Ravensthorpe 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 Ravensthorpe 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

Ravensthorpe Health Service
Martin St
RAVENSTHORPE WA 6346

PO Box 53
RAVENSTHORPE WA 6346

☎ *(08) 9838 1006*
(08) 9838 1238

Mission Statement

Our Mission
To work with our community to reach for the best possible health for all.

Broad Objectives

The objective of the Ravensthorpe Health Service is to:

- To provide accessible hospital and community-based care to those who require the service, at a recognised standard, in a manner acceptable to our clientele.

Enabling Legislation

The Ravensthorpe 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 Ravensthorpe 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.

The current arrangement of board management will change as per the Health Administrative Review Committee recommendation to cease board management arrangements as of 1 July 2002.

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 Ravensthorpe 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 Ravensthorpe 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:

- Ensuring all staff are aware of the standards, comply with them and are aware of the process to follow when a breach occurs.

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 Ravensthorpe 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 Ravensthorpe Health Service published in accordance with Section 175ZE of the *Electoral Act 1907*.

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies	4316	5800	6350
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations	–	–	–
Media Advertising Organisations	1486	1564	1044
TOTAL	**$5802**	**$7364**	**$7394**

Freedom of Information Act 1992

The Ravensthorpe Health Service received and dealt with no 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.

Most applications are 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 Ravensthorpe 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:

Rosemary Hunt
Information Coordinator
Ravensthorpe Health Service
PO Box 53
RAVENSTHORPE WA 6346

☎ *(08) 9838 1006*

Ravensthorpe Health Service

Key Operations and Achievements

- The Multi Purpose Service Agreement Delivery Plan Agreement has been fulfilled.
- The community has been invited to the Health Service for several introductory sessions in Telehealth.
- A fete was instrumental in increasing the community contact and money raised has been earmarked for the new building.
- The Project Control Group was successful in securing confirmation that the new facility would go ahead.

Multi Purpose Service Agreement Delivery Plan

The Ravensthorpe Health Service Board managed the provision of services to hospital and community-based clients. The Multi Purpose Service Agreement Delivery Plan Agreement has been fulfilled and the Service was able to deliver almost all services that were planned. The only exceptions to this were some services where staff left the area and we have been unable to replace them. The MPS service delivery plan is being developed now for the next three years, taking into consideration proposed developments for the region in the mining industry. Extra funding will be sought for an extension of existing services, particularly in the areas of physiotherapy, primary health care and health promotion.

Telehealth

Plans within the state to increase the use of Telehealth involve Ravensthorpe and the Lake Varley Nursing Post. These plans require the Health Service to help make the community more aware of the facility and the many applications. The community has been invited to the Health Service for several introductory sessions and seniors from Hopetoun have also attended for a special session. Our unit at the Lake Varley Nursing Post is also experiencing an increase in use, in particular in the area of speech pathology.

Fete

A fete was held on the premises this year and was instrumental in increasing the community contact with the Health Service. Money raised has been earmarked for the new building. The community wishes it to be used for making the new hospital more comfortable for patients.

Project Control Group Secures Confirmation of New Facility

The Project Control Group, initiated to facilitate the proposed new Health Service, was successful in securing confirmation that the new facility would go ahead in the new financial year. The expected start date is July 2002, with an expected completion date of August 2003. Tenders to this date have not yet been released.

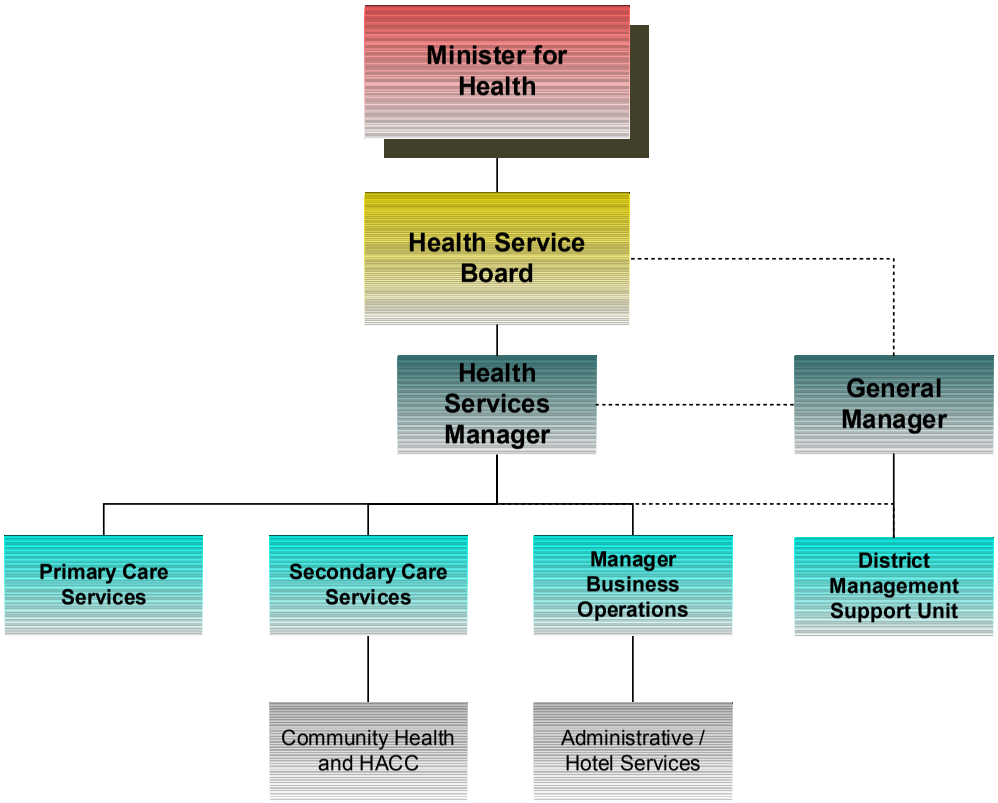
Major Capital Projects

The Ravensthorpe Health Service did not complete any major capital works during 2001/2002.

Projects in Progress

PROJECT DESCRIPTION	Expected Year of Completion	Estimated Cost to Complete	Estimated Total Cost
Redevelopment of the Ravensthorpe Health Service	2003	$3,900,000.00	$4,200,000.00

Organisational Chart



The Health Service Manager is directly responsible for all clinical and non-clinical Board employees operating within the Ravensthorpe Shire boundary and Varley Nursing Post. The General Manager of the Ravensthorpe Health Service reports to the Esperance Health Service Board.

Accountable Authority

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

Name	Position	Term of Office Expires
Sharon Bridger	Chairperson	23 December 2001
Janet Kuiper	Deputy Chairperson	31 December 2001
Robert Allen	Member	30 September 2002
Terry Dwyer	Member	30 September 2002
Stacey Hewson	Member	30 September 2003
John Macarthur	Member	30 September 2003
Terri Pens	Member	30 September 2001
Nancye Perkins	Member	30 September 2002
Darryl Quinn	Member	30 September 2003

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

Area of Responsibility	Title	Name	Basis of Appointment
Health Service Corporate Management	General Manager	Mark Edgar	Permanent
Nursing Services	Director of Nursing	Rosemary Hunt	Permanent
Medical Services	Visiting Medical Practitioner (VMP)	Dr A. Abedayo	Contract through River Medical

Pecuniary Interests

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

Demography

The Ravensthorpe Health Service delivers services to communities covered by the following local authority:

- Ravensthorpe Shire

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

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Ravensthorpe Shire	1435	1523	2102

*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*.

The Shire of Ravensthorpe covers an area of 12,872 square kilometres and comprises the townships of Ravensthorpe, Hopetoun and Munglinup, and the localities of Jerdacuttup and Fitzgerald. The Health Service boundary has been extended to include Lake King and Lake Varley, which are both in the Shire of Lake Grace. The agriculture income generated in the region is mostly from broad-acre farming operations producing cereal crops, and livestock — predominantly meat and wool. Tourism also figures significantly in the region with the Fitzgerald National Park and Fitzgerald River being magnificent assets sought after by international travellers.

The Ravensthorpe Health Service administers services for these areas. The shire employs two doctors through River Medical Services working to 1.5 FTEs. The practice spends two days a week in Hopetoun and five days in Ravensthorpe. The Health Service makes a large contribution to the surrounding and local community as a Multi Purpose Service.

The Hopetoun population can increase dramatically over the summer period, often swelling from 716 to 3000 people. This is a small coastal town, 49 kilometres from Ravensthorpe which is increasing in popularity with the senior populace. It is expected that the median age of the population will continue to rise above the average as more retirees settle in the area.

The town of Munglinup and the Lakes area consist primarily of farming families, with some mining employment. If the projected mining interests are expanded then it is expected that the primary source of income for this population in the area would be unlikely to change a great deal, unlike the Hopetoun and Ravensthorpe expectations.

All suppliers of essential services in the area have been working on forward plans that incorporate the mining operations, with the general consensus being that operations for Ravensthorpe Nickel Project will increase as of August 2003. The nickel mining project supported by BHP Billiton is expected to have a twenty-year life span and is an investment of $950 million dollars by BHP into the region.

The mine operators propose to engage 2000 contractors, who will initially be housed temporarily at the mine site on a fly-in, fly-out basis, moving to permanent housing in 2007.

Available Services

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

Direct Patient Services
Accident and Emergency 24-hour Care
Acute Medical
Antenatal Care
Extended Care Services
Immunisation Services for Adults and Children
Nursing Care 24-hour
Outpatient Services
Paediatric
Permanent Care
Postnatal Care
Psychiatric Services
Respite Care

Community Services
Child Development
Cleaning
Community Screening Programs and Healthy Lifestyle Assessments
Day Care Centre
Extended Care/Home Nursing
Home Aids
Home and Community Care Ravensthorpe
Home and Community Care Hopetoun
Home Care
Laundry Services
Limited Home Modification and Gardening
Meals on Wheels
Personal Care
Primary Health Care
Remote Area Nursing to Lake Varley and Lake King
School Health
Social Support

Medical Support Services
Dietetics
Occupational Therapy
Physiotherapy
Podiatry
Social Work
Speech Pathology
X-rays (limited)

Other Support Services
Community Health Promotion
Health Information
Hotel Services including:
- Catering
- Cleaning
- Laundry

Medical Records
Patient Assisted Travel Scheme

Specialist Services
None

Other Services
None

Disability Services

Our Policy
The Ravensthorpe 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 Ravensthorpe 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.

- As a Multi Purpose Service our provision of services to the disabled population has been reviewed within the Home and Community Care and Community Health provisions.

Outcome 2: Access to buildings and facilities is improved.

- Access to the health service has been difficult for some time as entry ramps are narrow and of an incorrect gradient. This issue has been addressed temporarily by increasing staff awareness of the problem, so they may facilitate disabled access. Long-term plans have been addressed in the new building.

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

- Regular community updates are given in the local paper regarding services provided by the health service for disabled community members. Occasional Open Day events have been held to encourage client education and a building of rapport.

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

- Regular staff education regarding latest disability services ensures that Health Service staff are able to facilitate clients with their inquiries.

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

- Public comment is welcome and we have a comments box at reception for clients to give feedback to the Service. The board brings public feeling and concerns to meetings and the Project Control Group, which works together for the planning of the new building and consists of Health Service staff and members of the public.

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

- The employees of the Health Service are aware of the Interpreter Service available via telephone, and are able to access this service as the need arises. This year the system has not been used.

Youth Services

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

- Coordinated work experience.
- Delivering sexual health programs.
- Facilitating drug education sessions.
- Assisting the local shire to develop plans for youth issues.
- Provision of counselling services.
- Provision of mental health staff for identified students and families considered at risk.
- Provision of health promotion activities within the school.
- Facilitating the local Drug Action Group in forming a regular Drop in Centre.
- Facilitating and supporting the introduction of Duke of Edinburgh Awards Programs into the community.
- Providing health education sessions out of the school focusing on youth outside the education department.

