esperance is currently trialing a domestic recycling program. The shire will hopefully be able to extend this program to include commercial waste over the next few years.

Pricing Policy

The Esperance 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.

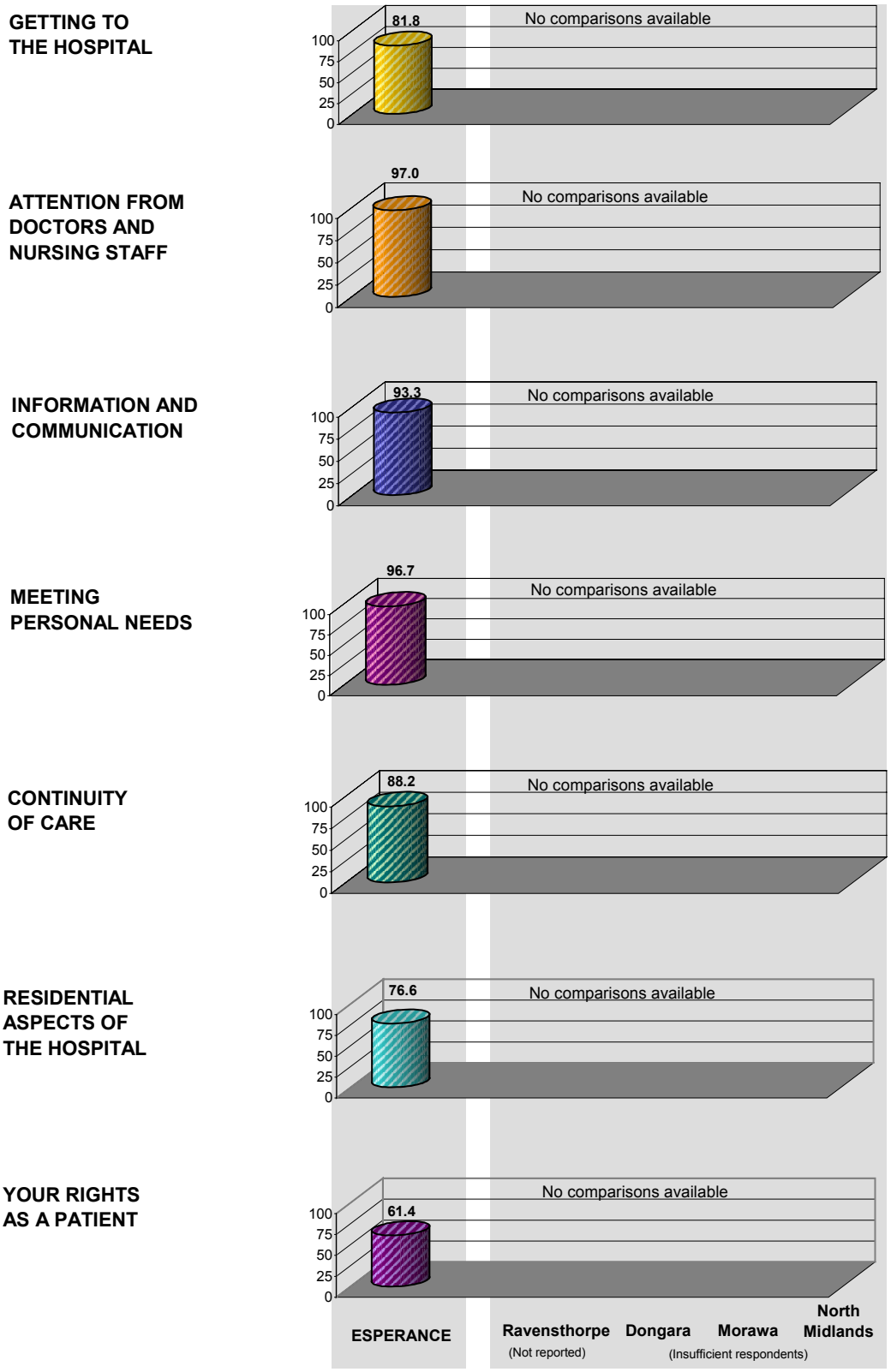
No fees are raised against registered public and private outpatients of the Health Service.

Client Satisfaction Surveys

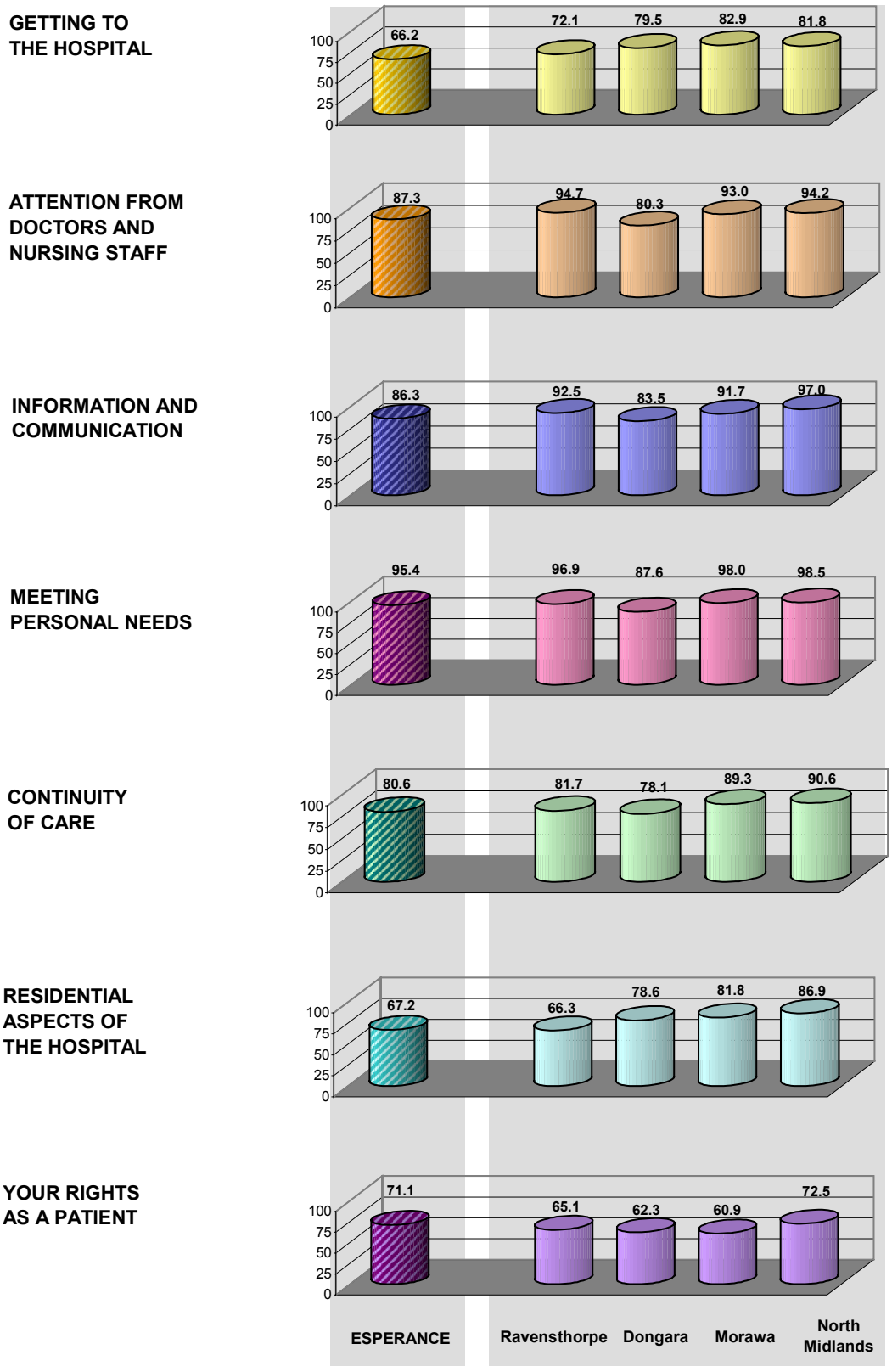
Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey 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 47) of this report.

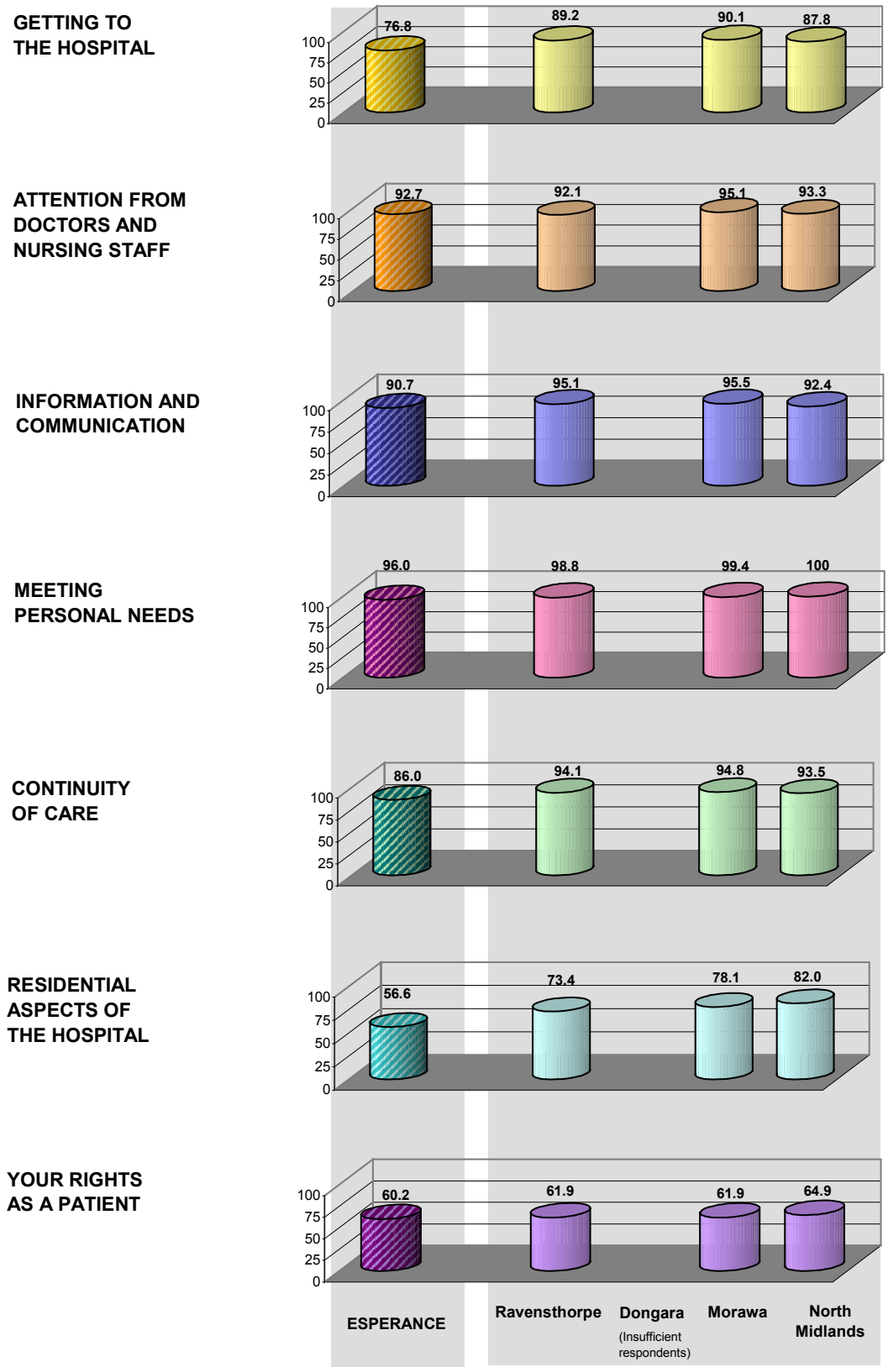
KPI 2.2: SAMEDAY PATIENTS — RURAL



KPI 2.2: EMERGENCY PATIENTS — RURAL



KPI 2.2: OUTPATIENTS — RURAL



AUDITOR GENERAL

To the Parliament of Western Australia

ESPERANCE HEALTH SERVICE
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the key effectiveness and efficiency performance indicators of the Esperance Health Service 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 Esperance Health Service.

