Roebourne District Hospital Board

Annual Report 2001/2002

Department of Health
Government of Western Australia

Statement of Compliance

To the Hon Bob Kucera MLA

MINISTER FOR HEALTH

In accordance with Section 66 of the *Financial Administration and Audit Act 1985*, I hereby submit for your information and presentation to Parliament, the Report of Roebourne District Hospital Board 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

West Pilbara Health Service Corporate Office
Nickol Bay Hospital
Millstream Rd
KARRATHA WA 6714

PO Box 519
KARRATHA WA 6714

☎ *(08) 9144 0305*
℻ *(08) 9144 0374*

Roebourne District Hospital
42–44 Hampton St
ROEBOURNE WA 6718

PO Box 81
ROEBOURNE WA 6718

☎ *(08) 9182 1004*
℻ *(08) 9182 1076*

Mission Statement

Our Mission
To bring together the expertise and professionalism of all our people and focus their combined skill, energy and commitment to ensure total customer health care to which others aspire.

Broad Objectives

The objectives of the Roebourne District Hospital are:

- To reduce the incidents of preventable disease, injury, disability and premature death.
- To provide accessible hospital care to those who require it and to provide those services according to recognised standards of quality in a way that is acceptable to clients.
- To improve the quality of life of people with chronic illness and disability.

Enabling Legislation

The Roebourne District Hospital 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 management and control of the Hospital is vested in the Minister for Health, Hon. R. C. Kucera AMP MLA, as the Board of Management under Section 7 of the *Hospitals and Health Services Act 1927*.

As the Accountable Authority for Roebourne District Hospital, the Director General is responsible to the Minister for Health, Hon. R. C. Kucera APM MLA, for the general administration of the Hospital.

The Roebourne District Hospital does not operate in coordination with any subsidiary, related or affiliated bodies.

Ministerial Directives

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

Submission of Annual Report

Approval was sought under the *Financial Administration and Audit Act 1985* to extend the Roebourne District Hospital'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 Roebourne District Hospital, 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.

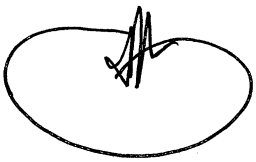
Such processes include:

- The hospital has updated policies supporting the *Public Sector Standards in Human Resource Management*.
- A *Code of Conduct* was adopted in 1998 and is provided on appointment to all staff. The Code outlines broad expectations of staff and provides direction to staff on a range of conduct issues.
- Policies and supporting guidelines are in each human resource manual, which is accessible to all staff.
- Staff have been advised they can access these policies and procedures and where they can be located.

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

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

The Roebourne District Hospital has not been investigated or audited by the Office of the Public Sector Standards Commissioner for the period to 30 June 2002.



Tim Shackleton
REGIONAL DIRECTOR
PILBARA GASCOYNE HEALTH REGION
December 2002

Advertising and Sponsorship — Electoral Act 1907

The following table lists the expenditure on advertising and sponsorship made by the West Pilbara Health Service, including Roebourne District Hospital, published in accordance with Section 175ZE of the *Electoral Act 1907*.

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies — Marketforce Productions	30,336.32	31,024.30	19,683.05
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations	–	–	–
Media Advertising Organisations	–	–	–
TOTAL	**$30,336.32**	**$31,024.30**	$19,683.05

Freedom of Information Act 1992

The West Pilbara Health Service, which incorporates Roebourne District Hospital, received and dealt with 219 formal applications under the Freedom of Information guidelines during 2001/2002.

Formal applications are defined as requests which:

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

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

The types of documents held by the Roebourne District Hospital include:

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

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

Health Information Officer
Nickol Bay Hospital
Millstream Road
KARRATHA WA 6714

☎ *(08) 9144 0380*

West Pilbara Health Service incorporating Roebourne District Hospital

Key Operations and Achievements

- Provision of hospital inpatient and outpatient services.
- Provision of community-based health services.
- Provision of health promotion and injury prevention activities and programs.
- Mental health services.
- Public health and aged care assessment services.
- Establishment of asthma and breast feeding clinics.
- Establishment and development of the shared model of care for antenatal patients.
- Development and implementation of a video conferencing service.
- Implementation of the full Emergency Management Plan for major disasters.

Hospital Inpatient and Outpatient Services
Hospital inpatient and outpatient services at public hospitals located in Karratha, Roebourne and Wickham continued to be provided.

Community-Based Health Services
Provision of community-based health services based in Karratha, Roebourne and Wickham and servicing outlying communities in Dampier, Point Samson and Pannawonica. Paediatric physiotherapy services are also provided to Tom Price and Paraburdoo.

Health Promotion and Injury Prevention
Provision of health promotion and injury prevention activities and programs in accordance with the New Vision Model for community health.

Mental Health Services
Mental Health Services are located in Nickol Bay Hospital but these are managed by the North West Mental Health Service under the auspices of the Kimberley Health Service.