Employee Profile

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	10.52	13.30	9.96
Administration and Clerical*	3.00	3.06	2.54
Medical Support*	–	–	–
Hotel Services*	5.32	3.75	4.39
Maintenance	0.75	0.75	–
Medical (salaried)	–	–	–
Other	2.35	3.17	5.03
TOTAL	**21.94**	**24.03**	**21.92**

*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 Health Service is trying innovative ways to attract and retain nursing staff to the area. Flexibility is encouraged — there are many young mothers amongst staff, and their needs are different from others in the employ of the Health Service.

It remains difficult to attract well-qualified Registered Nurses to the area, and equally difficult to retain them due to a multiplicity of factors, complicated by the remoteness of the area.

Vacancies are advertised in accordance with Public Sector Standards in Human Resource Management.

Staff Development

Ravensthorpe Health Service supports staff in their efforts to increase or maintain skills. Telehealth, Westnet and funding for self-directed learning have been managed to enable ongoing education.

Industrial Relations Issues

There have not been any Industrial Relations issues that have required the intervention of the Commissioner of Industrial Relations, and no issues sent to mediation.

Workers' Compensation and Rehabilitation

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

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

*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 has met less frequently in the last half of the financial year due to a loss of key members from staff. Interest has recently been revived in an effort to promote the committee and its objectives.

The Service has a local OSH manual that is accessible to all staff. Our orientation manual also discusses Occupational Health and Safety responsibilities and lists key officers. Plans have been made to send a staff member away to the next Occupational Safety and Health course in the coming year.

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 Ravensthorpe 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 Ravensthorpe 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.

- The Health Service recognises the need to provide a safe working environment free from all forms of discrimination and harassment.

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

- The Health Service ensures its attraction, recruitment, and retention standards and practices have no bias or discrimination against employees or potential employees.

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

- The Health Service is committed to equitable, open, merit-based processes to ensure the most suitable applicants are selected and recruited to the workforce.

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 Ravensthorpe 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	Implemented

Marketing

A Hospital Fete held in May this year encouraged the community to visit the site, view the plans for the new Health Service, and help raise money for the new facility.

Regular fortnightly newsletters in the local paper have increased awareness in the community regarding current health trends, primary health care and new services.

Publications

Publications available to the public consist of the following:

- **Annual Report**
- **Brochures on specific conditions and treatments**
- **Community Newsletter**
- **Departmental Brochures**
- **Departmental Newsletter**
- **Patient Information Brochure**
- **Patients Rights and Responsibilities**
- **Research and Publications report.**

Research and Development

The Health Service is currently facilitating a Research program designed to help determine the needs of the community related to child care facilities. This needs analysis will also supply information on the effect on families that require a second income to survive financially, but who cannot work due to limited childcare facilities.

Evaluations

Ravensthorpe Health Service values the process of reflection and review of the practices and forward planning of the service. To this end we constantly examine our processes in an effort to improve service delivery.

Recruitment and retention of staff
Purpose
To increase the pool of permanent staff, their satisfaction with employ and reduce our reliance on agency staff.

Outcomes
Indication by permanent staff that they are happier within the Health Service.

Action Taken or Proposed
Greater flexibility in management of work issues and facilitative approach to family/social pressures placed on staff. Sourcing funding for staff development.

Improved documentation and revision of MR forms
Purpose
To maintain acceptable standards of documentation whilst facilitating staff in developing autonomy within the profession, and determining changes in client occasions of service whilst acknowledging changing trends in health.

Outcomes
Revision of patient notes recording MR details thereby improving standard of documentation.

Action Taken or Proposed
Clinical Nurse and Health Service Manager reviewed client records to ensure correct information is presented. A proposal has been made to staff to form a review committee to examine MR forms and the newly released AIMS papers.

Review of the Telehealth facilities
Purpose
To investigate an increased utilisation of this service by the community, staff and clients.

Outcomes
An ongoing campaign is demonstrating that the applications have not yet fully been explored and the service is poorly utilised. A commitment by staff, clients and the community has been made to increase the use of the service.

Action Taken or Proposed
Increasing even further the community awareness of this service has been initiated. Target marketing is planned, a community need assessment is required. This assessment should be available by November 2002.

Childcare Facility
Purpose
To investigate realistic use of childcare services in the town. To facilitate the community in developing a model of Sessional Childcare services in the district.

Outcomes
To increase the social wellbeing of the families in the tow, by facilitating the return of family carers back to the workforce, in a low socioeconomic area that usually requires two incomes for the families to survive economically.

To return nursing staff to work that is currently off roster due to childcare difficulties, thereby reducing our dependency on agency staff.

Action Taken or Proposed
Needs analysis of the community undertaken in May 2002. Results to be made available to the Departments of Health, Education and Community Development, with recommendations by November 2002.

Aged Care and Disabled Support Services
Purpose
To reduce the number of aged and disabled clients that are left alone for long periods of time during weekend and public holiday breaks.

Outcomes
Increased social and health wellbeing of disadvantaged community members. Reduction in the number of clients found in a deleterious state of health after not being cared for over the breaks.

Action Taken or Proposed
Expressions of interest have been called for. Objectives and parameters have been set in conjunction with the seniors group and the HACC coordinator.

Risk Management

Our Policy
The Ravensthorpe 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 initiated during 2001/2002 include:

- The premises and standard practices have been regularly reviewed to ensure that any areas of concern in risk management are identified and dealt with as soon as they appear. The board inspects the grounds and buildings on a monthly basis and concerns and identified problem areas are dealt with as soon as practicable. Areas identified as dangerous are marked as such and access to that area is denied until the problem is rectified.

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

Internal Audit Controls

The Ravensthorpe 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.

The Health Service has contracted Options Projects Services to establish a system of internal controls to provide reasonable assurance that assets are safeguarded, proper accounting records are maintained and financial information is reliable.

Waste Paper Recycling

This year the Health Service recycled a total of approximately less than half a tonne of waste paper. This figure is comparable to a similar amount in 2000/2001. After investigations by the Health Service it is deemed uneconomical to transport waste paper for recycling. The Health Service recycles, within our own system, a large amount of paper. We also shred waste paper, which is used for packing and garden mulch.

Pricing Policy

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

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

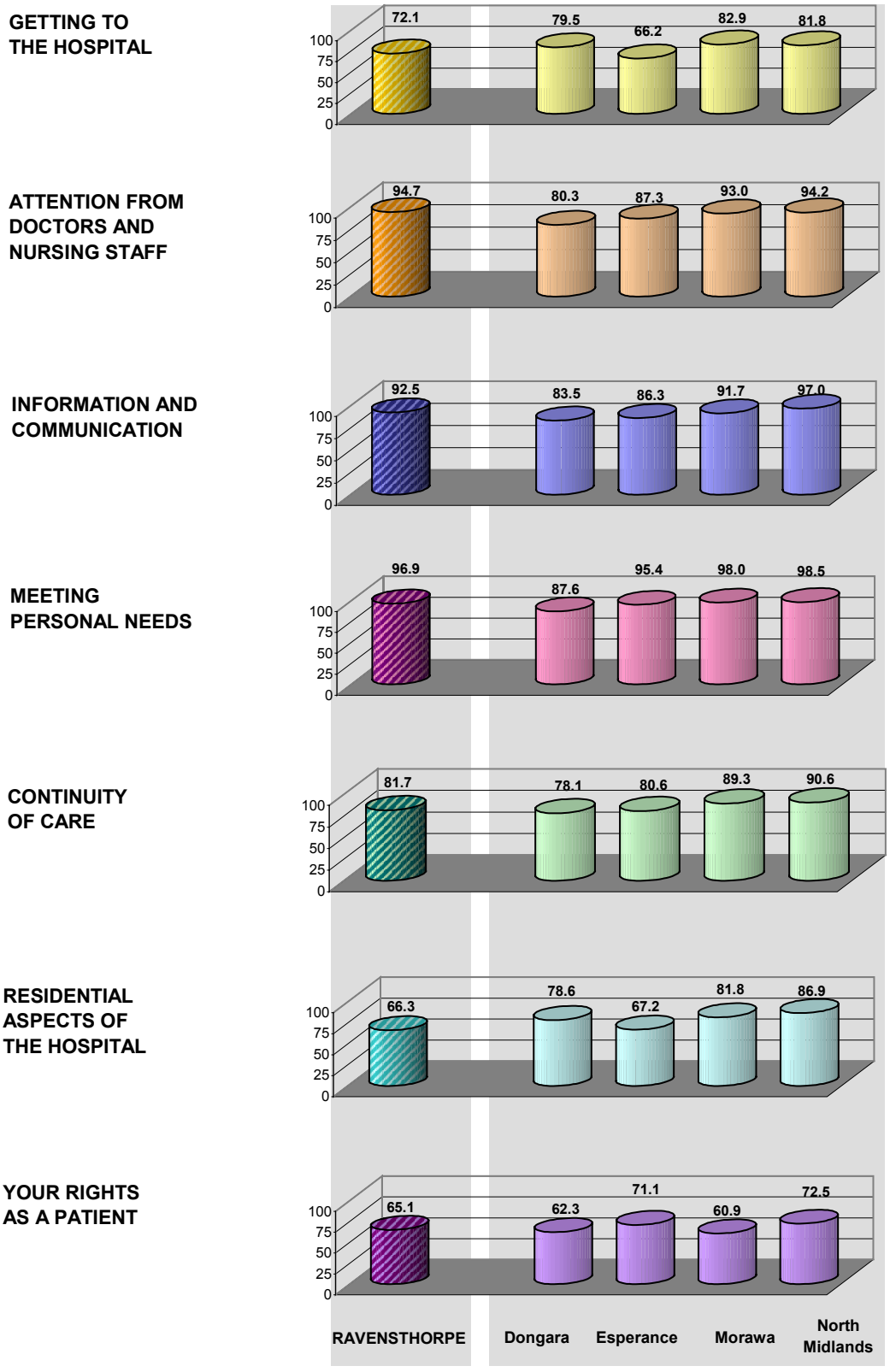
No fees are raised against registered public and private outpatients of the hospital.