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 Esperance Health Service 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 14, 2003

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

AUDITOR GENERAL

INTERIM REPORT

To the Parliament of Western Australia

ESPERANCE 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 Esperance Health Service for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Esperance 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.

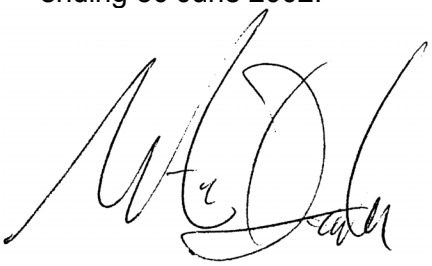
It is anticipated that the opinions will be issued by March 31, 2003.

D D R PEARSON
AUDITOR GENERAL
February 28, 2003

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

ESPERANCE 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 Esperance 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

Table of Contents

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.

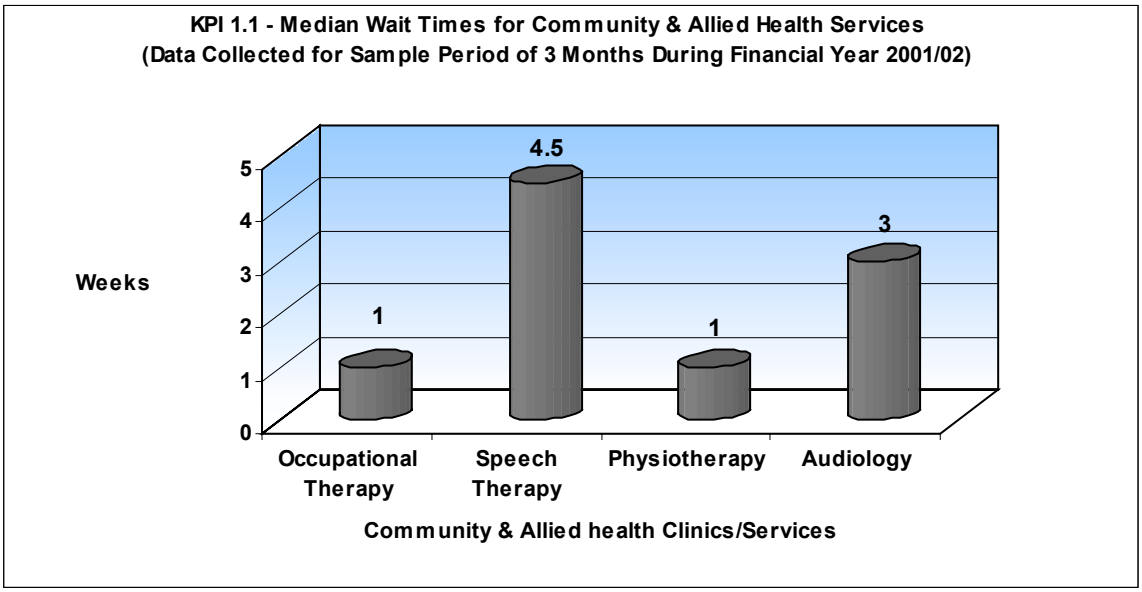
Access to health services are provided on the basis of clinical need but situations where clients are waiting longer than the average may reflect sub-optimal practices or under-resourcing within the organisation.

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 specialities.

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.

Waiting times for Occupational Therapy and Physiotherapy being one week are both regarded as acceptable. Significant waiting times for access to Audiology and Speech Pathology services indicate high demand relative to available services. Financial constraints limit the Audiology service to part-time only. The Health Service s experienced difficulties in filling Speech Pathology vacancies earlier this year.



RATE OF SCREENING IN CHILDREN	KPI 1.2

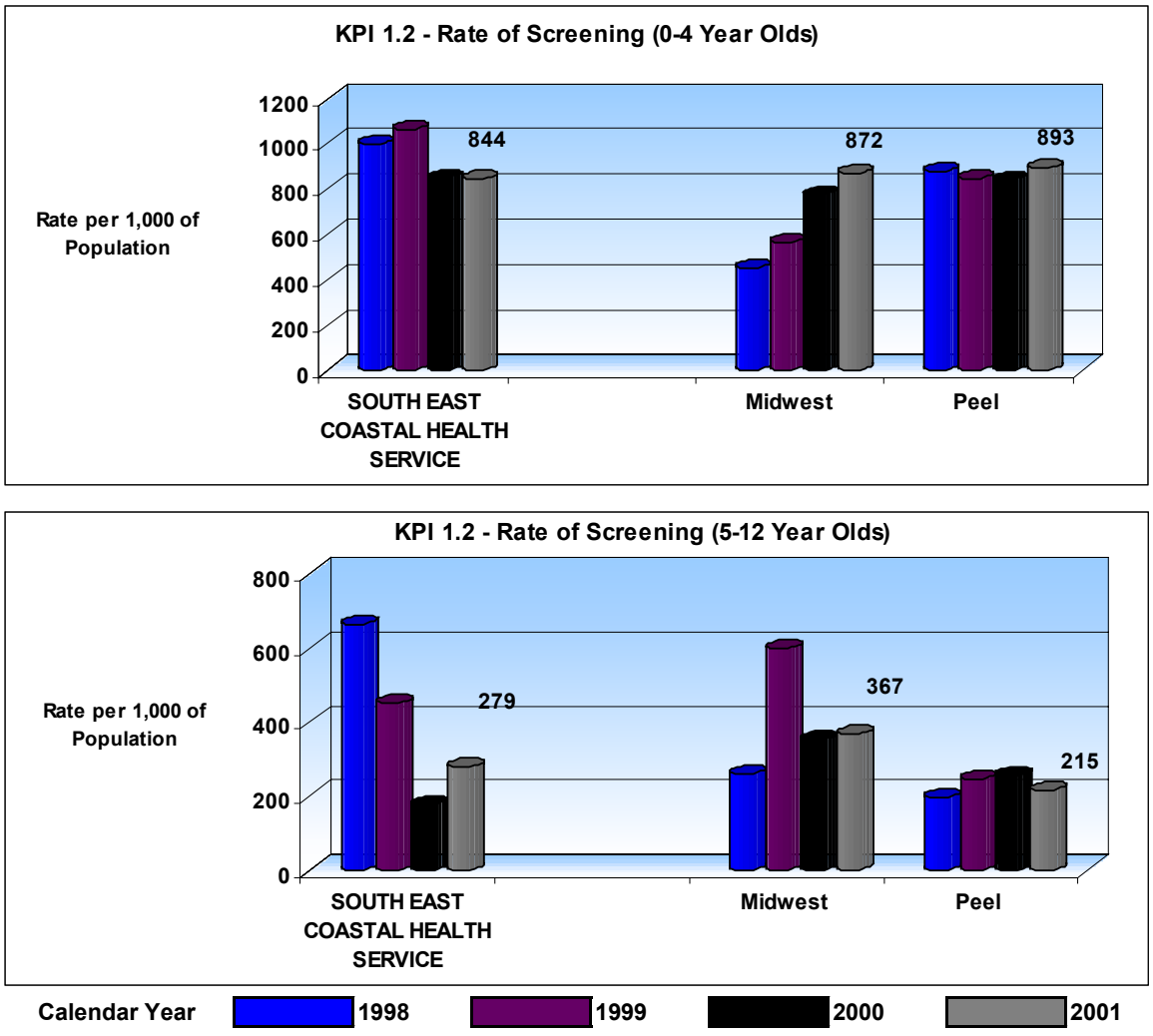
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good 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.

The Health Service has maintained high rates of screening in children over the past four years.

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.

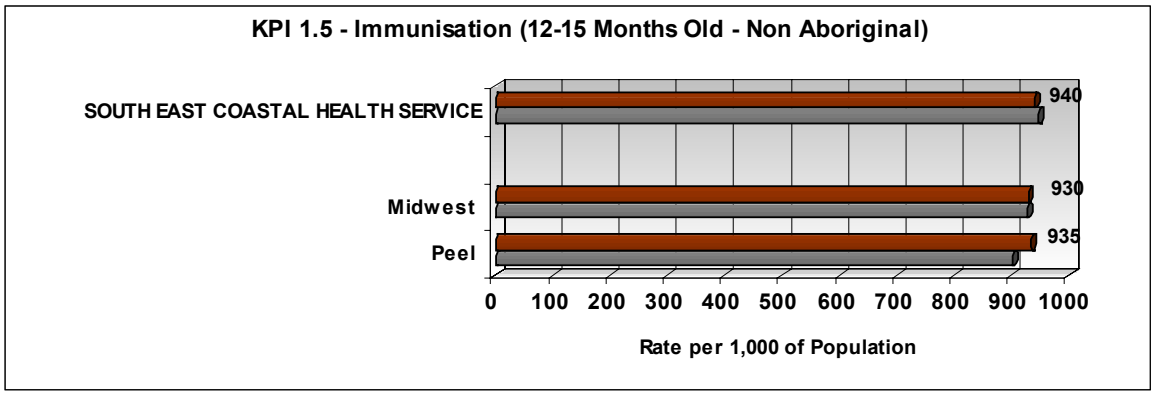
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