Public Health and Aged Care Assessment Services
Public Health and Aged Care Assessment Services continue to be provided by East Pilbara Health Service to the constituent communities of the West Pilbara Health Service district.

Asthma and Breast Feeding Clinics
The establishment of asthma and breastfeeding clinics at Nickol Bay Hospital with successful clinical outcomes for the communities of Karratha, Roebourne and Wickham.

Shared Model of Care
Establishment and development of the shared model of care (midwives and doctors) for antenatal patients.

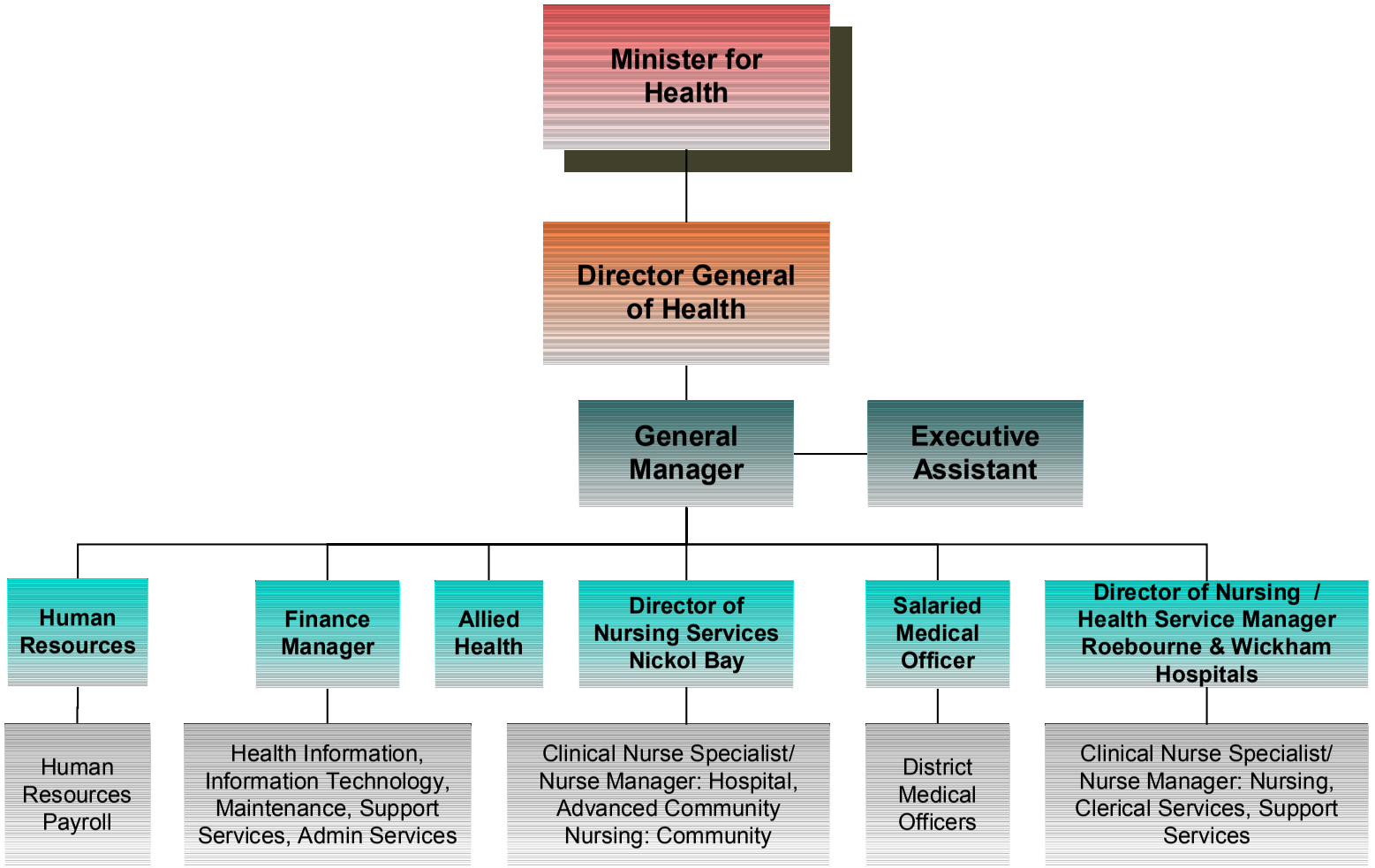
Video Conferencing Service
The development and implementation of a video conferencing service to all services within the West Pilbara Health Service.

Emergency Management Plan
The implementation of the full Emergency Management Plan for major disaster management and the implementation of recommendations that arose out of both a major exercise and a real offshore disaster.

Major Capital Projects

The Roebourne District Hospital did not complete or make progress on any major capital projects during 2001/2002.

Organisational Chart



Accountable Authority

The Director General of Health, Mike Daube represents the Accountable Authority for the Health Service.