Client Satisfaction Surveys

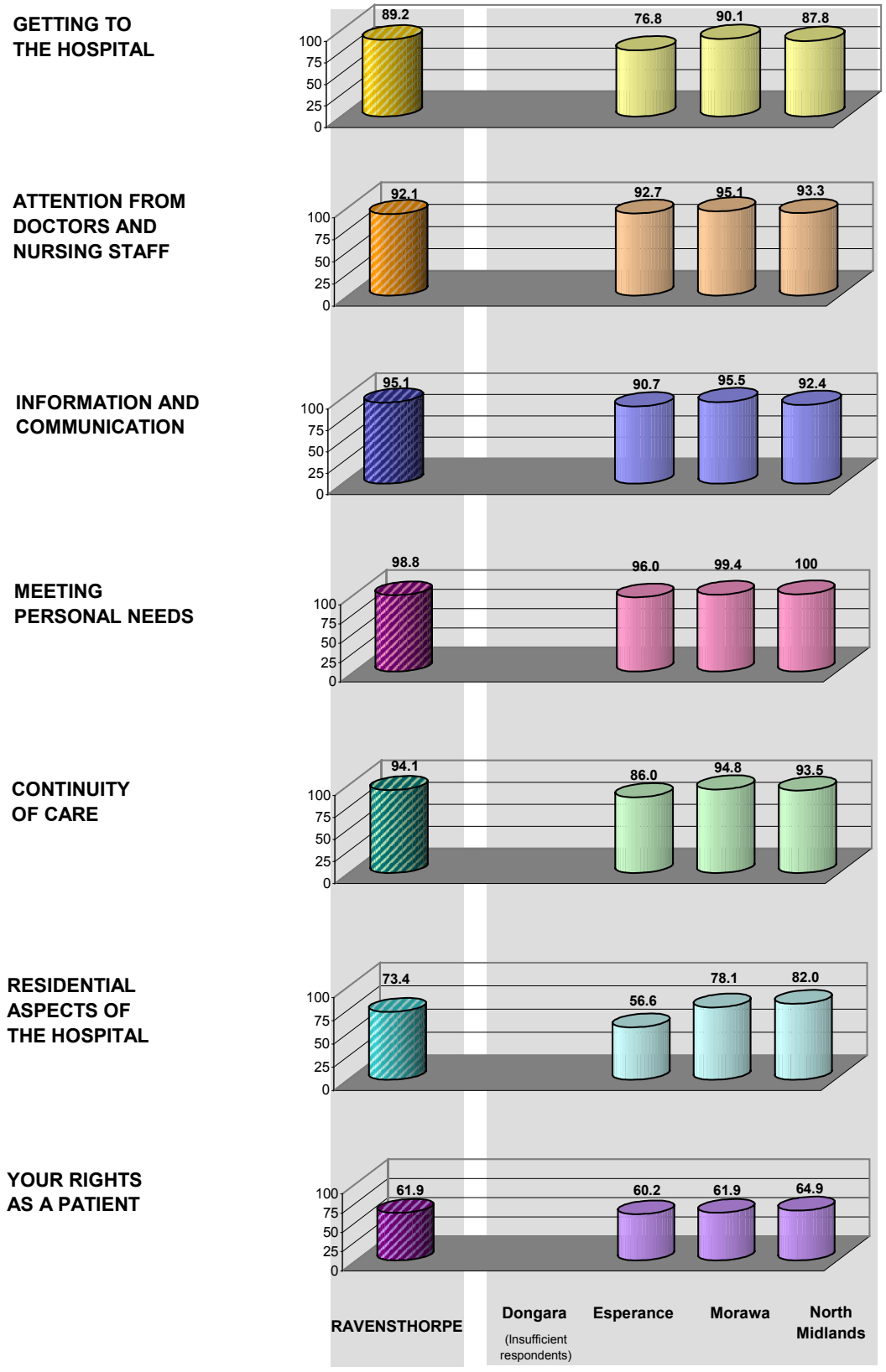
Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey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

Each year a number of client groups are selected to answer questions about their experiences within the health system. The survey process is managed by the Department of Health with questionnaires being posted to patients during a specified survey period. Details of the responses to individual questions are shown below and audited aggregate results of these surveys are shown in the Key Performance Indicator section (page 44) of this report.

KPI 2.2: EMERGENCY PATIENTS — RURAL



KPI 2.2: OUTPATIENTS — RURAL



AUDITOR GENERAL

To the Parliament of Western Australia

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

Scope

I have audited the key effectiveness and efficiency performance indicators of the Ravensthorpe 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 Ravensthorpe 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 Ravensthorpe 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

RAVENSTHORPE 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 Ravensthorpe Health Service for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Ravensthorpe 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.

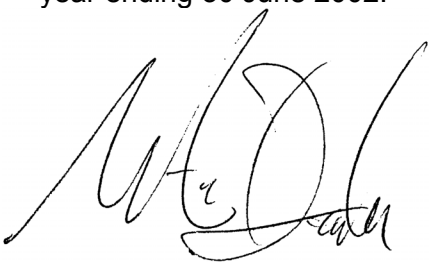
It is anticipated that the opinions will be issued by March 31, 2003.

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

RAVENSTHORPE 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 Ravensthorpe 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.*

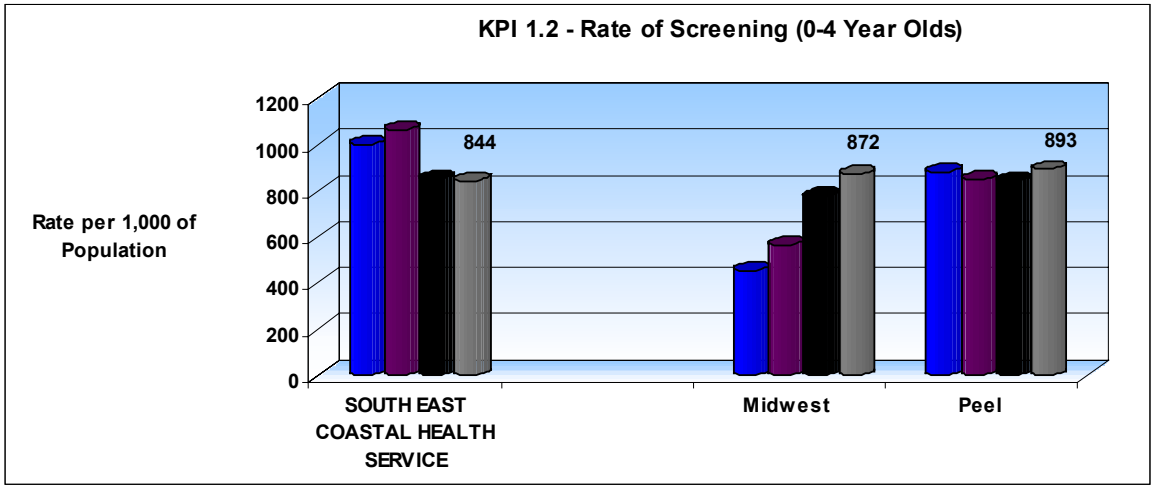
RATE OF SCREENING IN CHILDREN	KPI 1.2

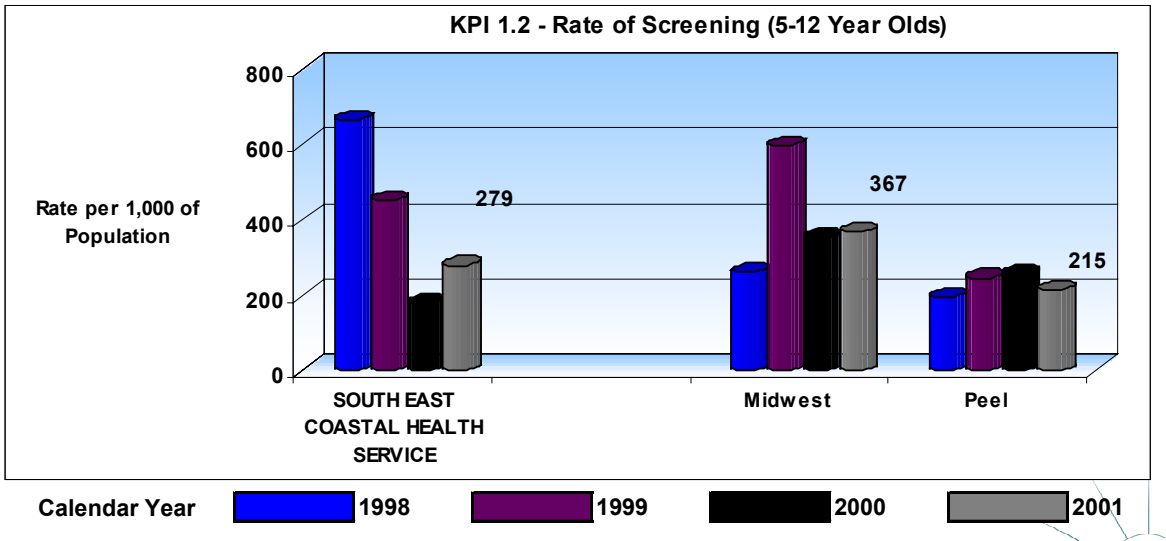
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good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

The consequences of any illness or disability not detected by routine screening programs for children are more likely to be permanently disabling or even contribute to their premature death.

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

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





RATE OF CHILDHOOD IMMUNISATION	KPI 1.5

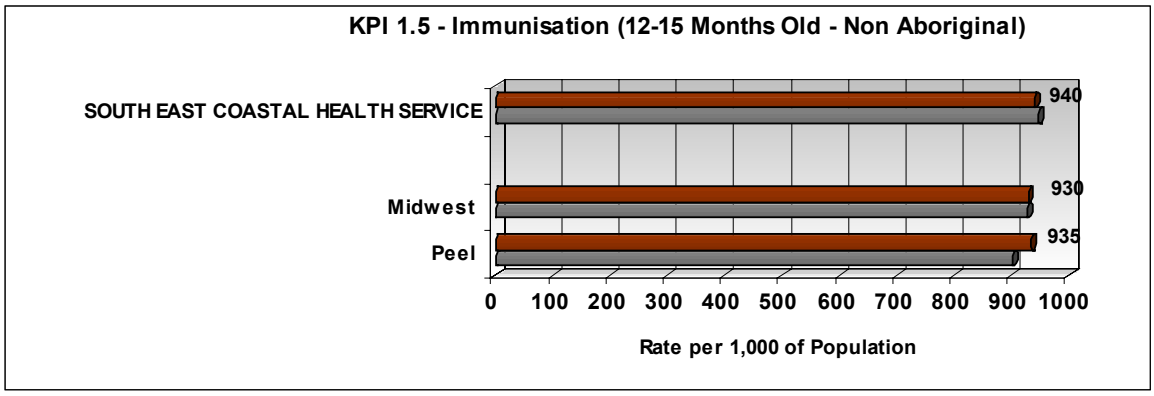
Vaccine preventable diseases are associated with considerable morbidity and mortality, and vaccination is effective in reducing the incidence of these diseases in the community. Through this adoption of the National Immunisation Schedule, health system effectiveness in providing vaccination coverage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

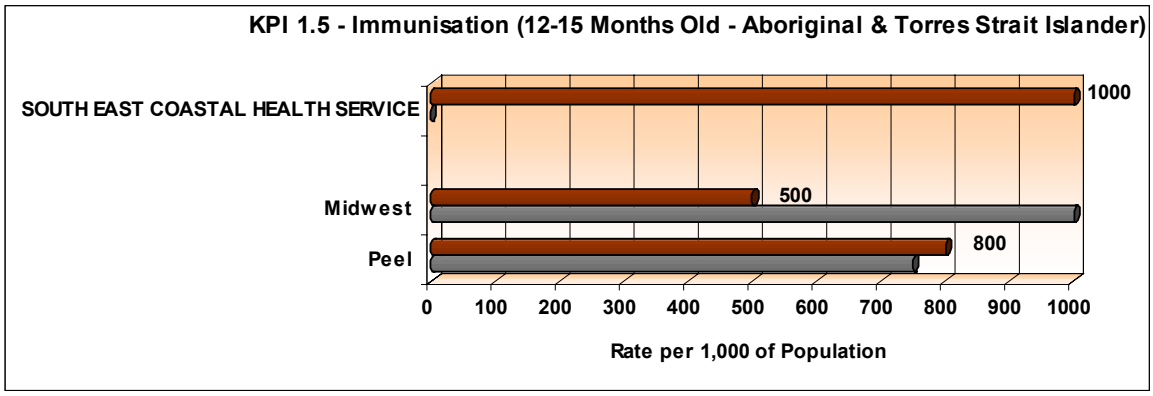
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

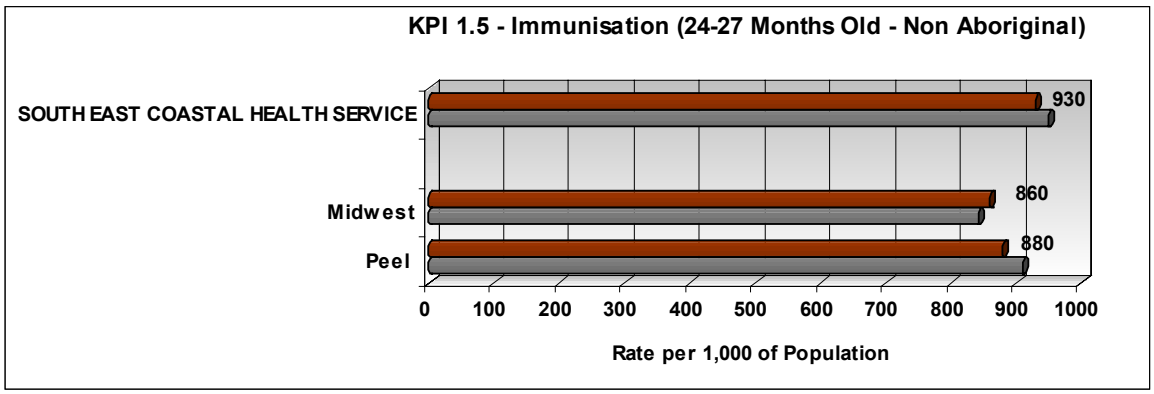
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