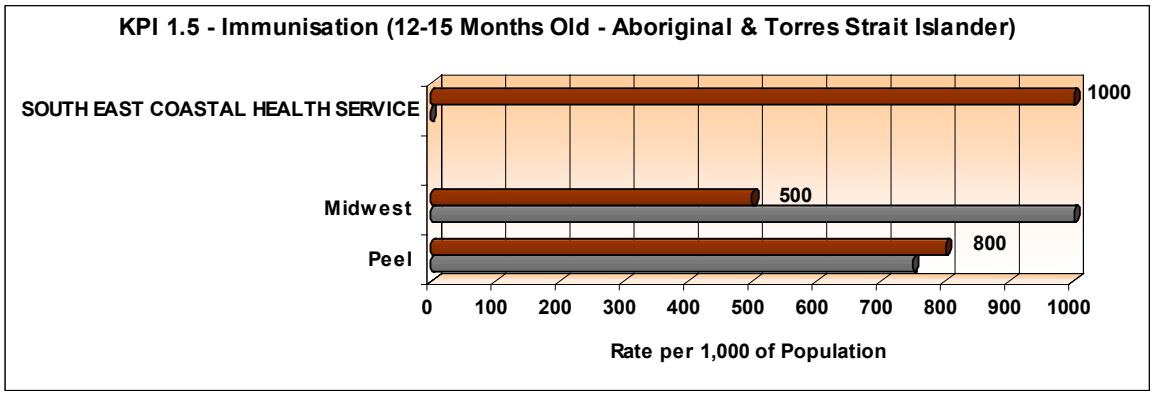
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

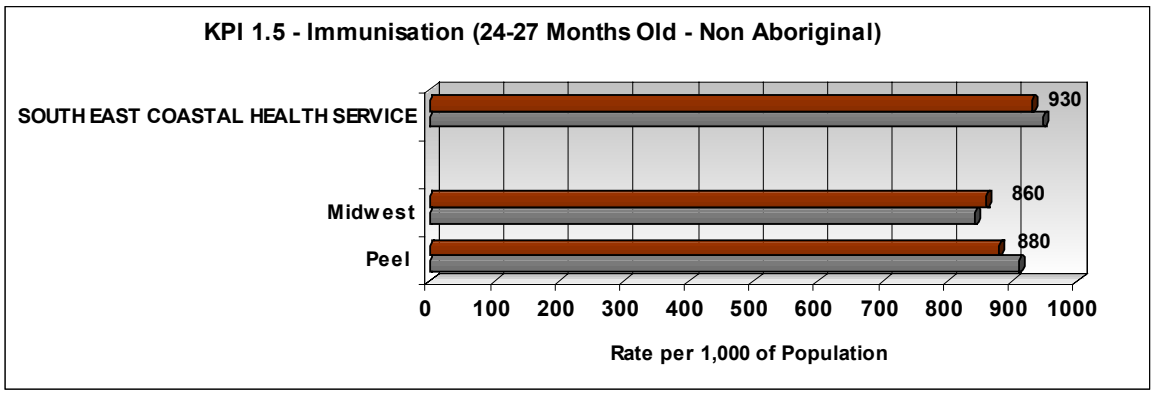
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

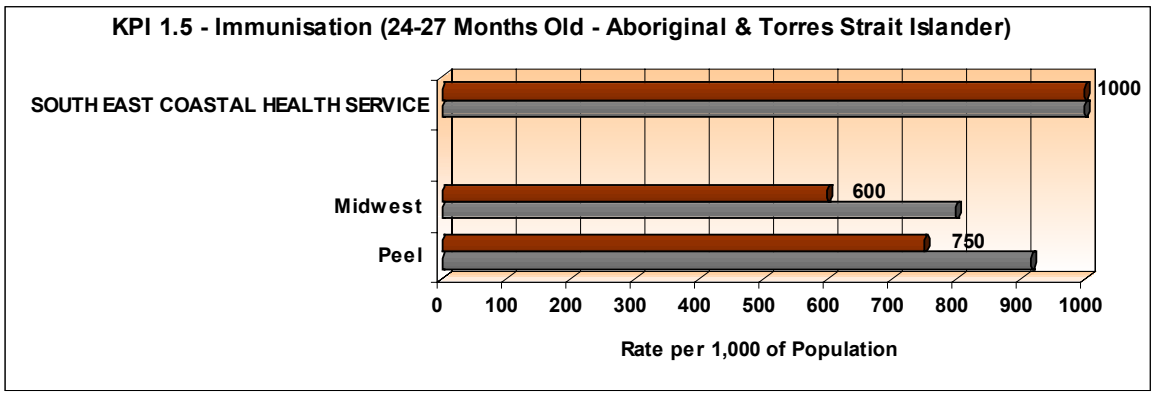
All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the 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.

Rates of childhood immunisations in the District are high. We have made a concerted effort in recent years to maximise our effectiveness in this area.


KPI 1.5 - Immunisation (12-15 Months Old - Non Aboriginal)
SOUTH EAST COASTAL HEALTH SERVICE
Midwest
Peel
940
930
935
0 100 200 300 400 500 600 700 800 900 1000
Rate per 1,000 of Population


KPI 1.5 - Immunisation (12-15 Months Old - Aboriginal & Torres Strait Islander)
SOUTH EAST COASTAL HEALTH SERVICE
Midwest
Peel
1000
500
800
0 100 200 300 400 500 600 700 800 900 1000
Rate per 1,000 of Population


KPI 1.5 - Immunisation (24-27 Months Old - Non Aboriginal)
SOUTH EAST COASTAL HEALTH SERVICE
Midwest
Peel
930
860
880
0 100 200 300 400 500 600 700 800 900 1000
Rate per 1,000 of Population


KPI 1.5 - Immunisation (24-27 Months Old - Aboriginal & Torres Strait Islander)
SOUTH EAST COASTAL HEALTH SERVICE
Midwest
Peel
1000
600
750
0 100 200 300 400 500 600 700 800 900 1000
Rate per 1,000 of Population


Calendar Year
2001
2002

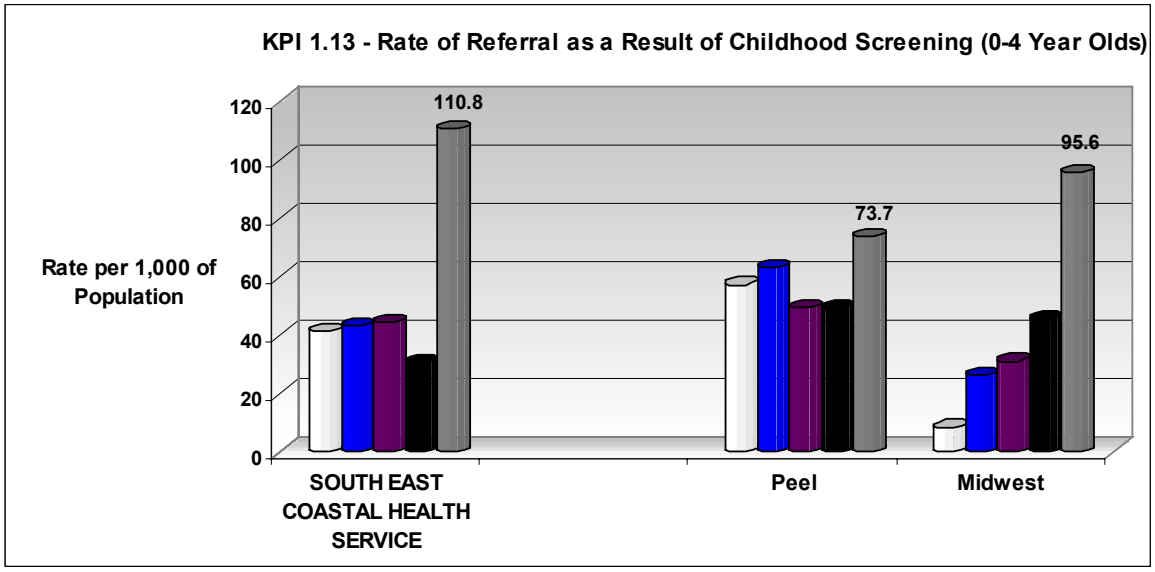
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

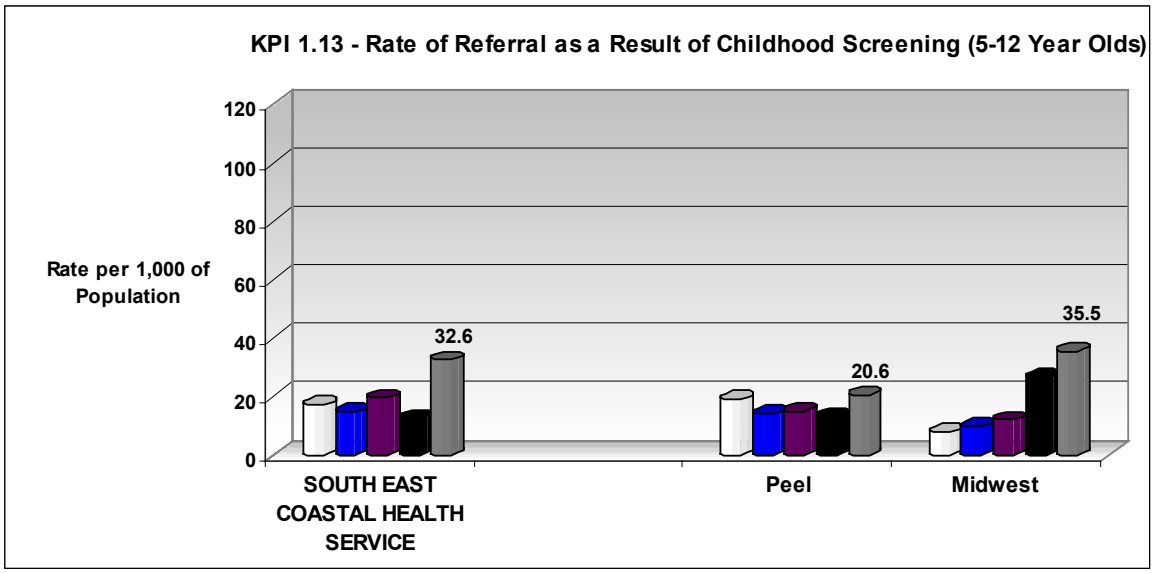
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill but also to maintain a state of 'wellness' that allows them to develop to full potential.

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.

There is a significant increase in the rate of referral as a result of childhood screening this year. This is in part due to the introduction of a new speech pathology screening program for community health nurses.