Note: The Governor in Executive Council approved the amalgamation of several hospital boards including the Roebourne Health Service 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

Members of the Roebourne District Hospital Board and their areas of responsibility are listed below:

Area of Responsibility	Title	Name	Basis of Appointment
Health Service and Corporate Management	General Manager Acting General Manager	Paul Aylward Tim Shackleton	Term Contract, July 2001– April 2002 April 2002– June 2002
Finance and Information Technology	Finance Manager	Christine Churchill	Permanent
Human Resources, Industrial Relations, Payroll, Administration	Acting Human Resource Manager	Nola Kevalaitis	**June 2002**
Roebourne and Wickham District Hospital	Health Service Manager/Director of Nursing	Lance Christie Dahnne Dray	Permanent July 2001– November 2001 Acting November 2001– June 2002
Engineering	Maintenance Manager	Brad West	Permanent

Pecuniary Interests

Members of the Roebourne District Hospital have declared no pecuniary interests other than those reported in the Financial Statements section of this report.

Demography

The Roebourne District Hospital delivers services to communities covered by the following local authority:

- Roebourne Shire

The following table shows population figures for the Roebourne Shire:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Roebourne Shire	13,862	15,138	15,577

*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 Roebourne is made up of five main towns: Karratha, Dampier, Roebourne, Wickham and Point Samson. There are also several large pastoral leases surrounding these communities.

Available Services

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

Direct Patient Services
Accident and Emergency
Asthma Services
Day Surgery
Domiciliary Care
Lactation Consultancy Service
Medical
Nursing (home type)
Obstetrics
Paediatric
Palliative Care
Respite Care
Surgical

Medical Support Services
Clinical Psychology
Medical Imaging Technology
Occupational Therapy
Pharmacy
Physiotherapy
Social Work
Speech Pathology

Community Services
Aboriginal Health and Aged Care
Child and Adolescent Health
Communicable Disease Control
Environmental Health Services
Health Promotion Services
Immunisation Services
Monitoring/Screening for Chronic Disease
School Health
Women's health

Other Support Services
Catering
Domestic
Health Information
Information Technology
Orderly

Note: Mental Health Services are provided within the West Pilbara Health Service by the North West Mental Health Service under the auspices of the Kimberley Health Service. A North West Mental Health Service is based at Nickol Bay Hospital.

Specialist Services
None

Other Services
None

Disability Services

Our Policy
The Roebourne District Hospital is committed to ensuring all people with disabilities can access the facilities provided by and within the Health Service.

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

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

- The Disability Service Plan was reviewed during 2000/2001 in consultation with key stakeholders. The plan is effective until 2003. Implementation of improvements in accordance with the spirit and intent of the plan have continued during 2001/2002. The health service is focusing on service delivery, staff education of disabilities, and the rights of the disabled and promoting community understanding and involvement.

Outcome 2: Access to buildings and facilities is improved.

- Regular audits and inspections are carried out to ensure that buildings continue to remain accessible for people with a disability. Bathroom hand rails were installed in Rooms 8 and 10 Nickol Bay Hospital.

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

- Assess and prioritisation of the need for alternative format of information for customers in hand continues to be reviewed.
- Disability Services Plan principles are included in the general orientation program.

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

- It is a condition of employment at the West Pilbara Health Service that all employees have knowledge of Disability Services and an awareness of access to West Pilbara Health Service facilities and programs that affect patients.
- Specific education for frontline staff regarding the philosophy and operation of the Disability Services Plan is provided.
- Managers continue to monitor the needs of clients with disabilities.

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

- The Health Service has established a communication network, formal and informal, to allow communication and feedback from people with disabilities, their carers and families.
- People with disabilities are provided the opportunity to participate in customer consultation and grievance mechanisms.

Future Direction
The Roebourne District Hospital 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 Roebourne District Hospital strives to ensure there is no discrimination against members of the public based upon race, ethnicity, religion, language or culture.

Programs and Initiatives
The Roebourne District Hospital 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:

No outcomes have been identified from the Cabinet endorsed Language Services Policy.

Youth Services

Our Policy
The Roebourne District Hospital acknowledges the rights and special needs of youth, and endeavours to provide appropriate services, supportive environments and opportunities for young people.

The Roebourne District Hospital 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.

Roebourne Community Health has been involved with the 15–25 age group primarily through the Antenatal Clinic which is run in Roebourne. We work mainly with females in this group, as for cultural reasons men do not attend the clinic with their partner for antenatal visits. Last year we identified a growing trend in the number of teenage Aboriginal girls who were attending the clinic with unplanned pregnancies. Most of these girls elected to continue their pregnancy. It is our vision to run a camp later this year for these girls, who are now mothers, to introduce some mothercraft skills along with self-esteem and image building sessions. We are looking to involve some of the older women in the community as well as health professionals for the teaching sessions.

Programs and Initiatives
The Roebourne District Hospital has run numerous programs targeting youth groups and introduced a number of innovations such as:

- Antenatal Clinic.
- Smarter than Smoking.
- Self-Esteem.
- Information providing awareness of Breast and Testicular Cancer.
- Healthy Foods in the Canteen.