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

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


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)
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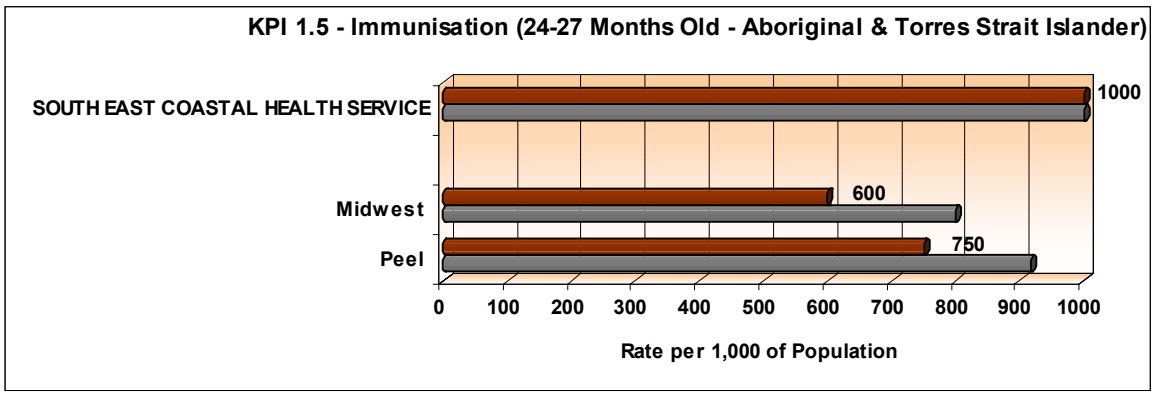
Midwest
Peel
930
860
880
0 100 200 300 400 500 600 700 800 900 1000
Rate per 1,000 of Population


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

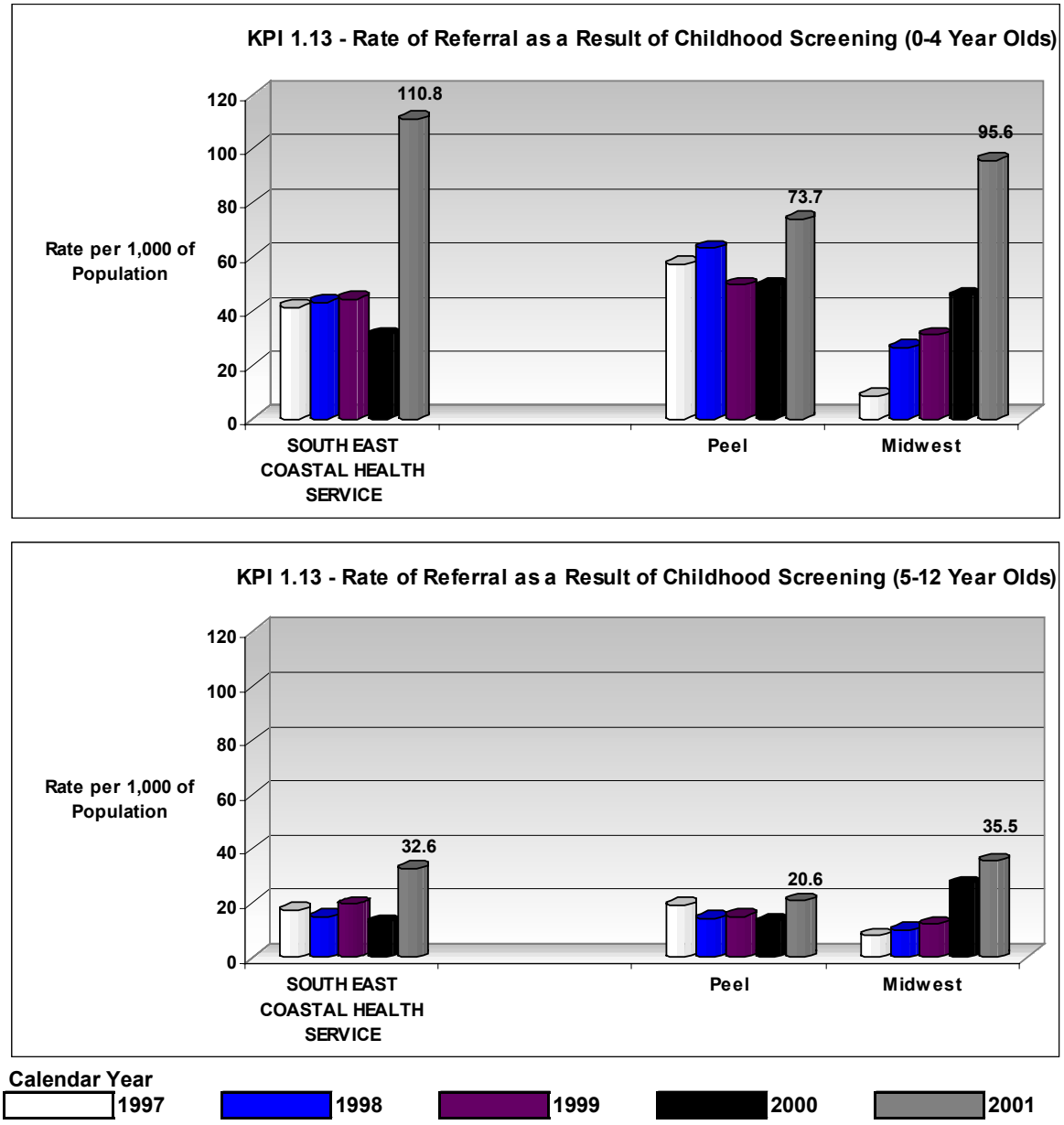
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

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 was a significant improvement 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.



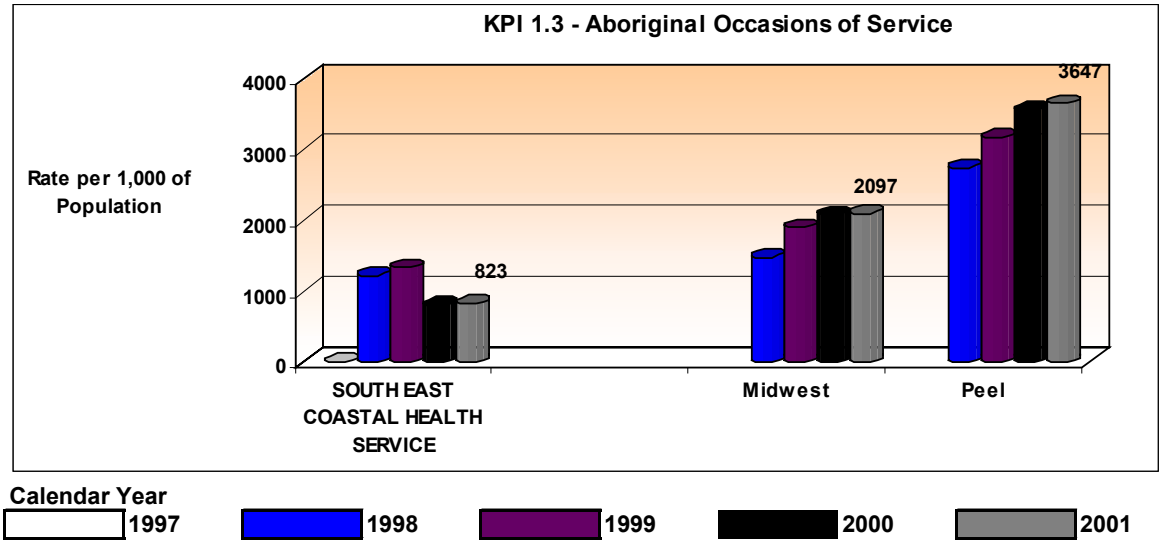
RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

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 slight fall in the rate ratio of Aboriginal to non Aboriginal people may be due to a vacancy in the Aboriginal Health worker position.



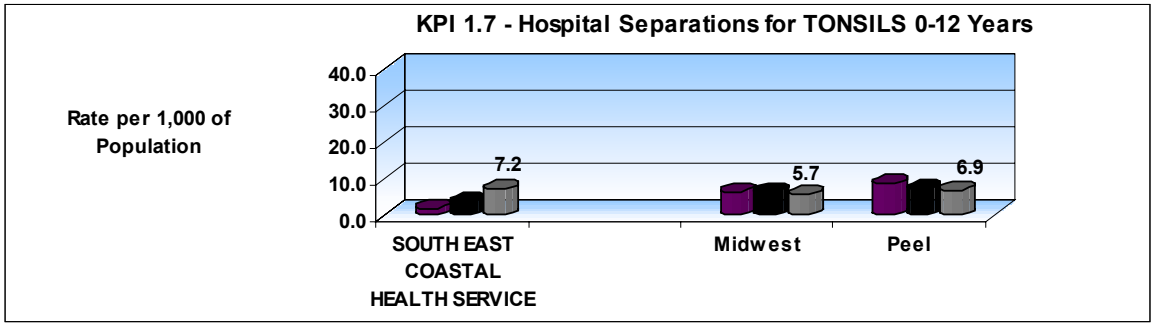
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS — KPI 1.7

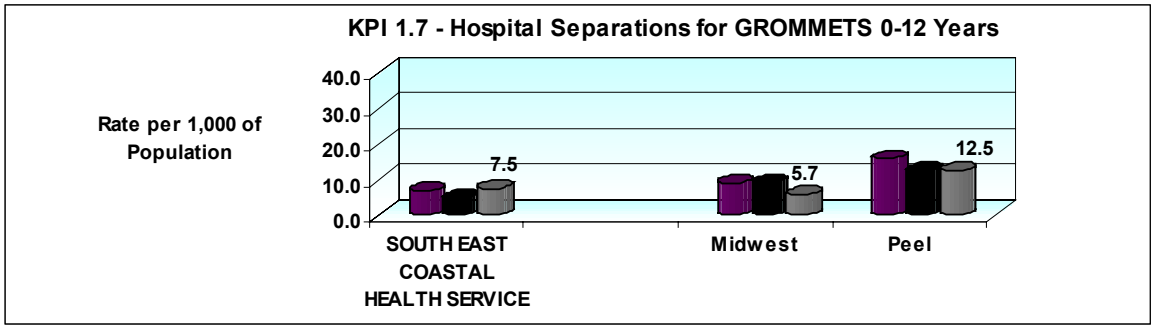
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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

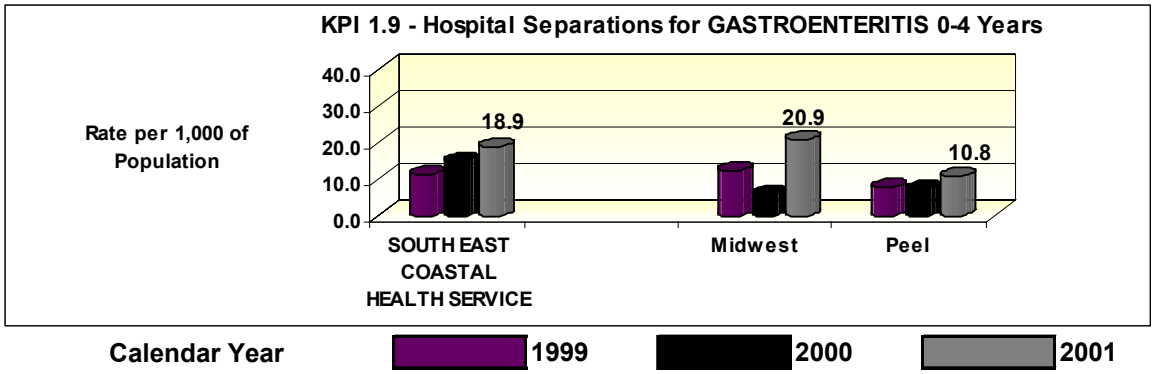
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN | KPI 1.9