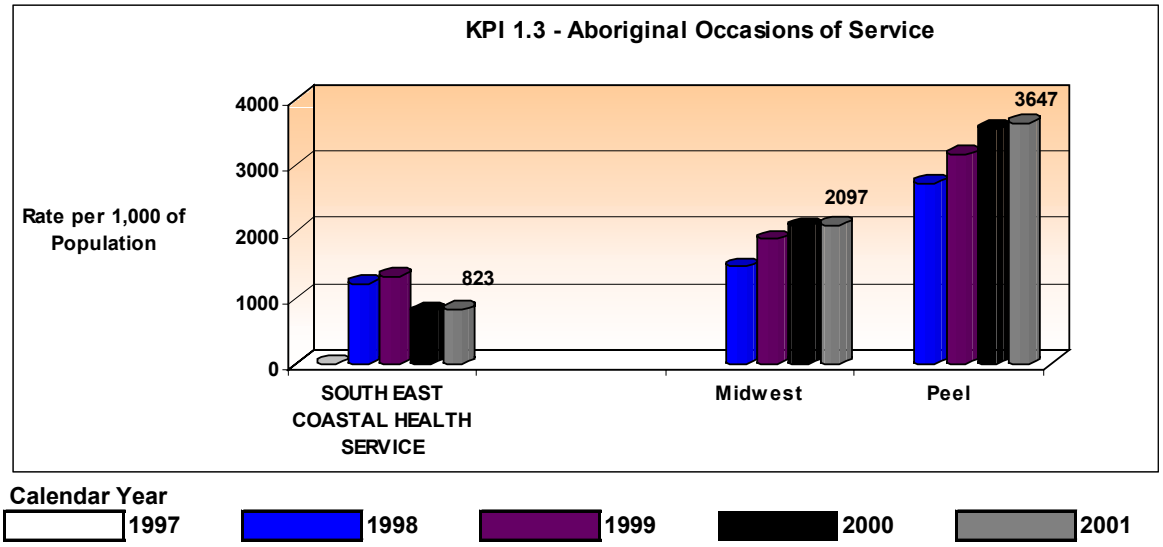
RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

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 occurs when individuals attend more than once in a year.

The rate of service provision to Aboriginal people has remained relatively static in recent years. The slight fall in the rate ratio of Aboriginal to non Aboriginal people may be due to a vacancy in the Aboriginal Health worker position.



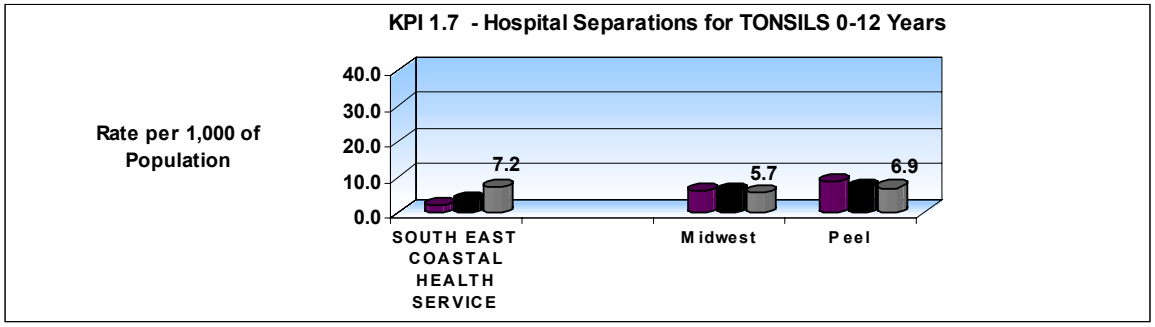
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS | KPI 1.7

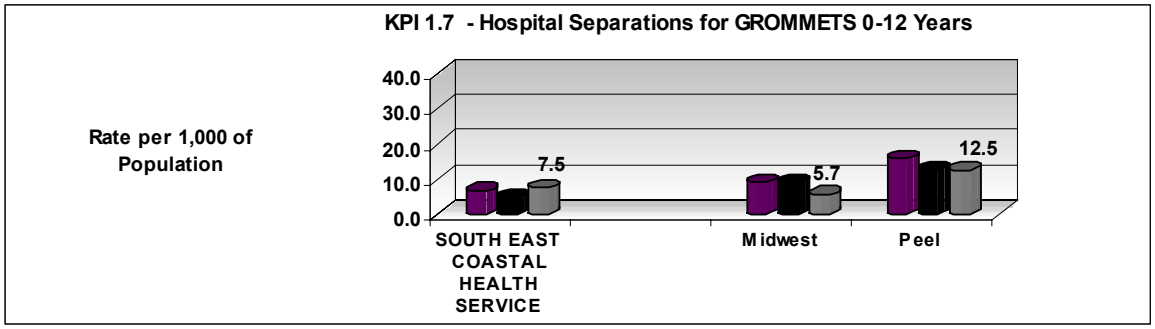
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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.





Calendar Year 1999 2000 2001

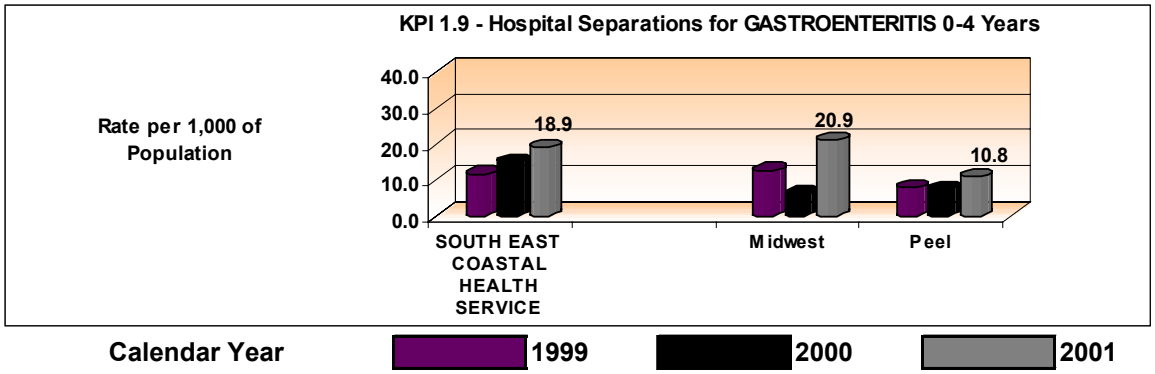
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN | KPI 1.9

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

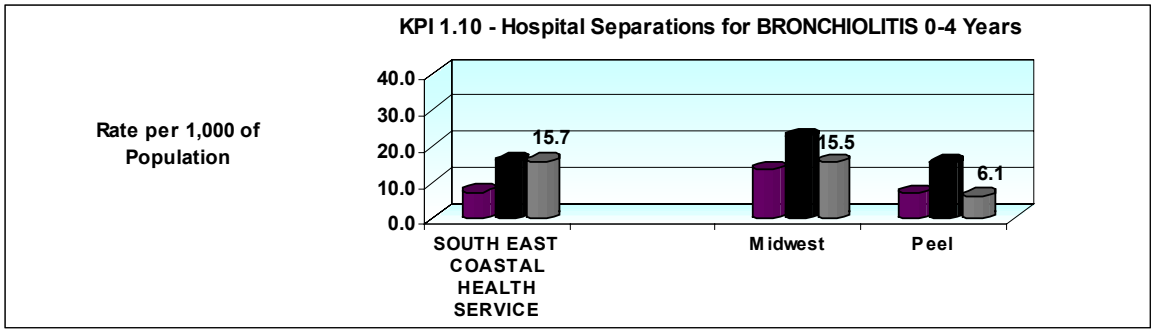
The graphs shows individuals aged 0-4. Of those individuals aged 5-12 and 13-18, none were hospitalised this year.

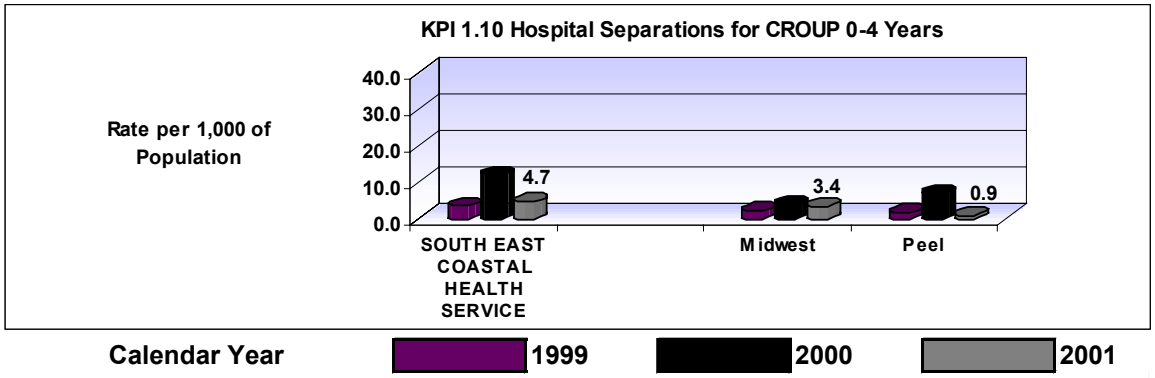
Croup

The graph shows individuals aged 0-4. Of those individuals aged 5-12, only 3 were hospitalised this year, a rate of 1.8 per thousand. Of those individuals aged 13-18, none were hospitalised this year.

Acute Bronchitis

9 individuals aged 0-4 at a rate of 7.1 per thousand were hospitalised this year and no individuals were admitted aged 5-12 or 13-18.





HOSPITAL ADMISSIONS FOR ASTHMA	KPI 3.7

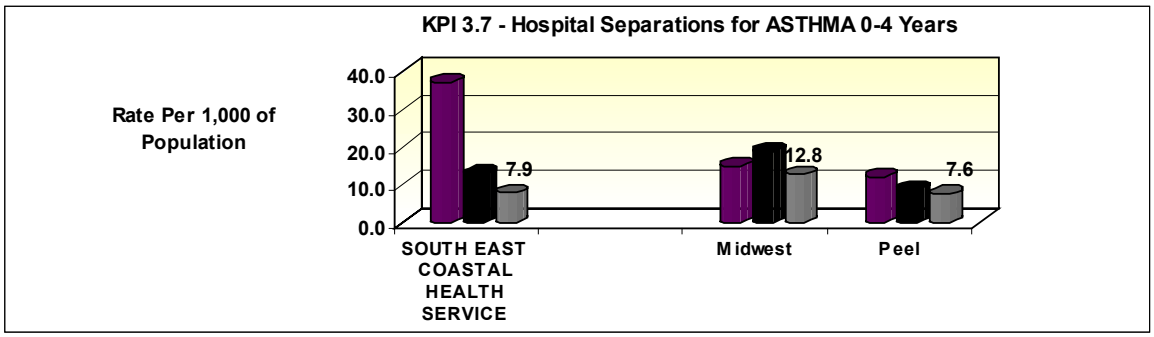
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

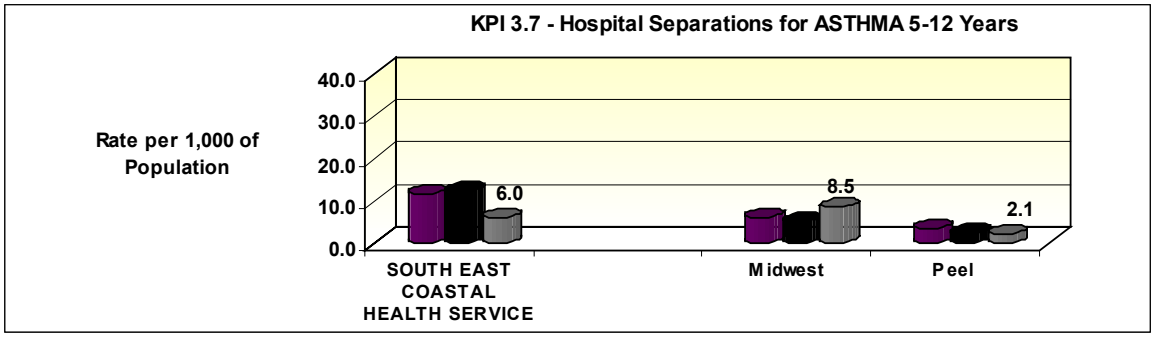
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

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. 5 individuals aged 13-18 at a rate of 3.8 per thousand were hospitalised this year, with 5 individuals being admitted aged 19-34 at a rate of 1.5 per thousand and 17 individuals aged 35 years and over at a rate of 2.1 per thousand.