Employee Profile

The following table shows the number of full-time equivalent staff employed by the Roebourne District Hospital:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	12.68	12.66	12.46
Administration and Clerical*	1.33	1.67	1.48
Medical Support*	–	–	–
Hotel Services*	9.95	10.41	9.30
Maintenance	–	–	–
Medical (salaried)	–	–	–
Other	–	–	–
TOTAL	**23.96**	**24.74**	**23.24**

*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 Roebourne District Hospital has continued experiencing minor difficulties in attracting and retaining experienced nursing staff during 2001/2002.

Staff Development

Nursing staff were exposed to a number of programs with a diverse range of content, presentation and topics. Major programs such as a Legal and Nursing Practice Issues study day saw a staff member from the Legal Branch of the Department of Health and a Nurse Adviser from the Nurses Board of Western Australia visit. They provided information on legal requirements in relation to confidentiality, consent, duty of care, negligence, liability, coroners requirements, code of conduct, code of ethics and code of practice.

Another major program was the Icarus exercise, examining Health Service response to a joint major incident exercise involving the North West Shelf, Nickol Bay Hospital, Metropolitan Hospitals Disaster Planning Committee and the Burns Unit at Royal Perth Hospital. In the lead-up to this exercise, education was provided to staff in Burns Management and a Major Incident Medical Management and Support course.

In-house nursing staff development has been provided on a monthly basis along with compulsory training such as fire training, Manutension and Basic Life Support.

Costs for nursing staff development were in the vicinity of $43,000, including costs for orientation of nursing staff of $5976.

Industrial Relations Issues

The Roebourne District Hospital did not experience any industrial activity during the period 2001/2002.

There was little industrial impact on the Health Service from the recent Australian Nursing Federation EBA negotiations.

Workers' Compensation and Rehabilitation

Workers' compensation claims for the year 2001/2002 show a significant drop compared to 2000/2001 and 1999/2000 with only one active claim throughout the reporting period, which should result in a considerable saving in workers' compensation premiums. This drop could be attributed to the proactive establishment and training of Occupational Safety and Health representatives.

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 Roebourne District Hospital 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.

Roebourne District Hospital recognises the need to provide a safe working environment, free from all forms of discrimination and harassment. The Roebourne District Hospital encourages all employees to take action when confronted with, or having witnessed any form of discrimination or harassment.

Programs and Initiatives
The Roebourne District Hospital 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:

Integration of EEO Outcomes

- Multicultural displays and art are displayed in the Health Service.

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

EEO contact officers were appointed from within the West Pilbara Health Service and training and policies were provided in the following areas:

- The *Equal Opportunity Act 1984*, legal implications, discrimination and harassment, and confidentiality.
- The role and responsibilities of the contact officers.
- Conflict management skills, problem solving and effective communication.

There were no complaints in the reporting period

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

- Policies within the West Pilbara Health Service including recruitment and selection, partnerships in performance, temporary filling of positions, discipline and a comprehensive induction program for new employees were reviewed, developed or updated to ensure that employment practices are non-discriminatory.
- The Roebourne District Hospital recognises the need to provide a safe working environment, free from all forms of discrimination and harassment.

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

- The health system has an endorsed policy statement on the employment of people with disabilities and from non-English speaking backgrounds.
- There has been an increase in the percentage of people from EEO groups employed, retained and undertaking developmental opportunities.
- A series of interventions to provide women with experience in a range of management/administrative positions was developed.
- All staff complete compulsory EEO and diversity information.

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 Roebourne District Hospital 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

The Health Service participated in the following marketing activities during 2001/2002:

- Sunsmart Pool Day.
- Australia's Biggest Morning Tea.
- Australia's Breast Cancer Day.
- Cancer Foundation Parental Guidance Recommended nutrition program.
- Ngala sleep management satellite broadcast.
- Teddy Bears Picnic at Millar's Well Oval.
- Measles Campaign for 18–30 year olds.
- Fluvax Campaign.
- Positive Parenting Program (ongoing).
- Pap Smears Campaign.
- Keeping Safe Program at Roebourne Regional Prison (ongoing).
- Best Start Program at Yaandina Family Centre.
- Ante Natal Education Package.

Publications

In accordance with Treasurer's Instruction 903 (vii) an Annual Report was published by the West Pilbara Health Service during 2000/2001.

Research and Development

The Roebourne District Hospital carried out no major research and development programs during 2001/2002.

Evaluations

The Roebourne District Hospital carried out no major evaluations during 2001/2002.

Risk Management

Our Policy
The Roebourne District Hospital 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
In accordance with the Treasurer's Instruction, West Pilbara Health Service is planning to define a systematic process of policies, procedures and practices to identify, analyse, assess, treat and monitor those risks which are inherent to the operations of the West Pilbara Health Service.

Future Direction
The Roebourne District Hospital will continue to review its risk management and quality improvement processes in keeping with the above policy.

Internal Audit Controls

The Roebourne District Hospital 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.

A recent review of the checking process indicated that some further development would be required.