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

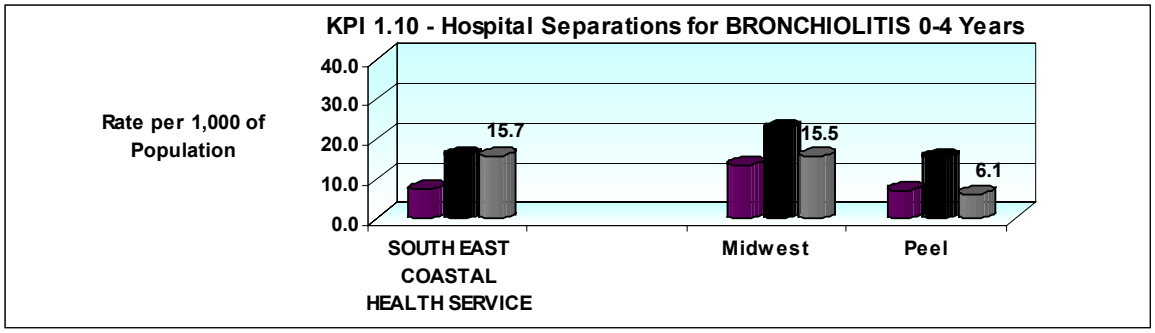
The graph shows individuals aged 0-4. Of those aged 5-12 and 13-18, none were hospitalised this year.

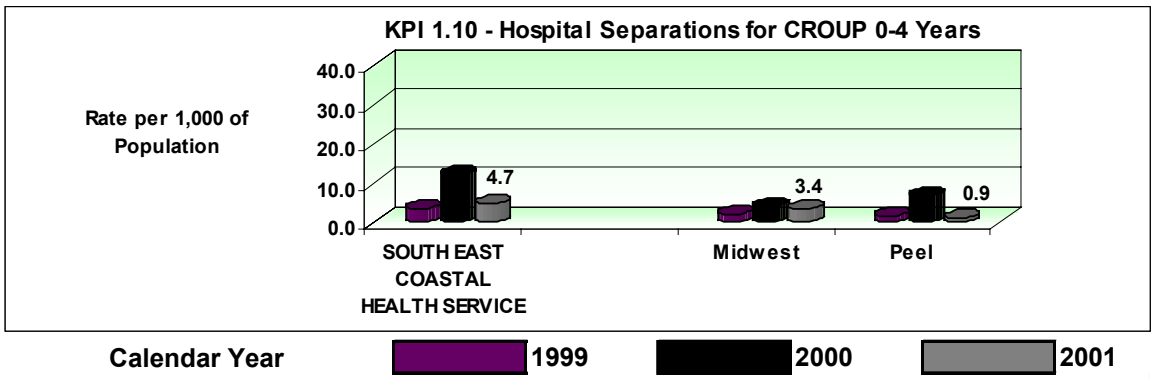
Croup

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

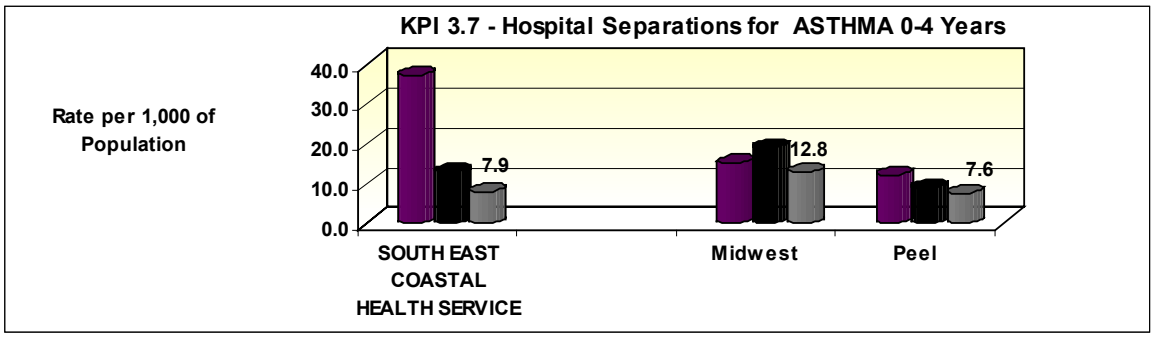
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

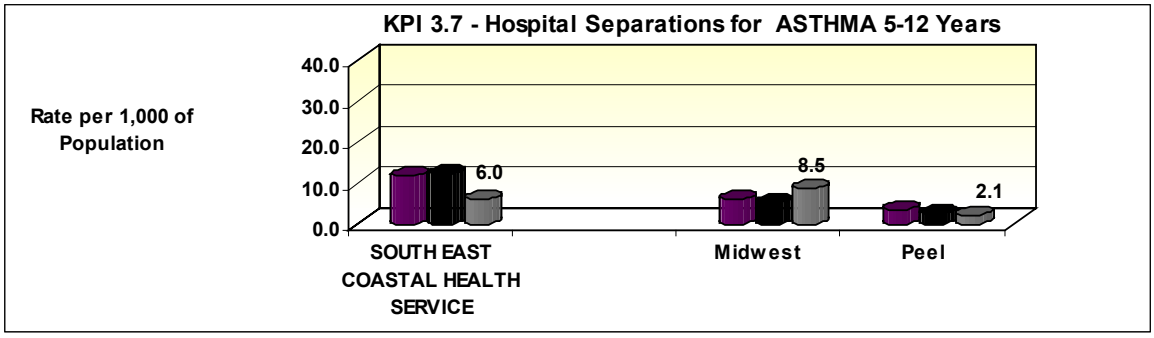
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

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 0-5 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 Raventhorpe District Hospital reports an overall satisfaction score 81 for emergency patients and 86 for outpatients for this financial year with standard errors of 2.19 and 2.17 respectively.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Emergency Patients	54	19	35%
Outpatients	54	20	37%

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.

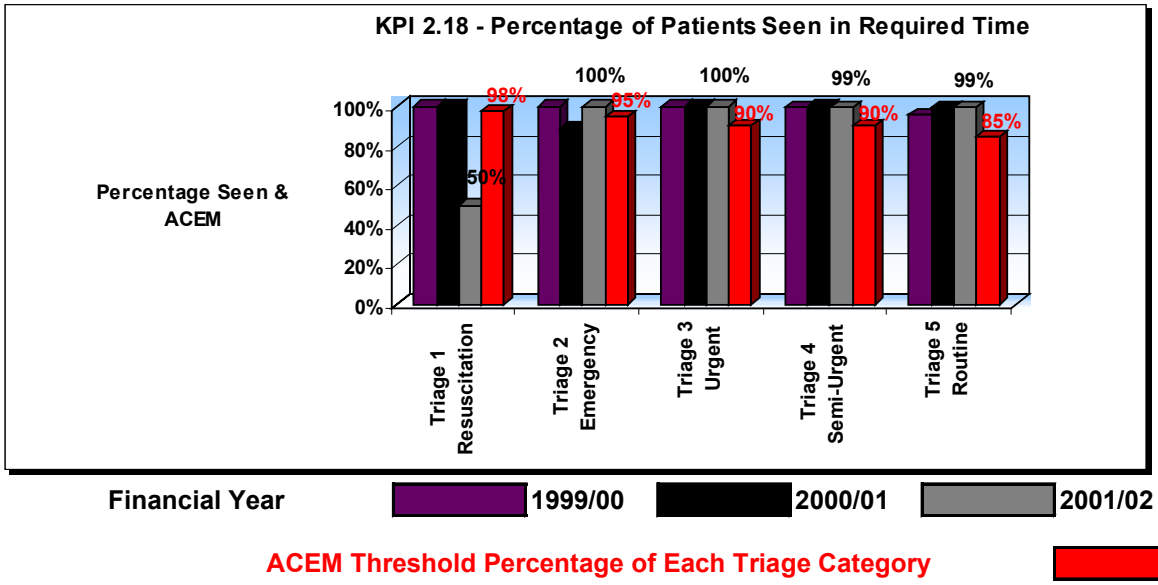
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

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.

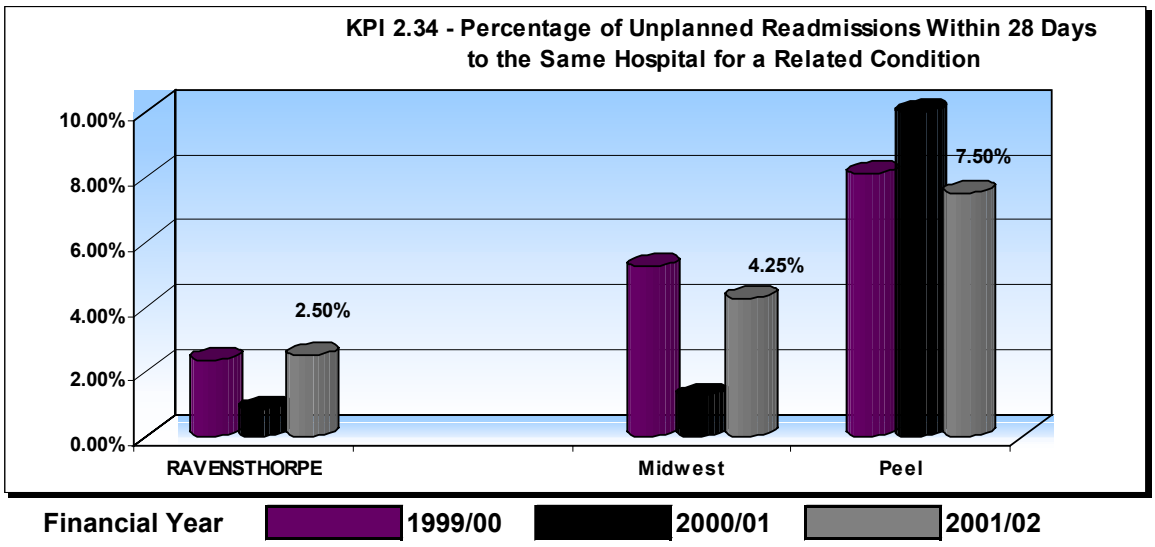
TRIAGE CATEGORY	TYPE OF PATIENT	REQUIRED TIME TO BE FIRST SEEN (By Practitioner)	ACEM THRESHOLD FOR PERCENTAGE SEEN WITHIN REQUIRED TIME
Triage 1	Resuscitation	Immediately	98%
Triage 2	Emergency	Within 10 Minutes	95%
Triage 3	Urgent	Within 30 Minutes	90%
Triage 4	Semi-Urgent	Within 60 Minutes	90%
Triage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


KPI 2.18 - Percentage of Patients Seen in Required Time
Percentage Seen & ACEM
100%
80%
60%
40%
20%
0%
98%
50%
100%
95%
100%
90%
99%
90%
99%
85%
Triage 1 Resuscitation
Triage 2 Emergency
Triage 3 Urgent
Triage 4 Semi-Urgent
Triage 5 Routine
Financial Year
1999/00
2000/01
2001/02
ACEM Threshold Percentage of Each Triage Category