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.

The cost of providing community health services in the South East Coastal Health Service has risen slightly in the past year. The Health Service has expanded the range of services offered to include more expensive professional services. The Health Service also experiences a disadvantage due to remoteness from Perth. Freight and transport charges contribute to increased overall costs.

HEALTH SERVICE	COST PER OCCASION OF COMMUNITY HEALTH SERVICE
South East Coastal	$75.40

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 Esperance District Hospital reports an overall satisfaction score of 85 for same-day patients, 79 for emergency patients and 80 for outpatients for this financial year with standard errors of 0.96, 2.68 and 2.17 respectively.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Same-day Patients	246	133	54%
Emergency Patients – Centrally Administered	52	17	33%
Emergency Patients – Centrally Administered*	100	13	13%
Outpatients – Centrally Administered	52	21	40%
Outpatients – Hospital Administered*	85	20	24%

* *Response rates for hospital administered surveys are very low because the number of survey forms actually distributed is not known. The number sent reflects the number of forms given to the hospital.*

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.

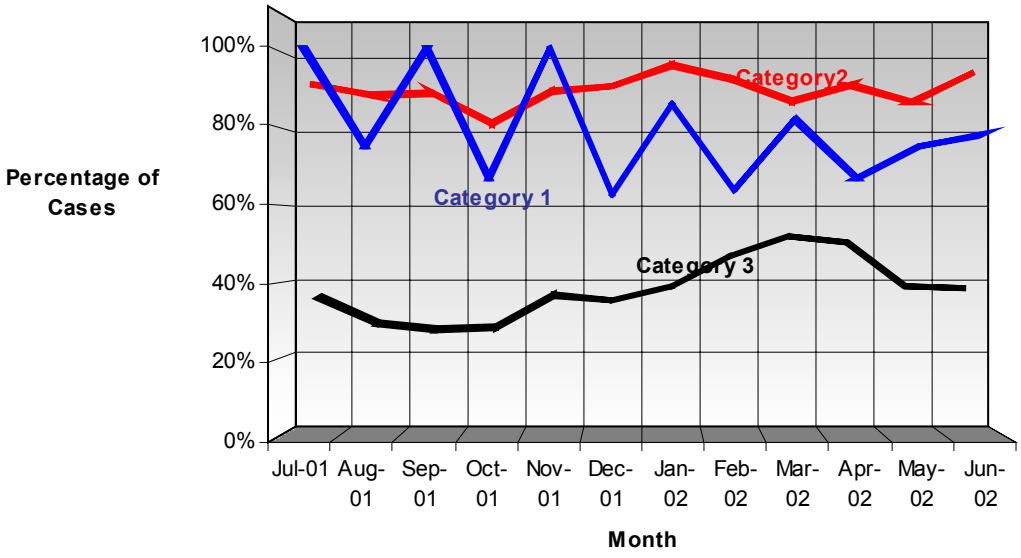
All patients who are referred for elective surgery must be classified by senior medical staff into one of the three following admission categories:

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 generally high waiting times for elective surgery are a reflection of the lack of locally available specialist surgical services. Esperance does have some visiting specialists but their visits are scheduled according to the availability of the practitioner and often will not allow treatment within the prescribed time frame.

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.

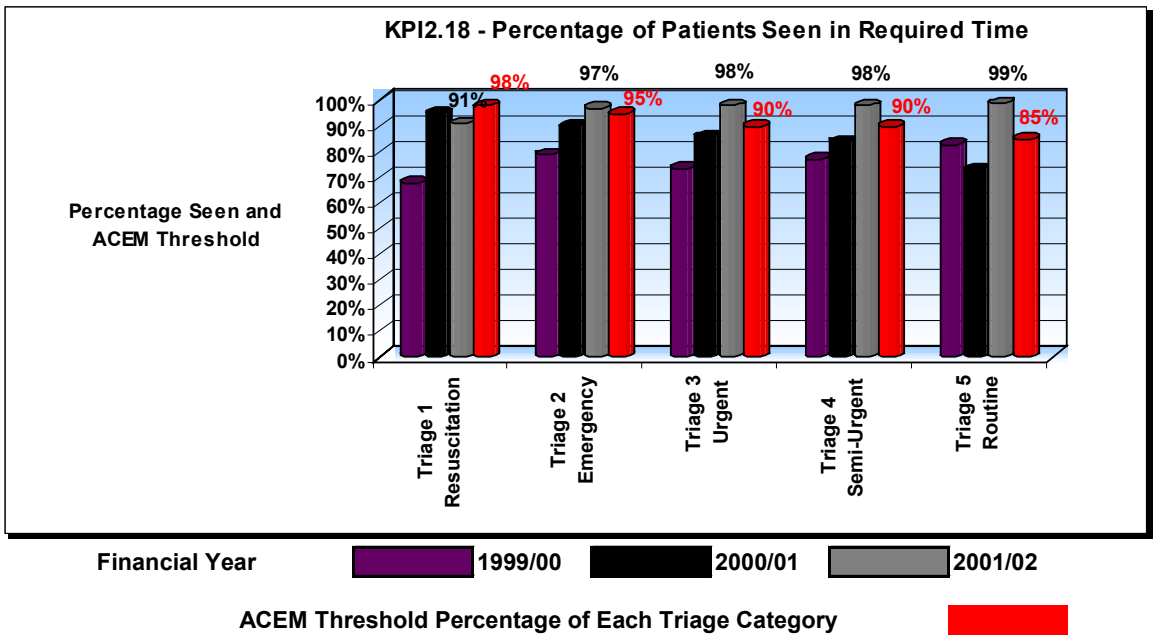
When patients first enter an Emergency Department, they are assessed by nursing staff and allocated a triage code between 1 and 5 that indicates their urgency. This code provides an indication of how quickly patients should be reviewed by medical staff. In rural areas however, where a medical practitioner 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%

Esperance Hospital has provided timely treatment to patients within most triage categories. The hospital does not have medical staff on site and relies on the services of visiting medical practitioners. It is not always possible to meet the stringent deadline for category 1 triage patients.

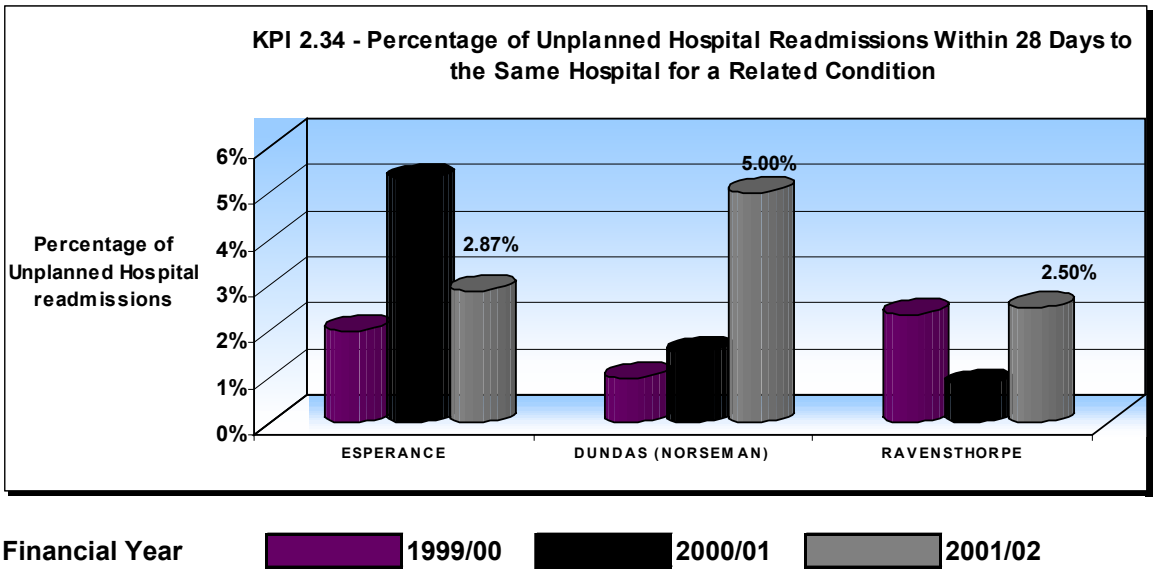


UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR A RELATED CONDITION	KPI 2.34

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.

The Health Service has been able to reduce the rate of unplanned re-admissions this year.