Waste Paper Recycling

No facilities or storage capacity are available for recycling.

Pricing Policy

The Roebourne District Hospital 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.

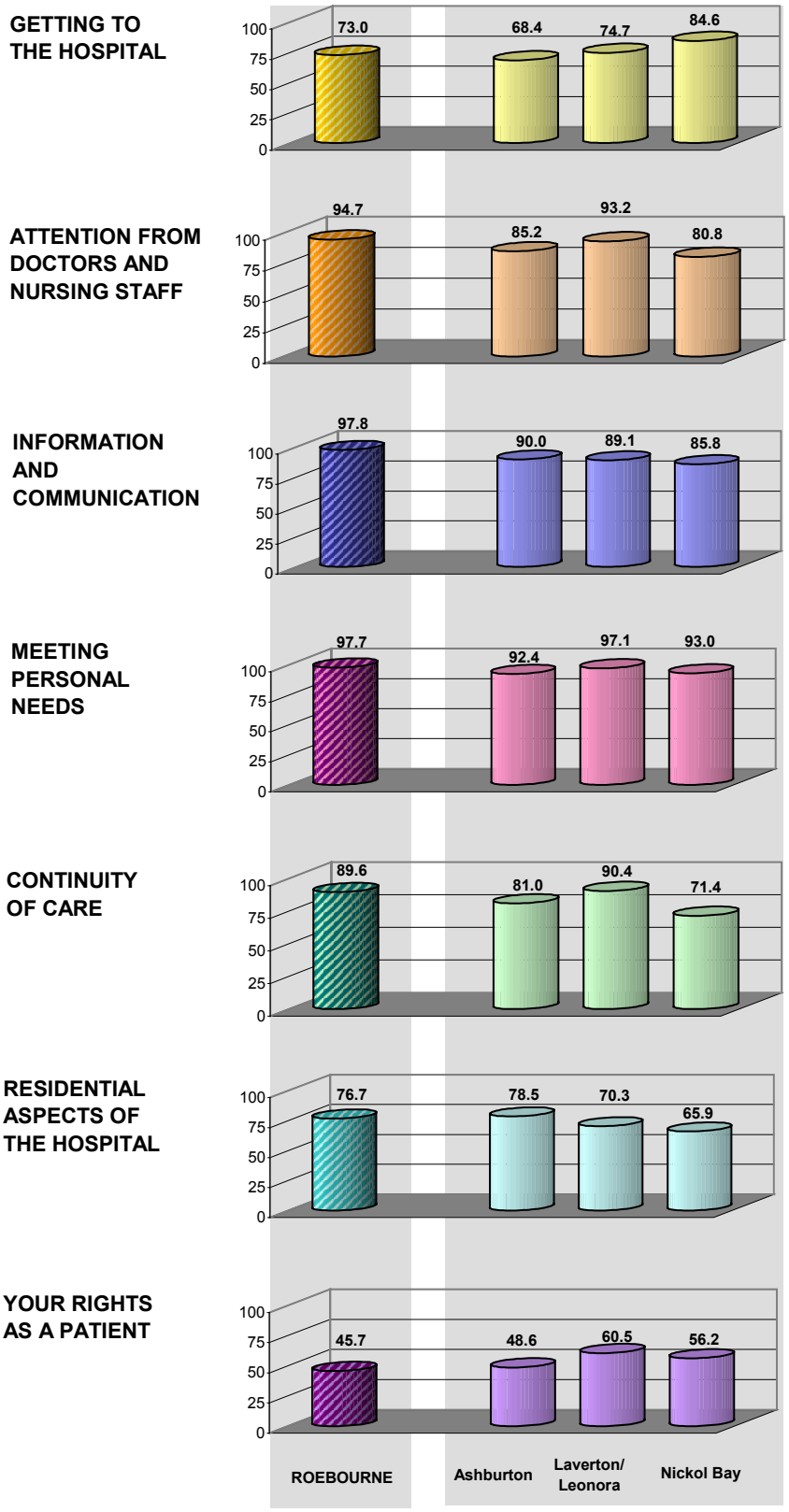
No fees are raised against registered public and private outpatients of the hospital.

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 43) of this report.

KPI 2.2: EMERGENCY PATIENTS — RURAL



AUDITOR GENERAL

To the Parliament of Western Australia

ROEBOURNE DISTRICT HOSPITAL
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the key effectiveness and efficiency performance indicators of the Roebourne District Hospital for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

The Director General, Department of Health 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 Roebourne District Hospital.

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 Hospital'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 Roebourne District Hospital are relevant and appropriate for assisting users to assess the Hospital'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

ROEBOURNE DISTRICT HOSPITAL

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 Roebourne District Hospital for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Roebourne District Hospital 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.