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

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

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

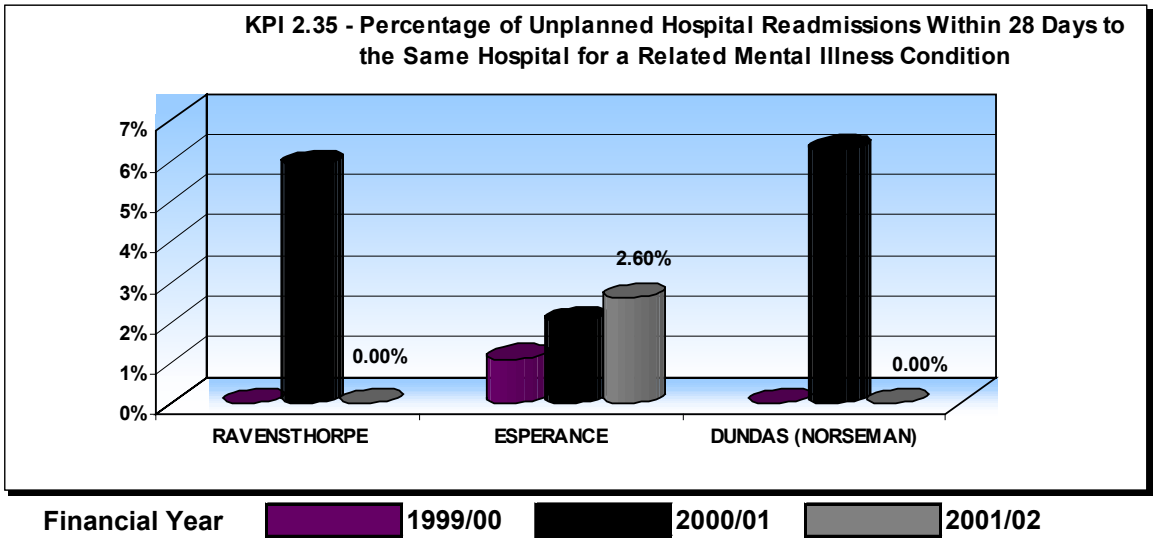


UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR TREATMENT AND CARE FOR A RELATED MENTAL HEALTH ILLNESS	KPI 2.35

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.

The Health Service has not experienced any re-admissions in this category this year.



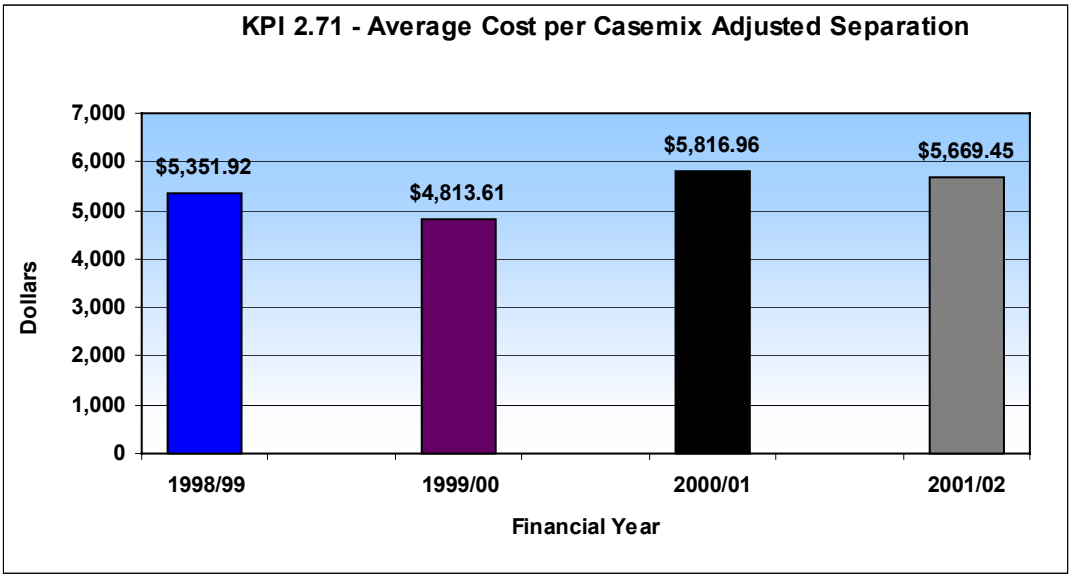
AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

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.

The cost of providing inpatient care has fallen slightly in the past year. The hospital has worked hard to contain costs and to provide services in an efficient manner.



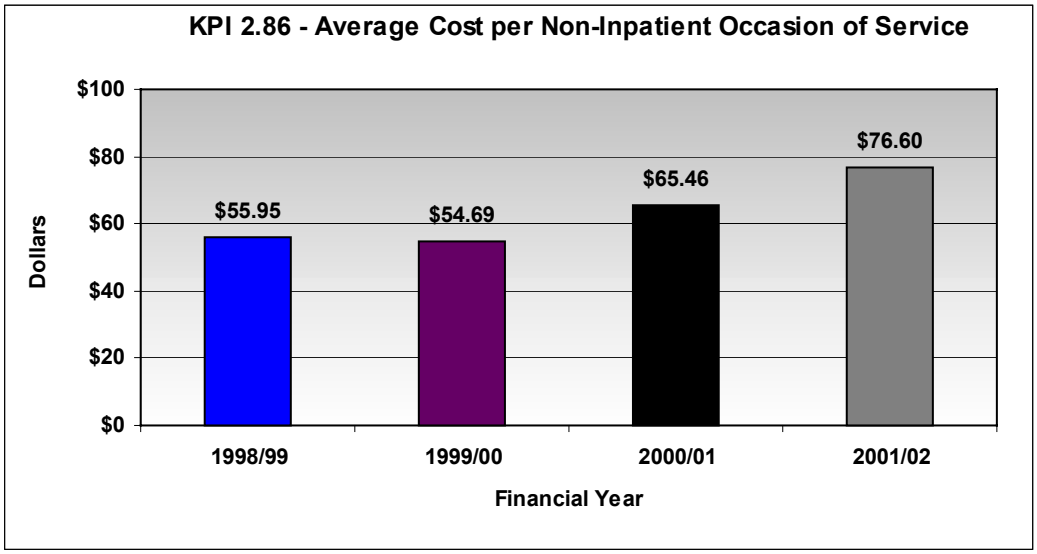
AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

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.

The cost per occasion of service has risen slowly over the last three years. This is a reflection of rising wages and costs in the industry.



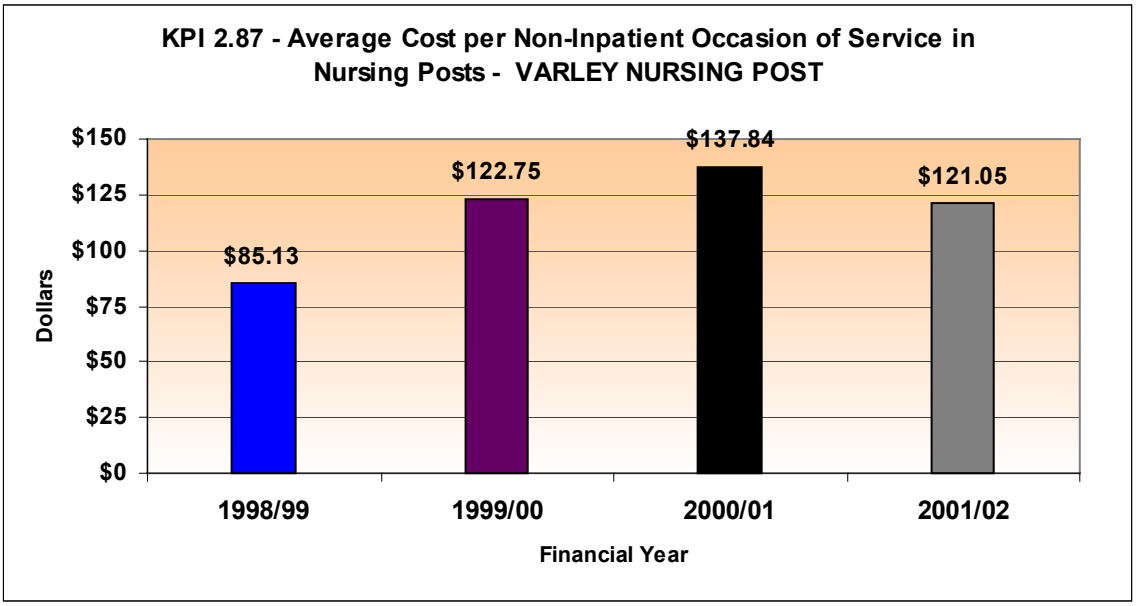
AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE IN NURSING POSTS	KPI 2.87

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

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

This indicator measures the average cost per non-inpatient occasion of service and is presented using CPI adjusted costs.

The cost average cost per non-inpatient occasion of service in nursing posts for Lake Varley has fallen slightly this year. Lake Varley is a very small community and there is great variation in patient numbers each year. Consequently the cost per service varies as the fixed costs of maintaining the service is apportioned over the changing patient numbers.



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 GROUPS ADMITTED AS A NURSING HOME TYPE PATIENT AVERAGE COST PER NURSING HOME TYPE PATIENT BED DAY	KPI 3.5 KPI 3.10

Number of Individuals Admitted as a Nursing Home Type Patient

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

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

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

The Ravensthorpe Health Service maintains a comprehensive extended care service, which supports people in need of care in the home. There were a total of five Nursing Home Type Patients admitted at Ravensthorpe District Hospital with a bed day average of 1.6. The low rates of admission for Nursing Home Type care is a testimony to the success of this service. There were no Aboriginal patients admitted as Nursing Home Type Patients within Ravensthorpe Health Service over the past three years.

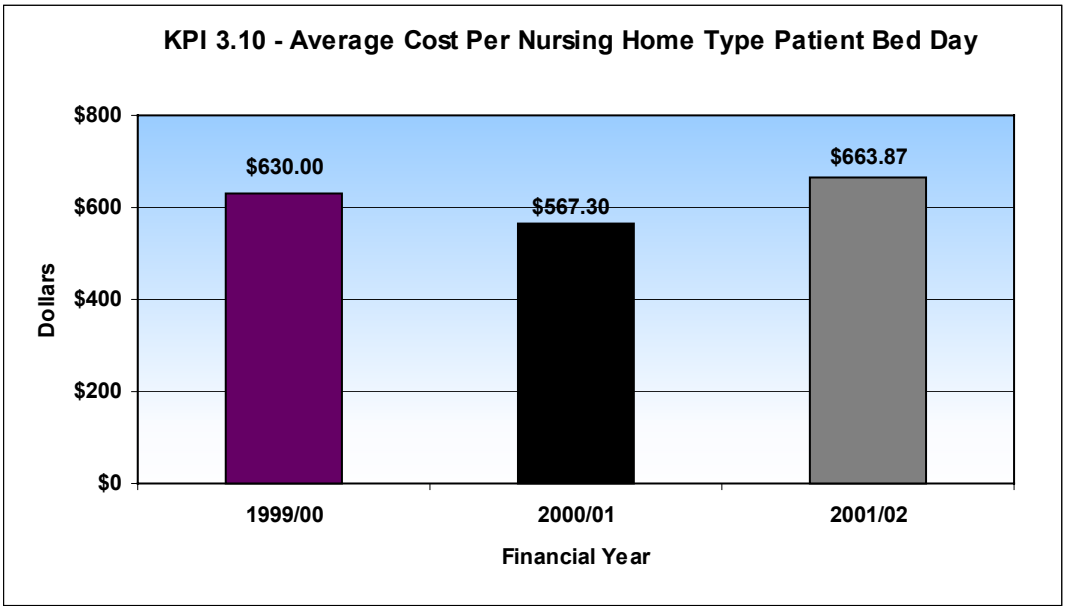
Average Cost per Nursing Home Type Patient Bed Day

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

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

The cost per Nursing Home Type Patient bed day has risen slightly over the past few years. There have been fewer Nursing Home Type Patient patients in that time and so static costs are distributed over fewer numbers.