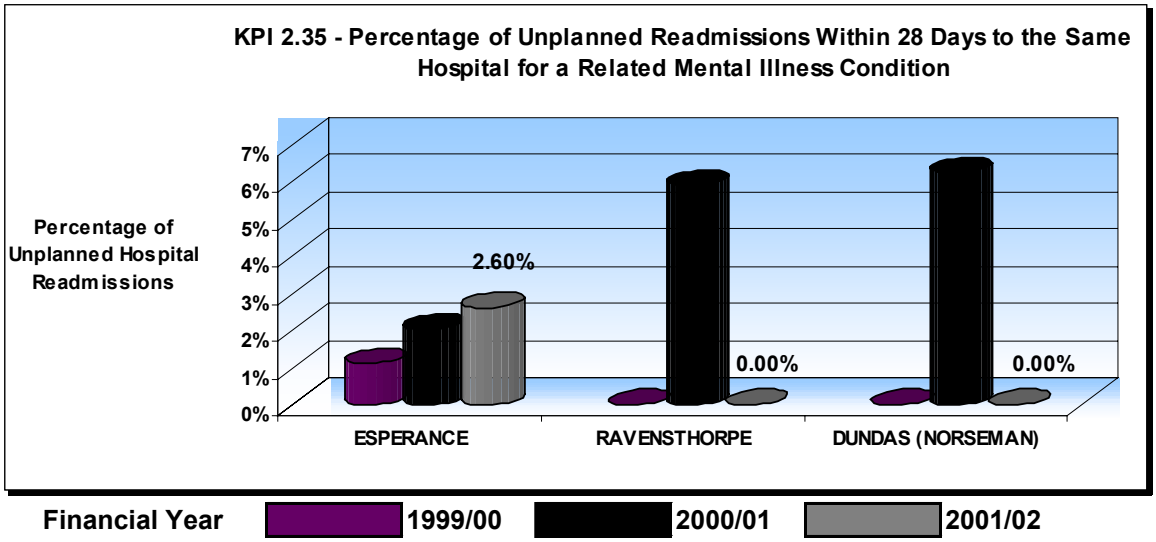


UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR TREATMENT AND CARE FOR A RELATED MENTAL HEALTH ILLNESS	KPI 2.35

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.

Results show an increasing rate of re-admission in the past three years. There are very few cases in this category at the health service each year and so small variations in numbers can have a marked effect on the rate.



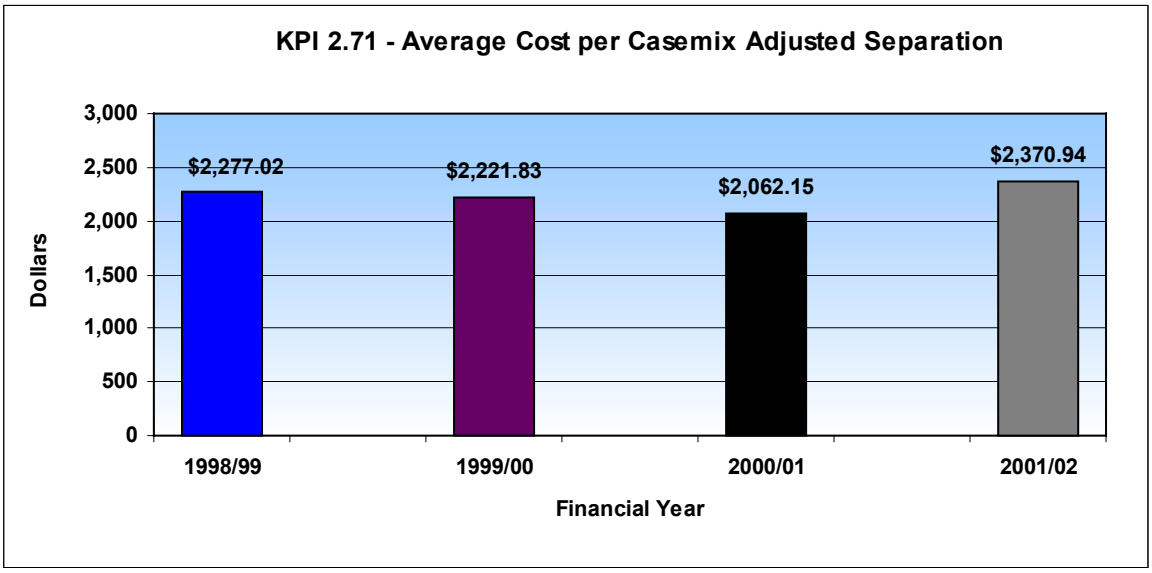
AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

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 and is presented using CPI adjusted costs.

Esperance's costs for inpatient services has remained stable in the past three years. The Hospital has worked hard to contain costs and to provide services in an efficient manner.



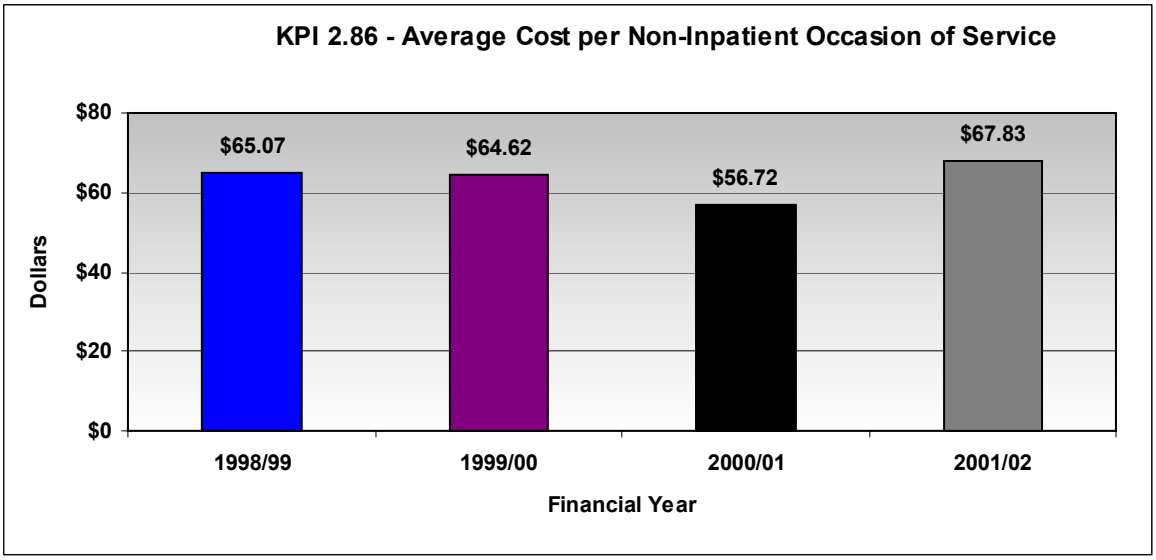
AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

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 and is presented using CPI adjusted costs.

Esperance's costs for outpatient services has remained stable in the past three years. The Hospital has worked hard to contain costs and to provide services in an efficient manner.



KPI 3.7 : Hospital separations for Asthma

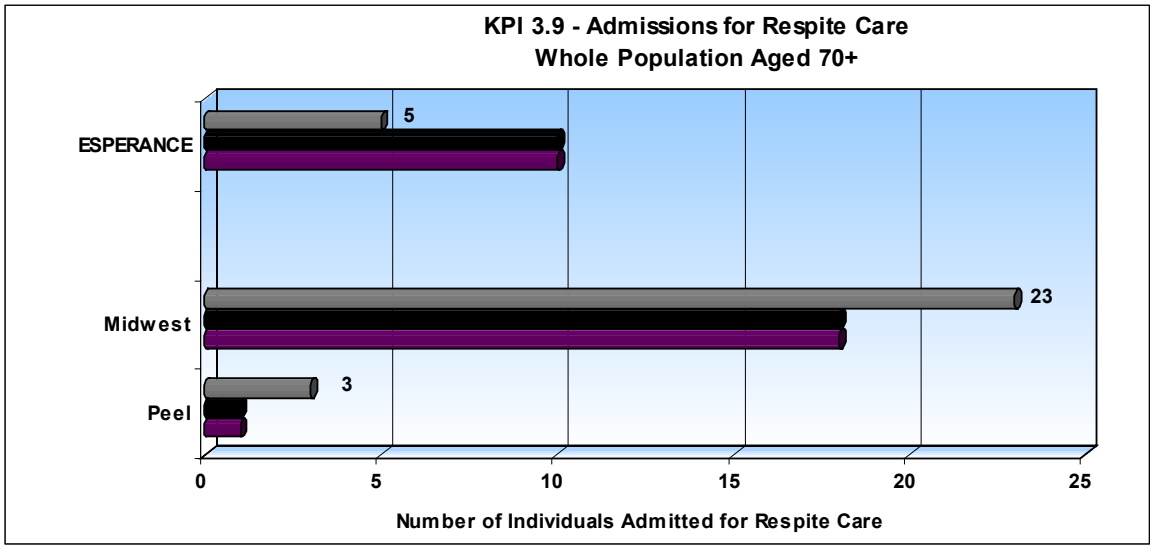
Hospitalisation for acute Asthma is part of managing chronic conditions. The indicator has been moved to Output 1 from Output 3 in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

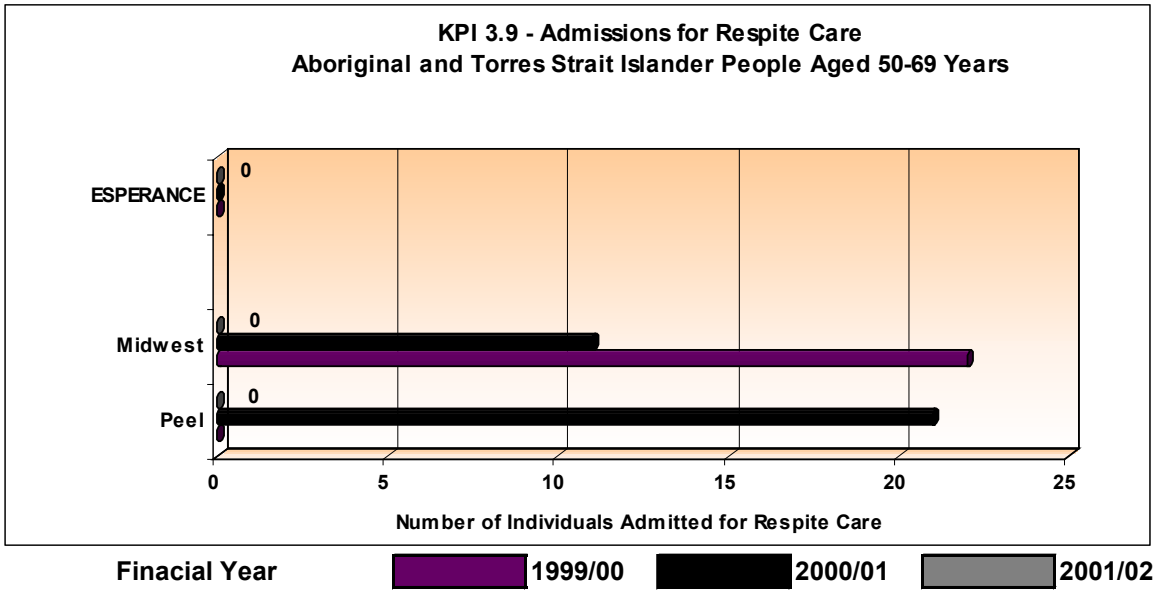
NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

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.

Esperance maintains a comprehensive extended care service, which supports people in need of care in the home. The relatively low rate of admission for respite care is a testimony to the success of this service.





AUDITOR GENERAL

To the Parliament of Western Australia

ESPERANCE HEALTH SERVICE
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the accounts and financial statements of the Esperance Health Service 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 Health Service 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 Health Service's financial position, its financial performance and its cash flows.