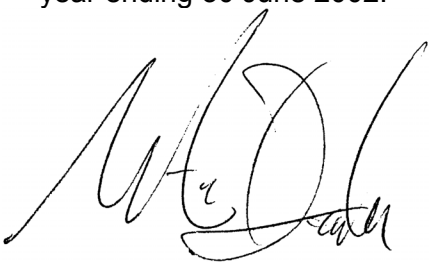
It is anticipated that the opinions will be issued by March 31, 2003.

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

ROEBOURNE DISTRICT HOSPITAL BOARD
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 Roebourne District Hospital Board 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

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Background

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

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

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

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

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

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

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

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

Output 1: *Prevention and Promotion*

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

Output 2: *Diagnosis and Treatment*

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

Output 3: *Continuing Care*

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

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

General Approach

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

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

- reduction of the incidence of preventable disease, injury, disability and premature death and
- the improvement of the quality of life of people with chronic illness and disability,

the graphs used indicate performance for those who live in each catchment area irrespective of where service is provided and whether service is delivered in private or public hospitals.

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

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

Comparative Results

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

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

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

Output Measures

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

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

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

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

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

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

Assessing the Performance of the Health Service

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

Glossary of Terms

Performance Indicator *– information about output performance or outcome achievement, usually expressed as a unit, index or ratio.*
Efficiency Indicator *– a performance indicator that relates an output to the level of resource input required to produce it.*
Effectiveness Indicator *– a performance indicator which provides information on the extent to which a government desired outcome has been achieved through the funding and production of an agreed output.*

MEDIAN WAITING TIMES FOR COMMUNITY AND ALLIED HEALTH SERVICES (HOSPITAL AND COMMUNITY BASED)	KPI 1.1

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

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

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

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

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

Roebourne District Hospital has a one week waiting period for physiotherapy.

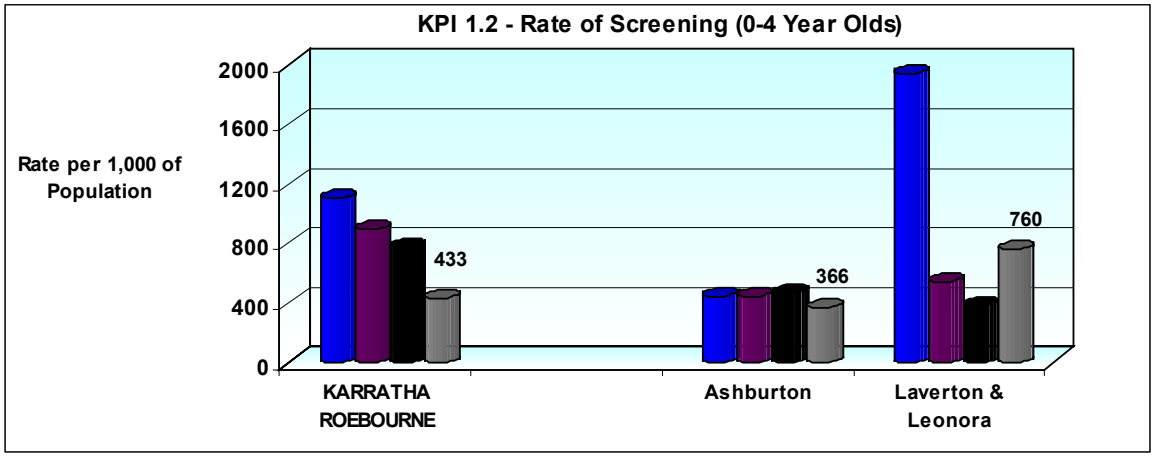
RATE OF SCREENING IN CHILDREN	KPI 1.2

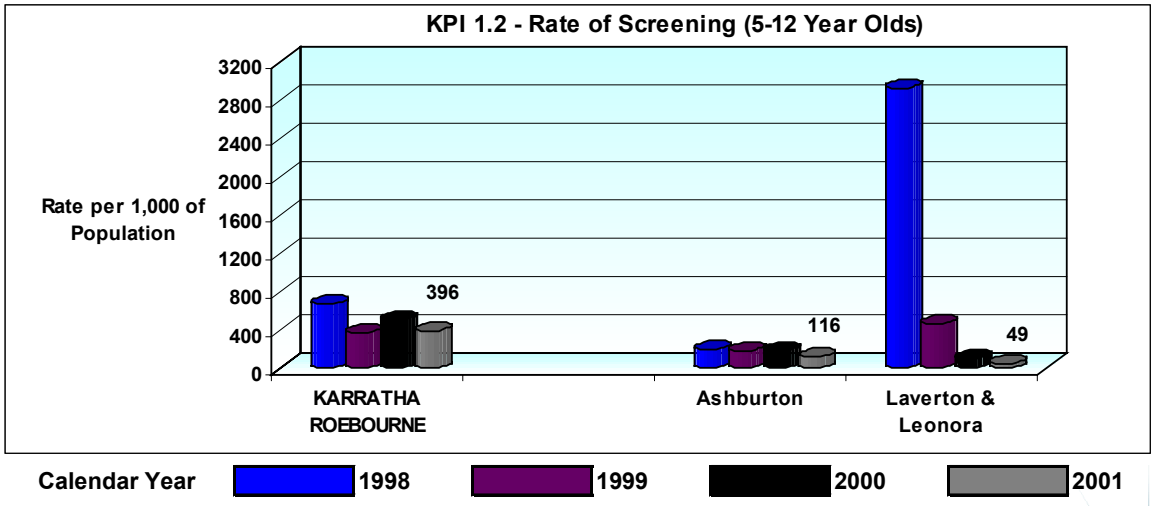
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good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