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

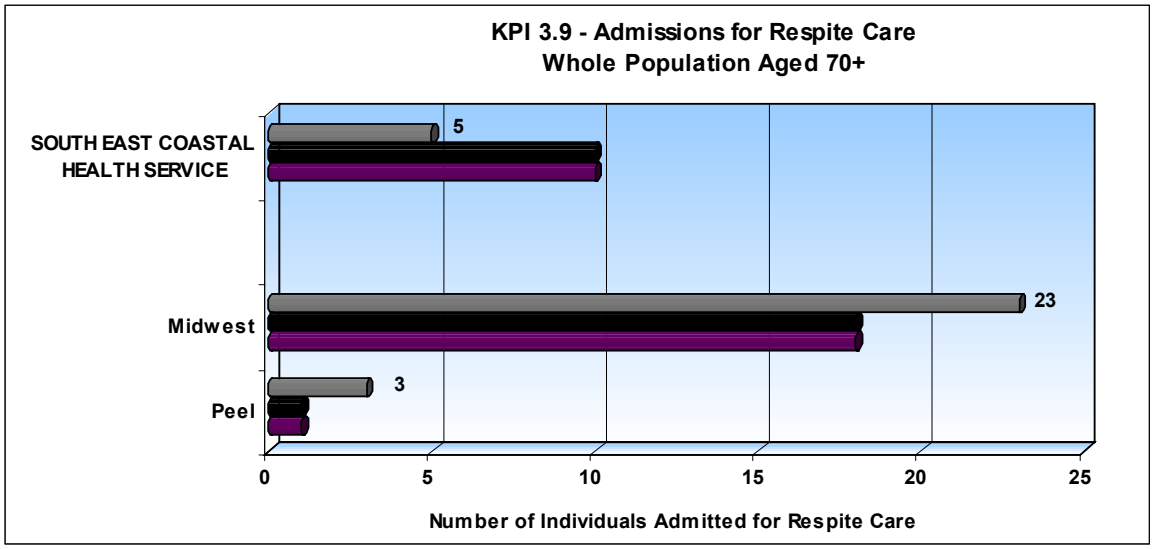


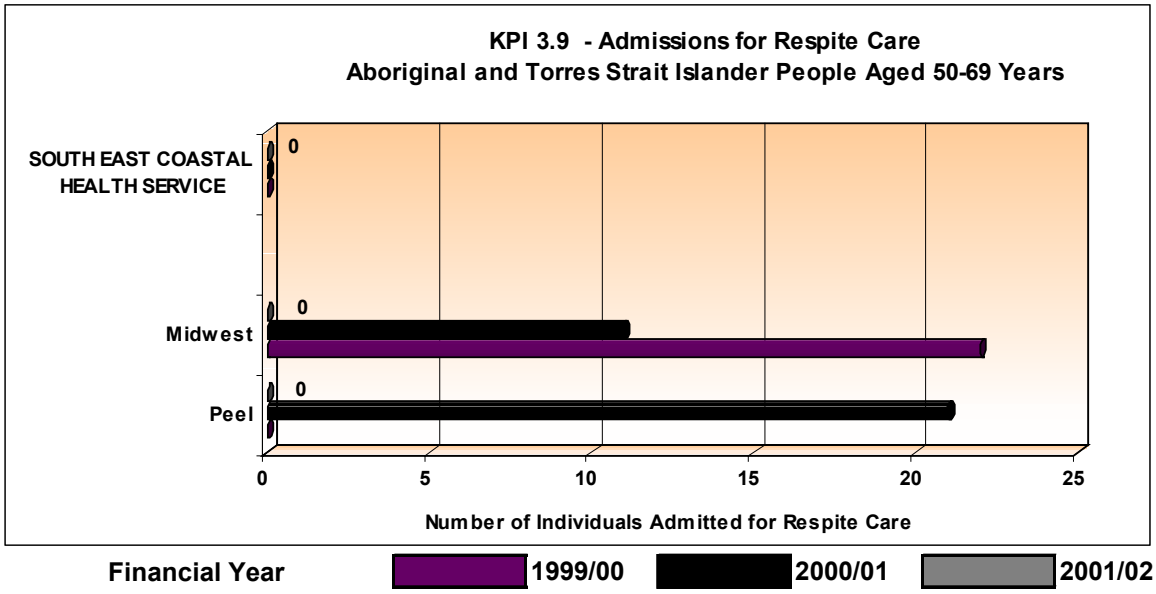
NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

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.

The Ravensthorpe Health Service 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

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

Scope

I have audited the accounts and financial statements of the Ravensthorpe 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

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

Audit Opinion
In my opinion,

(i) the controls exercised by the Ravensthorpe 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.

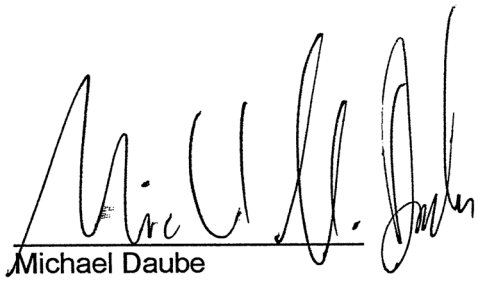
D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

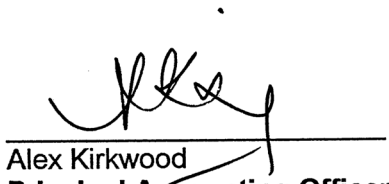
The accompanying financial statements of the Ravensthorpe Health Service have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002 and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

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Ravensthorpe 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		1,223,644	1,121,743
Fees for visiting medical practitioners		67,407	100,952
Superannuation expense		85,034	86,017
Patient support costs	3	154,963	166,469
Patient transport costs		80,685	71,418
Borrowing costs expense		0	8,273
Repairs, maintenance and consumable equipment expense		32,710	70,421
Depreciation expense	4	99,751	105,068
Net loss on disposal of non-current assets	5	7,204	37,157
Asset revaluation decrement	23	90,788	0
Capital user charge	6	229,957	0
Other expenses from ordinary activities	7	131,813	160,078
Total cost of services		2,203,956	1,927,596
Revenues from Ordinary Activities			
Patient charges	8	23,635	31,654
Donations revenue	9	3,973	1,286
Interest revenue		2	1,201
Other revenues from ordinary activities	10	47,655	30,117
Total revenues from ordinary activities		75,265	64,258
NET COST OF SERVICES		**2,128,691**	**1,863,338**
Revenues from Government			
Output appropriations	11	2,022,450	1,633,833
Capital appropriations	11	0	371,231
Assets assumed / (transferred)	12	95,867	0
Liabilities assumed by the Treasurer	13	0	85,993
Resources received free of charge	14	7,500	6,500
Total revenues from government		2,125,817	2,097,557
Change in net assets		**(2,874)**	**234,219**
Net increase / (decrease) in asset revaluation reserve	23	1,234	0
Total revenues, expenses and valuation adjustments recognised directly in equity		1,234	0
Total changes in equity other than those resulting from transactions with WA State Government as owners		**(1,640)**	**234,219**

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	15	55,425	12,092
Receivables	16	16,084	16,079
Inventories	18	13,124	13,422
Prepayments		0	610
Total current assets		84,633	42,203
NON-CURRENT ASSETS			
Amounts receivable for outputs	17	107,800	0
Property, plant and equipment	19	2,588,295	2,687,015
Construction works in progress		338,260	330,640
Total non-current assets		3,034,355	3,017,655
Total assets		**3,118,988**	**3,059,858**
CURRENT LIABILITIES			
Payables		85,555	45,880
Accrued salaries	21	66,812	21,271
Provisions	22	109,549	129,189
Total current liabilities		261,916	196,340
NON-CURRENT LIABILITIES			
Provisions	22	17,118	21,923
Total non-current liabilities		17,118	21,923
Total liabilities		**279,034**	**218,263**
Net Assets		**2,839,954**	**2,841,595**
EQUITY			
Asset revaluation reserve	23	608,416	607,182
Accumulated surplus / (deficiency)	24	2,231,538	2,234,413
Total Equity		**2,839,954**	**2,841,595**

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)	1,684,693	1,521,700
Net cash provided by Government		1,684,693	1,521,700
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(511,915)	(534,475)
Employee costs		(1,205,619)	(1,135,828)
GST payments on purchases		(38,852)	(32,301)
Receipts			
Receipts from customers		27,522	27,845
Donations		3,973	1,286
Interest received		2	1,201
GST receipts on sales		2,065	1,422
GST receipts from taxation authority		35,924	26,503
Other receipts		47,463	25,336
Net cash (used in) / provided by operating activities	25(b)	(1,639,437)	(1,619,011)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	19	(1,922)	(45,925)
Proceeds from sale of non-current assets	5	0	1,818
Net cash (used in) / provided by investing activities		(1,922)	(44,107)
Net increase / (decrease) in cash held		43,334	(141,418)
Cash assets at the beginning of the reporting period		12,091	153,509
Cash assets at the end of the reporting period	25(a)	55,425	12,091

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.		
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	291	1,586
Add Receipts		
- Patient Deposits	165	3,099
- Interest	0	9
	456	4,694
Less Payments		
- Patient Withdrawals	110	4,403
Closing Balance	346	291
Note 3 Patient support costs		
Medical supplies and services	43,171	48,419
Domestic charges	11,739	21,505
Fuel, light and power	41,832	44,490
Food supplies	29,911	27,076
Purchase of external services	28,310	24,979
	154,963	166,469
Note 4 Depreciation expense		
Buildings	74,732	73,068
Computer equipment and software	5,297	6,427
Furniture and fittings	4,296	4,863
Motor vehicles	4,388	7,019
Other mobile plant	0	45
Other plant and equipment	11,038	13,646
	99,751	105,068
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	0	1,818
Gross proceeds from sale of non-current assets	0	1,818
b) **Profit / (Loss) on disposal of non-current assets:**		
Computer equipment and software	(2,951)	(1,809)
Furniture and fittings	(1,477)	(17,882)
Other mobile plant	0	(238)
Other plant and equipment	(2,776)	(17,228)
	(7,204)	(37,157)

Note 6 Capital user charge	2001/02 $	2000/01 $
	229,957	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	20,540	19,554
Other employee expenses	11,045	20,811
Motor vehicle expenses	17,484	28,097
Insurance	4,265	2,968
Communications	19,355	34,915
Printing and stationery	5,141	10,730
Rental of property	12,644	15,832
Audit fees - external	7,530	9,000
Bad and doubtful debts expense	1,388	765
Other	32,421	17,406
	131,813	160,078

Note 8 Patient charges

Inpatient charges	23,506	31,494
Outpatient charges	129	160
	23,635	31,654

Note 9 Donations revenue

General public contributions	3,973	1,286

Note 10 Other revenues from ordinary activities

Rent from properties	8,761	1,754
Recoveries	2,346	13,768
Use of hospital facilities	6,242	3,749
Other	30,306	10,846
	47,655	30,117

Note 11 Government appropriations

Output appropriations (I)	2,022,450	1,633,833
Capital appropriations (II)	0	371,231
	2,022,450	2,005,064

(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 Assets assumed / (transferred)

The following assets have been assumed from / (transferred to) other government agencies during the year:

- Land and buildings	95,867	0
Total assets assumed / (transferred)	95,867	0

Note 13 Liabilities assumed by the Treasurer	2001/02 $	2000/01 $
Superannuation	0	85,993

The change in funding arrangement for the Gold State Superannuation Scheme and the West State Superannuation Scheme has resulted in the decrease in "Liabilities assumed by Treasurer". (Refer note 1(n)(ii)).