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

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

Esperance Health Service
Financial Statements for the year ended June 30, 2002

Audit Opinion
In my opinion,

(i) the controls exercised by the Esperance Health Service 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 and 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 Health Service at June 30, 2002 and its financial performance and its cash flows for the year then ended.

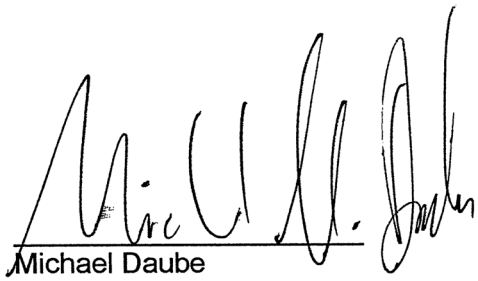
D D R PEARSON
AUDITOR GENERAL
March 14, 2003

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

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

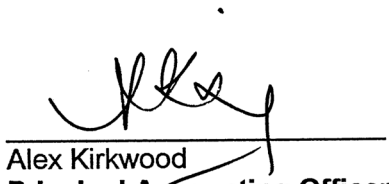
The accompanying financial statements of the Esperance Health Service have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002 and the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

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Esperance 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		5,593,179	4,902,799
Fees for visiting medical practitioners		919,602	951,067
Superannuation expense		465,090	427,982
Patient support costs	3	996,615	1,095,409
Patient transport costs		545,585	476,476
Borrowing costs expense		192,158	203,003
Repairs, maintenance and consumable equipment expense		306,378	260,352
Depreciation expense	4	426,358	413,033
Net loss on disposal of non-current assets	5	27,669	33,240
Capital user charge	6	620,484	0
Other expenses from ordinary activities	7	435,736	581,937
Total cost of services		10,528,854	9,345,298
Revenues from Ordinary Activities			
Patient charges	8	389,929	374,056
Donations revenue	9	13,673	49,072
Interest revenue		64	114
Other revenues from ordinary activities	10	260,532	252,815
Total revenues from ordinary activities		664,198	676,057
NET COST OF SERVICES		**9,864,656**	**8,669,241**
Revenues from Government			
Output appropriations	11	9,812,579	7,573,980
Capital appropriations	11	0	523,938
Liabilities assumed by the Treasurer	12	10,588	395,079
Resources received free of charge	13	9,500	9,750
Total revenues from government		9,832,667	8,502,747
Change in net assets		**(31,989)**	**(166,494)**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**(31,989)**	**(166,494)**

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	14	181,814	45,071
Receivables	15	185,625	187,920
Inventories	17	80,905	78,188
Prepayments		0	319
Total current assets		448,344	311,498
NON-CURRENT ASSETS			
Amounts receivable for outputs	16	427,300	0
Property, plant and equipment	18	10,784,072	11,155,296
Total non-current assets		11,211,372	11,155,296
Total assets		**11,659,716**	**11,466,794**
CURRENT LIABILITIES			
Payables		449,646	691,864
Interest-bearing liabilities	19	86,933	83,566
Accrued salaries	20	240,859	91,736
Provisions	21	898,122	802,634
Total current liabilities		1,675,560	1,669,800
NON-CURRENT LIABILITIES			
Interest-bearing liabilities	19	2,320,312	2,408,039
Provisions	21	528,078	520,082
Total non-current liabilities		2,848,390	2,928,121
Total liabilities		**4,523,950**	**4,597,921**
Net Assets		**7,135,766**	**6,868,873**
EQUITY			
Contributed equity	22	298,882	0
Asset revaluation reserve	23	2,176,777	2,176,777
Accumulated surplus / (deficiency)	24	4,660,107	4,692,096
Total Equity		**7,135,766**	**6,868,873**

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	25(c)	8,707,637	7,334,168
Net cash provided by Government		8,707,637	7,334,168
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(3,782,108)	(3,096,658)
Employee costs		(5,357,648)	(4,776,609)
GST payments on purchases		(294,079)	(256,878)
Receipts			
Receipts from customers		394,462	358,751
Donations		13,673	34,079
Interest received		64	114
GST receipts on sales		34,748	19,289
GST receipts from taxation authority		245,386	245,506
Other receipts		244,324	206,182
Net cash (used in) / provided by operating activities	25(b)	(8,501,178)	(7,266,224)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	18	(86,737)	(220,992)
Proceeds from sale of non-current assets	5	17,021	0
Net cash (used in) / provided by investing activities		(69,716)	(220,992)
Net increase / (decrease) in cash held		136,743	(153,048)
Cash assets at the beginning of the reporting period		45,071	198,119
Cash assets at the end of the reporting period	25(a)	181,814	45,071

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

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.

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

(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.

iii) Deferred Salary Scheme

With the written agreement of the Health Service, an employee may elect to receive, over a four-year period, 80% of the salary they would otherwise be entitled to receive. On completion of the fourth year, an employee will be entitled to 12 months leave and will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. An employee may withdraw from this scheme prior to completing a four-year period by written notice. The employee will receive a lump sum payment of salary forgone to that time.

The liability for deferred salary scheme represents the amount which the Health Service is obliged to pay to the employees participating in the deferred salary scheme. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the reporting date and includes related on-costs.

(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.

(s) Foreign Currency Translation

Transactions denominated in a foreign currency are translated at the rates in existence at the dates of the transactions. Foreign currency receivables and payables at reporting date are translated at exchange rates current at reporting date. Exchange gains and losses are brought to account in determining the result for the year.

	2001/02 $	2000/01 $
Note 2 Administered trust accounts		
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	2,147	1,709
Add Receipts		
- Patient Deposits	3,548	4,150
- Interest	2	8
	5,697	5,867
Less Payments		
- Patient Withdrawals	3,096	3,720
- Interest / Charges	12	0
Closing Balance	2,589	2,147
Note 3 Patient support costs		
Medical supplies and services	404,364	424,615
Domestic charges	86,237	83,610
Fuel, light and power	284,783	327,950
Food supplies	108,887	110,972
Purchase of external services	112,344	148,262
	996,615	1,095,409
Note 4 Depreciation expense		
Buildings	255,971	253,153
Computer equipment and software	38,114	45,739
Furniture and fittings	25,813	25,465
Motor vehicles	636	1,023
Other plant and equipment	105,824	87,653
	426,358	413,033
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	17,021	0
Gross proceeds from sale of non-current assets	17,021	0
b) **Profit / (Loss) on disposal of non-current assets:**		
Computer equipment and software	(9,728)	(10,824)
Furniture and fittings	(20,765)	(3,639)
Other plant and equipment	2,824	(18,777)
	(27,669)	(33,240)

		2001/02 $	2000/01 $
Note 6	**Capital user charge**		
		620,484	0

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	89,774	78,524
Other employee expenses	74,490	126,023
Motor vehicle expenses	51,162	40,714
Insurance	29,060	26,543
Communications	59,664	73,206
Printing and stationery	39,865	50,274
Rental of property	11,677	2,123
Audit fees - external	14,500	14,795
Bad and doubtful debts expense	11	11,652
Other	65,533	158,083
	435,736	581,937

Note 8 Patient charges

Inpatient charges	385,227	367,731
Outpatient charges	4,702	6,325
	389,929	374,056

Note 9 Donations revenue

General public contributions	13,673	49,072

Note 10 Other revenues from ordinary activities

Rent from properties	35,013	35,933
Recoveries	62,010	64,893
Use of hospital facilities	156,028	131,011
Other	7,481	20,978
	260,532	252,815

Note 11 Government appropriations

Output appropriations (I)	9,812,579	7,573,980
Capital appropriations (II)	0	523,938
	9,812,579	8,097,918

(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.

Note 12 Liabilities assumed by the Treasurer

Superannuation	10,588	395,079

The change in funding arrangement for the Gold State Super Scheme and the West State Super Scheme has resulted in the decrease. (refer note 1(n)(ii).

	2001/02 $	2000/01 $
Note 13 Resources received free of charge		
Office of the Auditor General - Audit Services	9,500	9,750

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 14 Cash assets		
Cash on hand	3,620	3,620
Cash at bank - general	150,780	3,271
Cash at bank - donations	27,414	38,180
	181,814	45,071
Note 15 Receivables		
Patient fee debtors	3,010	28,232
GST receivable	30,170	25,836
Other receivables	153,477	134,884
	186,657	188,952
Less: Provision for doubtful debts	(1,032)	(1,032)
	185,625	187,920
Note 16 Amounts receivable for outputs		
Non-current	427,300	0

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 17 Inventories		
Supply stores - at cost	42,749	40,176
Pharmaceutical stores - at cost	35,299	36,280
Engineering stores - at cost	2,857	1,732
	80,905	78,188
Note 18 Property, plant and equipment		
Land		
At valuation - 30.6.2000 (iii)	1,641,000	1,641,000
	1,641,000	1,641,000
Buildings		
Clinical:		
At valuation - 30.6.2000 (iii)	16,917,078	17,129,078
Accumulated depreciation	(8,840,239)	(8,596,798)
	8,076,839	8,532,280
Non-Clinical:		
At valuation - 30.6.2000 (iii)	212,000	0
Accumulated depreciation	(12,530)	0
	199,470	0
Computer equipment and software		
At cost	245,021	292,606
Accumulated depreciation	(152,427)	(163,593)
	92,594	129,013
Furniture and fittings		
At cost	429,191	453,418
Accumulated depreciation	(190,471)	(177,746)
	238,720	275,672

Note 18 Property, plant and equipment - continued	2001/02 $	2000/01 $
Motor vehicles		
At cost	4,350	4,350
Accumulated depreciation	(3,290)	(2,654)
	1,060	1,696
Other plant and equipment		
At cost	1,109,204	1,069,845
Accumulated depreciation	(574,815)	(494,210)
	534,389	575,635
Total of property, plant and equipment	10,784,072	11,155,296

Land and buildings

(i) Land, clinical buildings and non-clinical buildings that are yet to 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	52,387	183,778
Paid as cash by the Health Service from capital contributions	23,550	0
Paid as cash by the Health Service from other funding sources	10,800	37,214
SubTotal paid by the Health Service	86,737	220,992
Paid by the Department of Health	13,087	616,245
Gross payments for purchases of non-current assets	99,824	837,237

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	1,641,000
Carrying amount at end of year	1,641,000
Buildings	
Carrying amount at start of year	8,532,280
Depreciation	(255,971)
Carrying amount at end of year	8,276,309
Computer equipment and software	
Carrying amount at start of year	129,013
Additions	11,423
Disposals	(9,728)
Depreciation	(38,114)
Carrying amount at end of year	92,594
Furniture and fittings	
Carrying amount at start of year	275,672
Additions	9,626
Disposals	(20,765)
Depreciation	(25,813)
Carrying amount at end of year	238,720
Motor vehicles	
Carrying amount at start of year	1,696
Depreciation	(636)
Carrying amount at end of year	1,060
Other plant and equipment	
Carrying amount at start of year	575,635
Additions	78,775
Disposals	(14,197)
Depreciation	(105,824)
Carrying amount at end of year	534,389

	2001/02 $	2000/01 $
Note 19 Interest-bearing liabilities		
a) **Western Australian Treasury Corporation (WATC) loans**		
Balance at beginning of year	614,888	637,134
Less repayments this year	(22,928)	(22,246)
Balance at end of year	591,960	614,888
Amount repayable within the next 12 months	22,672	22,197
Amount repayable after 12 months	569,288	592,691
Balance at end of year	591,960	614,888

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.

b) **Department of Treasury and Finance loans**		
Balance at beginning of year	1,876,717	1,891,280
Less repayments this year	(61,432)	(14,563)
Balance at end of year	1,815,285	1,876,717
Amount repayable within the next 12 months	64,261	61,369
Amount repayable after 12 months	1,751,024	1,815,348
Balance at end of year	1,815,285	1,876,717

This debt relates to funds advanced to the Health Service via the now defunct General Loan and Capital Works Fund. Funds advanced and related interest costs are repaid to the Department of Treasury and Finance by the Department of Health on behalf of the Health Service. Interest rates are linked to the State's debt servicing costs.