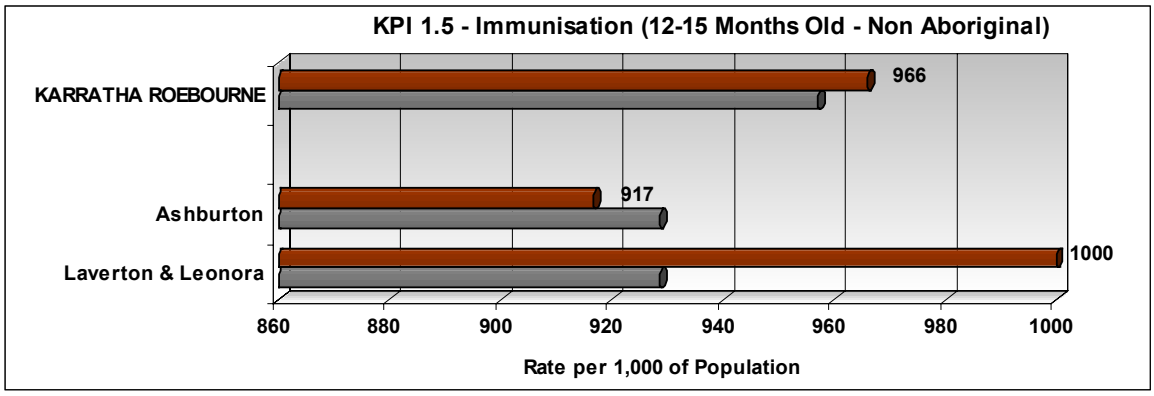
Vaccine preventable diseases are associated with considerable morbidity and mortality, and vaccination is effective in reducing the incidence of these diseases in the community. Through this adoption of the National Immunisation Schedule, health system effectiveness in providing vaccination coverage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

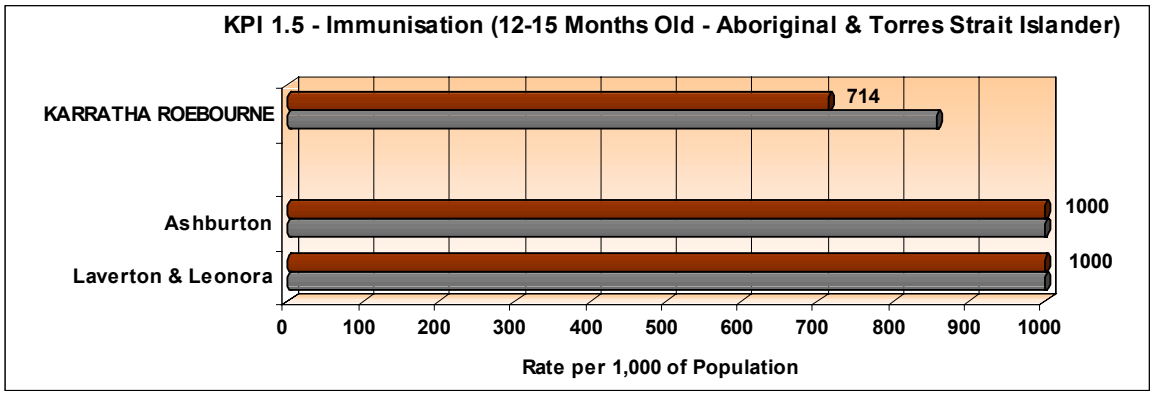
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

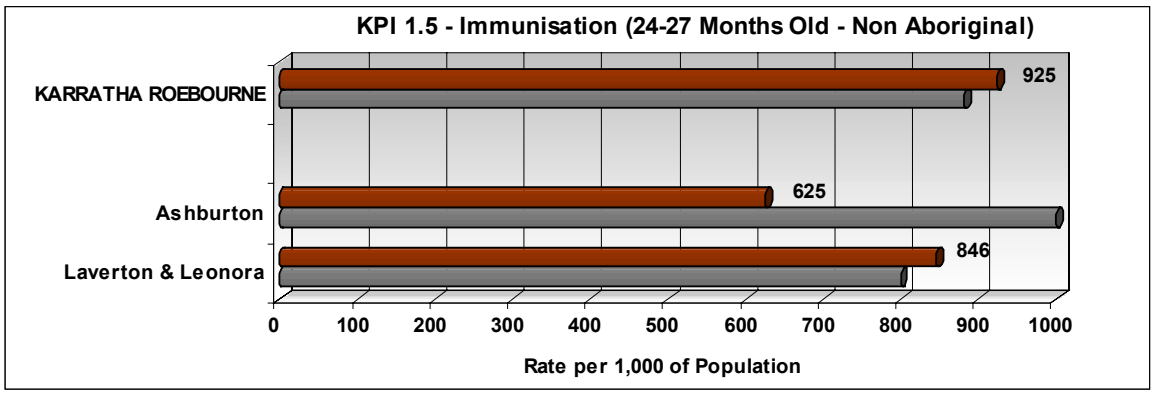
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