Note 14 Resources received free of charge

Resources received free of charge has been determined on the basis of the following estimates provided by agencies.

Office of the Auditor General		
- Audit services	7,500	6,500

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 15 Cash assets

Cash on hand	50	80
Cash at bank - general	39,675	294
Cash at bank - donations	15,700	11,718
	55,425	12,092

Note 16 Receivables

Patient fee debtors	2,169	6,667
GST receivable	4,892	4,528
Other receivables	9,788	5,649
	16,849	16,844
Less: Provision for doubtful debts	(765)	(765)
	16,084	16,079

Note 17 Amounts receivable for outputs

Non-current	107,800	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 18 Inventories

Supply stores - at cost	9,245	7,536
Pharmaceutical stores - at cost	3,879	5,886
	13,124	13,422

Note 19 Property, plant and equipment	2001/02 $	2000/01 $
Land		
At valuation - 30.6.2000 (iii)	31,800	29,166
	31,800	29,166
Buildings		
Clinical:		
At valuation - 30.6.2000 (iii)	2,847,108	3,508,492
Accumulated depreciation	(1,330,611)	(1,200,434)
	1,516,497	2,308,058
Non-Clinical:		
At cost (i)	0	185,250
Accumulated depreciation	0	(1,979)
	0	183,271
At fair value (ii)	87,000	0
Accumulated depreciation	0	0
	87,000	0
At valuation - 30.6.2000 (iii)	876,384	0
Accumulated depreciation	(59,605)	0
	816,779	0
Computer equipment and software		
At cost	24,854	41,831
Accumulated depreciation	(13,194)	(21,923)
	11,660	19,908
Furniture and fittings		
At cost	54,916	67,483
Accumulated depreciation	(18,463)	(25,257)
	36,453	42,226
Motor vehicles		
At cost	38,301	38,301
Accumulated depreciation	(30,987)	(26,599)
	7,314	11,702
Other plant and equipment		
At cost	167,836	194,230
Accumulated depreciation	(87,044)	(101,546)
	80,792	92,684
Total of property, plant and equipment	2,588,295	2,687,015

Land and buildings

(i) Land, clinical buildings and non-clinical buildings that are yet to be revalued are carried at their cost of acquisition.

(ii) Land, clinical buildings and non-clinical buildings have been subject to a recent revaluation and are carried at their fair value.

(iii) Land, clinical buildings and non-clinical buildings are yet to be revalued at fair value.

Payments for non-current assets

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

Paid as cash by the Health Service from output appropriations	1,922	45,925
Paid by the Department of Health	0	185,250
Gross payments for purchases of non-current assets	1,922	231,175

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	29,166
Additions	1,400
Revaluation increments / (decrements)	1,234
Carrying amount at end of year	31,800
Buildings	
Carrying amount at start of year	2,491,329
Additions	94,467
Revaluation increments / (decrements)	(90,788)
Depreciation	(74,732)
Carrying amount at end of year	2,420,276
Computer equipment and software	
Carrying amount at start of year	19,908
Disposals	(2,951)
Depreciation	(5,297)
Carrying amount at end of year	11,660
Furniture and fittings	
Carrying amount at start of year	42,226
Disposals	(1,477)
Depreciation	(4,296)
Carrying amount at end of year	36,453
Motor vehicles	
Carrying amount at start of year	11,702
Depreciation	(4,388)
Carrying amount at end of year	7,314
Other plant and equipment	
Carrying amount at start of year	92,684
Additions	1,922
Disposals	(2,776)
Depreciation	(11,038)
Carrying amount at end of year	80,792

Note 20 Interest-bearing liabilities

	2001/02 $	2000/01 $
a) **Department of Treasury and Finance loans**		
Balance at beginning of year	0	103,860
Less repayments this year	0	(103,860)
Balance at end of year	0	0

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	0	103,860
Less repayments this year	0	(103,860)
Balance at end of year	0	0

Note 21 Accrued salaries

Amounts owing for:	66,812	21,271
All Staff		
7 days from 23 June to 30 June 2002		
(2001: 6 days from 25 June to 30 June 2001)		

Note 22 Provisions	2001/02 $	2000/01 $
Current liabilities:		
Annual leave	79,604	104,907
Long service leave	28,221	24,282
Deferred salary scheme	0	0
Superannuation	1,724	0
	109,549	129,189
Non-current liabilities:		
Long service leave	17,118	21,923
Total employee entitlements	126,667	151,112

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 23 Asset revaluation reserve

Balance at beginning of the year	607,182	607,182
Net revaluation increments / (decrements) :		
Land	1,234	0
Balance at end of the year	608,416	607,182
Asset revaluation decrements recognised as an expense (iii):		
Buildings	90,788	0

(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	2,234,413	2,000,194
Change in net assets	(2,874)	234,219
Balance at end of the year	2,231,539	2,234,413

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 15)	55,425	12,091
	55,425	12,091

Note 25 Notes to the statement of cash flows - continued	2001/02 $	2000/01 $
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)	(1,639,437)	(1,619,011)
Increase / (decrease) in assets:		
GST receivable	364	4,484
Other receivables	(359)	2,594
Inventories	(298)	571
Prepayments	(610)	610
Decrease / (increase) in liabilities:		
Doubtful debts provision	0	(765)
Payables	(39,675)	(23,302)
Accrued salaries	(45,541)	(5,586)
Provisions	24,445	21,019
Non-cash items:		
Depreciation expense	(99,751)	(105,068)
Profit / (loss) from disposal of non-current assets	(7,204)	(37,157)
Interest paid by Department of Health	0	(8,273)
Capital user charge paid by Department of Health	(229,957)	0
Asset revaluation decrements	(90,788)	0
Superannuation liabilities assumed by the Treasurer	0	(85,993)
Resources received free of charge	(7,500)	(6,500)
Other	7,620	(961)
Net cost of services (Statement of Financial Performance)	(2,128,691)	(1,863,338)
c) **Notional cash flows**		
Output appropriations as per Statement of Financial Performance	2,022,450	1,633,833
Capital appropriations as per Statement of Financial Performance	0	371,231
	2,022,450	2,005,064
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 Department of Treasury & Finance	0	(8,273)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	0	(103,860)
Capital user charge	(229,957)	0
Other non cash adjustments to output appropriations	(107,800)	(371,231)
	(337,757)	(483,364)
Output appropriations as per Statement of Cash Flows	1,684,693	1,521,700

Note 26 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
$20,001 - $30,000	1	0
$40,001 - $50,000	1	0
$60,001 - $70,000	0	1
$70,001 - $80,000	0	1
Total	2	2
	$	$
The total remuneration of senior officers is:	72,741	137,790

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

Note 27 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 $
Fees for visiting medical practitioners	66,909	100,952	(34,043)
Patient support costs	144,314	166,469	(22,155)
Borrowing costs expense	0	8,273	(8,273)
Repairs, maintenance and consumable equipment expense	30,559	70,421	(39,862)
Net loss on disposal of non-current assets	7,204	37,157	(29,953)
Asset revaluation decrement	90,788	0	90,788
Capital user charge	229,957	0	229,957
Other expenses from ordinary activities	119,597	160,078	(40,481)

Fees for visiting medical practitioners Patient Support Costs	Ravensthorpe Hospital experienced reductions in patient numbers which reduced patient related expenses
Borrowing costs expense	The borrowing liability was paid out last year
Repairs, maintenance and consumable equipment expense	Maintenance has been reduced to a minimum pending the building of the new hospital
Net loss on disposal of non-current assets	Few assets were disposed of this year
Asset revaluation decrement	Revaluations were made in respect of properties in Lake Varley
Capital user charge	The capital user charge was introduced this year
Other expenses from ordinary activities	Other expenses reduced in line with lower activity

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%

	2001/02 Actual $000	2001/02 Estimate $000	Variation $000
Salaries and wages	1,214	1,089	125
Visiting medical practitioners	67	90	(23)
Superannuation	83	95	(12)
Direct patient support cost	144	130	14
Indirect patient support cost	77	85	(8)
Repairs, maintenance and consumable equipment	31	40	(9)
Net loss from disposal of non-current assets	7	0	7
Asset revaluation decrement	91	0	91
Capital user charge	230	0	230
Other expenses from ordinary activities	120	150	(30)

Salaries and wages	Salaries have increased with introduction of new services
Fees for visiting medical practitioners Patient support costs	Ravensthorpe Hospital experienced reductions in patient numbers which reduced patient related expenses
Borrowing costs expense	The borrowing liability was paid out last year
Repairs, maintenance and consumable equipment expense	Maintenance has been reduced to a minimum pending the building of the new hospital
Net loss on disposal of non-current assets	Few assets were disposed of this year
Asset revaluation decrement	Revaluations were made in respect of properties in Lake Varley
Capital user charge	The capital user charge was introduced this year
Other expenses from ordinary activities	Other expenses reduced in line with lower activity

Note 28 Commitments for Expenditure	2001/02 $	2000/01 $
a) **Capital expenditure commitments**		
Capital expenditure commitments contracted for at reporting date are payable:		
Later than one year, and not later than five years	3,629,360	3,629,360
b) **Operating lease commitments:**		
Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	1,245	8,704
Later than one year, and not later than five years	9,320	1,006
	10,565	9,710

Note 29 Contingent liabilities

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

Note 30 Events occurring after reporting date

The Ravensthorpe 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 31 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 32 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 33 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	Fixed interest rate maturities: 1 to 5 years $000	Fixed interest rate maturities: Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2002							
Financial Assets							
Cash assets	0.3%	55	0	0	0	0	55
Receivables		0	0	0	0	16	16
		55	0	0	0	16	71
Financial Liabilities							
Payables		0	0	0	0	86	86
Net financial assets / (liabilities)		55	0	0	0	(70)	(15)
As at 30th June 2001							
Financial Assets							
Cash assets	0.3%	12	0	0	0	0	12
Receivables		0	0	0	0	16	16
		12	0	0	0	16	28
Financial Liabilities							
Payables		0	0	0	0	46	46
Net financial assets / (liabilities)		12	0	0	0	(30)	(18)

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 34 Output information

	Prevention & Promotion		Diagnosis & Treatment		Total	
	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01
COST OF SERVICES	$000	$000	$000	$000	$000	$000
Expenses from Ordinary Activities						
Employee expenses	154	128	1,069	994	1,223	1,122
Fees for visiting medical practitioners	0	0	67	101	67	101
Superannuation expense	9	11	76	75	85	86
Patient support costs	5	4	150	162	155	166
Patient transport costs	1	0	80	71	81	71
Borrowing costs expense	0	0	0	8	0	8
Repairs, maintenance and consumable equipment expense	2	10	31	60	33	70
Depreciation expense	6	4	94	101	100	105
Net loss on disposal of non-current assets	2	6	5	31	7	37
Asset revaluation decrement	91	0	0	0	91	0
Capital user charge	0	0	230	0	230	0
Other expenses from ordinary activities	12	10	120	150	132	160
Total cost of services	282	173	1,922	1,753	2,204	1,926
Revenues from Ordinary Activities						
Patient charges	0	0	24	32	24	32
Donations revenue	0	0	4	1	4	1
Interest revenue	0	0	0	1	0	1
Other revenues from ordinary activities	3	1	44	29	47	30
Total revenues from ordinary activities	3	1	72	63	75	64
NET COST OF SERVICES	**279**	**172**	**1,850**	**1,690**	**2,129**	**1,862**
Revenues from Government						
Output appropriations	183	144	1,839	1,490	2,022	1,634
Capital appropriations	0	93	0	278	0	371
Assets assumed / (transferred)	96	(0)	0	0	96	0
Liabilities assumed by the Treasurer	0	11	0	75	0	86
Resources received free of charge	0	0	8	7	8	7
Total revenues from government	279	248	1,847	1,850	2,126	2,098
Change in net assets	**0**	**76**	**1**	**160**	**1**	**236**

Note 34 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).