Total interest-bearing liabilities:		
Balance at beginning of year	2,491,605	2,528,414
Less repayments this year	(84,360)	(36,809)
Balance at end of year	2,407,245	2,491,605
Amount repayable within the next 12 months	86,933	83,566
Amount repayable after 12 months	2,320,312	2,408,039
Balance at end of year	2,407,245	2,491,605

Note 20 Accrued salaries		
Amounts owing for:	240,859	91,736
Nursing staff		
7 days from 24 June to 30 June 2002		
(2001:6 days from 25 June to 30 June 2001)		
Non-nursing staff plus Accrual for Voluntary Severance Scheme		
7 days from 24 June to 30 June 2002		
(2001: 6 days from 25 June to 30 June 2001)		

Note 21 Provisions		
Current liabilities:		
Annual leave	587,798	500,671
Long service leave	276,487	278,954
Superannuation	33,837	23,009
	898,122	802,634
Non-current liabilities:		
Long service leave	206,240	196,753
Superannuation	321,838	323,329
	528,078	520,082
Total employee entitlements	1,426,200	1,322,716

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 22 Contributed equity	2001/02 $	2000/01 $
Balance at beginning of the year	0	0
Capital contributions (i)	298,882	0
Balance at end of the year	298,882	0

(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 23 Asset revaluation reserve

Balance at beginning of the year	2,176,777	2,176,777
Balance at end of the year	2,176,777	2,176,777

(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.

Note 24 Accumulated surplus / (deficiency)

Balance at beginning of the year	4,692,096	4,858,590
Change in net assets	(31,989)	(166,494)
Balance at end of the year	4,660,107	4,692,096

Note 25 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 14)	181,814	45,071

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)	(8,501,178)	(7,266,224)
Increase / (decrease) in assets:		
GST receivable	4,334	25,600
Other receivables	(6,629)	71,626
Inventories	2,717	15,873
Prepayments	(319)	319
Decrease / (increase) in liabilities:		
Payables	242,218	(357,179)
Accrued salaries	(149,123)	(15,547)
Provisions	(103,484)	(122,307)
Non-cash items:		
Depreciation expense	(426,358)	(413,033)
Profit / (loss) from disposal of non-current assets	(27,669)	(33,240)
Interest paid by Department of Health	(192,158)	(203,003)
Capital user charge paid by Department of Health	(620,484)	0
Superannuation liabilities assumed by the Treasurer	(10,588)	(395,079)
Resources received free of charge	(9,500)	(9,750)
Other	(66,435)	32,703
Net cost of services (Statement of Financial Performance)	(9,864,656)	(8,669,241)

Note 25 Notes to the statement of cash flows - continued	2001/02 $	2000/01 $
c) **Notional cash flows**		
Output appropriations as per Statement of Financial Performance	9,812,579	7,573,980
Capital appropriations as per Statement of Financial Performance	0	523,938
Capital appropriations credited directly to Contributed Equity	298,882	0
	10,111,461	8,097,918
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	(33,271)	(38,672)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(22,928)	(22,246)
Interest paid to Department of Treasury & Finance	(158,887)	(164,331)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(61,432)	(14,563)
Capital user charge	(620,484)	0
Other non cash adjustments to output appropriations	(506,822)	(523,938)
	(1,403,824)	(763,750)
Output appropriations as per Statement of Cash Flows	8,707,637	7,334,168

Note 26 Revenue, public and other property written off or presented as gifts

a) Revenue and debts written off.	11	10,951
b) Public and other property written off.	27,989	34,149

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

Note 27 Remuneration of members of the accountable authority and senior officers

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
$40,001 - $50,000	0	1
$50,001 - $60,000	1	2
$60,001 - $70,000	3	2
$70,001 - $80,000	2	1
Total	6	6

	$	$
The total remuneration of senior officers is:	415,324	365,614

Note 28 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%

	2001/02 $	2000/01 $	Variation $
Expenses			
Employee expenses	5,593,179	4,902,799	690,380
Patient transport	545,585	476,476	69,109
Repairs, maintenance and consumable equipment	306,378	260,352	46,026
Capital user charge	620,484	0	620,484
Other expenses from ordinary activities	435,736	581,937	(146,201)
Revenue			
Donations revenue	13,673	49,072	(35,399)

Employee expense - Nursing, Hotel Services and General Maintenance are all well under 10%, the increases are in General Administration which includes the amount for the Voluntary Severance Scheme and Medical Support Services reflecting the better success this year in filling more of our Allied Health positions.

Patient transport - this year has followed the trend of the past few years with increased usage of the PATs Scheme

Repairs, maintenance and consumable equipment - Due to major storm damage, repairs were considerably higher than normal

Capital User Charge - First year

Other expenses from ordinary activities - this decrease is in the area we could exercise the most control over without reducing services, with most administration areas spending less, increases only in insurance, workers compensation and motor vehicle expenses

Donation revenue - Last year included large amount from Variety club not received this year

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.

	2001/02 Actual $	2001/02 Estimate $	Variation $
Employee expenses	5,593,179	4,828,000	765,179
Borrowing costs expense	192,158	240,000	(47,842)
Repairs, maintenance and consumable equipment	306,378	200,000	106,378
Capital user charges	620,484	0	620,484
Other expenses from ordinary activities	435,736	552,000	(116,264)
Donations revenue	13,673	49,000	(35,327)
Other revenue	260,532	157,000	103,532

Salaries and wages - This estimate was less than actual for 2000-01 considering the award increases unsure why it was set this low, actuals this year include Voluntary Severence Scheme

Borrowing costs expense - down on estimate, no new loans and lower interest rates

Repairs, maintenance and consumable equipment - Major storm damage contributed to higher costs.

Capital User Charges-First year

Other expenses from ordinary activites - We identified this area for a cut in expenditure and achieved far greater savings than estimated

Donations revenue - estimate based on last years actual, No Variety Club donation this year.

Other revenue - the major portion of the increase comes from the fees from Radiology - reflecting the increase in activity.

Note 29 Commitments for Expenditure	2001/02 $	2000/01 $
a) **Operating lease commitments:** Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	68,800	34,074
Later than one year, and not later than five years	49,549	23,792
	118,349	57,866

These commitments are all inclusive of GST.

Note 30 Contingent liabilities

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

Note 31 Events occurring after reporting date

The Esperance Health Service ceased to exist as a legal entity as at 1 July 2002. The Health Service was 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 32 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 33 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.

Note 34 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	Fixed interest rate maturities: Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2002							
Financial Assets							
Cash assets	0.5%	178	0	0	0	4	182
Receivables		0	0	0	0	186	186
		178	0	0	0	190	368
Financial Liabilities							
Payables		0	0	0	0	450	450
Interest-bearing liabilities							
- W A Treasury Corporation	5.7%	0	23	96	473	0	592
- Department of Treasury & Finance	8.6%	0	64	289	1,462	0	1,815
		0	87	385	1,935	450	2,857
Net financial assets / (liabilities)		178	(87)	(385)	(1,935)	(260)	(2,489)
As at 30th June 2001							
Financial Assets							
Cash assets	0.5%	41	0	0	0	4	45
Receivables		0	0	0	0	188	188
		41	0	0	0	192	233
Financial Liabilities							
Payables		0	0	0	0	692	692
Interest-bearing liabilities							
- W A Treasury Corporation	5.7%	0	22	94	499	0	615
- Department of Treasury & Finance	8.9%	0	61	240	1,575	0	1,876
		0	83	334	2,074	692	3,183
Net financial assets / (liabilities)		41	(83)	(334)	(2,074)	(500)	(2,950)

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.

Note 35 Output information

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses from Ordinary Activities								
Employee expenses	479	435	5,114	4,467	0	0	5,593	4,903
Fees for visiting medical practitioners	0	0	920	951	0	0	920	951
Superannuation expense	39	32	426	396	0	0	465	428
Patient support costs	29	35	968	1,061	0	0	997	1,095
Patient transport costs	0	0	546	476	0	0	546	476
Borrowing costs expense	0	0	192	203	0	0	192	203
Repairs, maintenance and consumable equipment expense	22	13	285	247	0	0	306	260
Depreciation expense	32	34	394	379	0	0	426	413
Net loss on disposal of non-current assets	14	0	14	33	0	0	28	33
Capital user charge	0	0	620	0	0	0	620	0
Other expenses from ordinary activities	37	35	398	547	0	0	436	582
Total cost of services	652	585	9,877	8,760	0	0	10,529	9,345
Revenues from Ordinary Activities								
Patient charges	0	0	390	374	0	0	390	374
Donations revenue	0	0	14	49	0	0	14	49
Other revenues from ordinary activities	6	7	255	246	0	0	261	253
Total revenues from ordinary activities	6	7	658	669	0	0	664	676
NET COST OF SERVICES	**646**	**578**	**9,219**	**8,091**	**0**	**0**	**9,865**	**8,669**
Revenues from Government								
Output appropriations	641	481	9,171	7,093	0	0	9,813	7,574
Capital appropriations	0	0	0	524	0	0	0	524
Liabilities assumed by the Treasurer	0	33	11	362	0	0	11	395
Resources received free of charge	0	0	10	10	0	0	10	10
Total revenues from government	641	514	9,191	7,989	0	0	9,833	8,503
Change in net assets	**(4)**	**(64)**	**(28)**	**(102)**	**0**	**0**	**(32)**	**(166)**

Note 35 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).