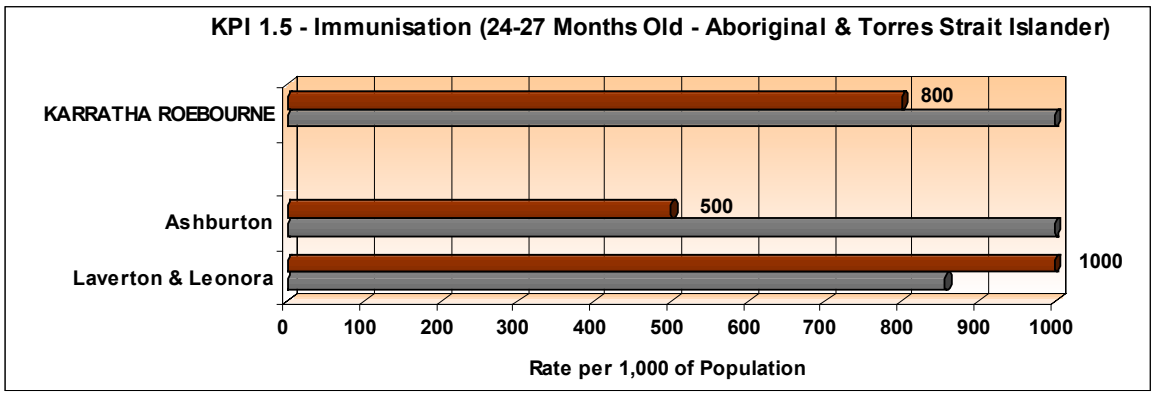
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

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)
KARRATHA ROEBOURNE
Ashburton
Laverton & Leonora
966
917
1000
860
880
900
920
940
960
980
1000
Rate per 1,000 of Population


KPI 1.5 - Immunisation (12-15 Months Old - Aboriginal & Torres Strait Islander)
KARRATHA ROEBOURNE
Ashburton
Laverton & Leonora
714
1000
1000
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)
KARRATHA ROEBOURNE
Ashburton
Laverton & Leonora
925
625
846
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)
KARRATHA ROEBOURNE
Ashburton
Laverton & Leonora
800
500
1000
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000 of Population


Calendar Year
2001
2002

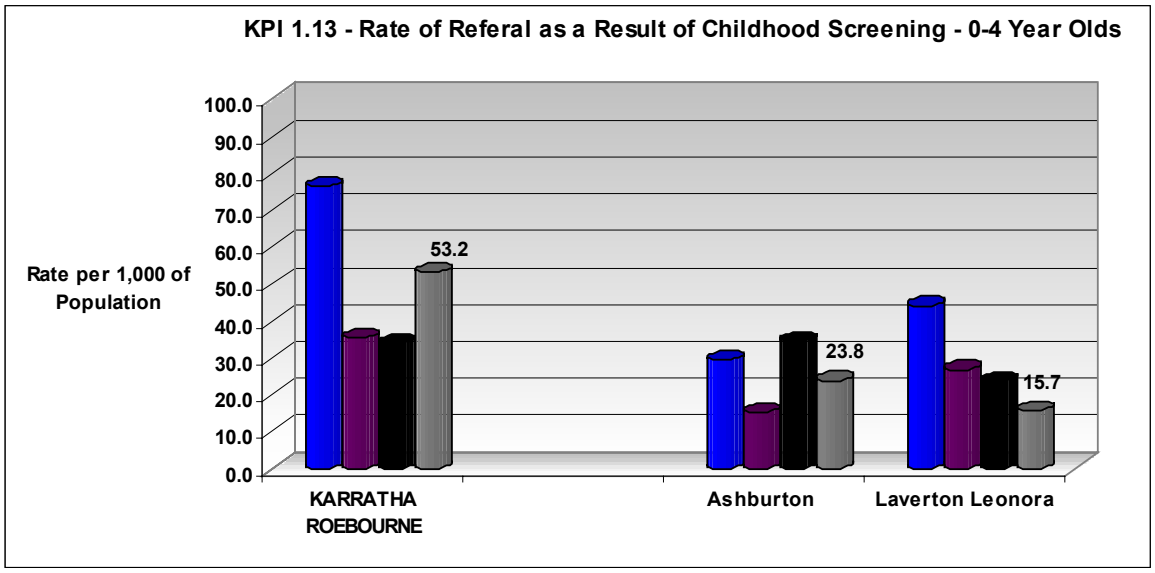
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

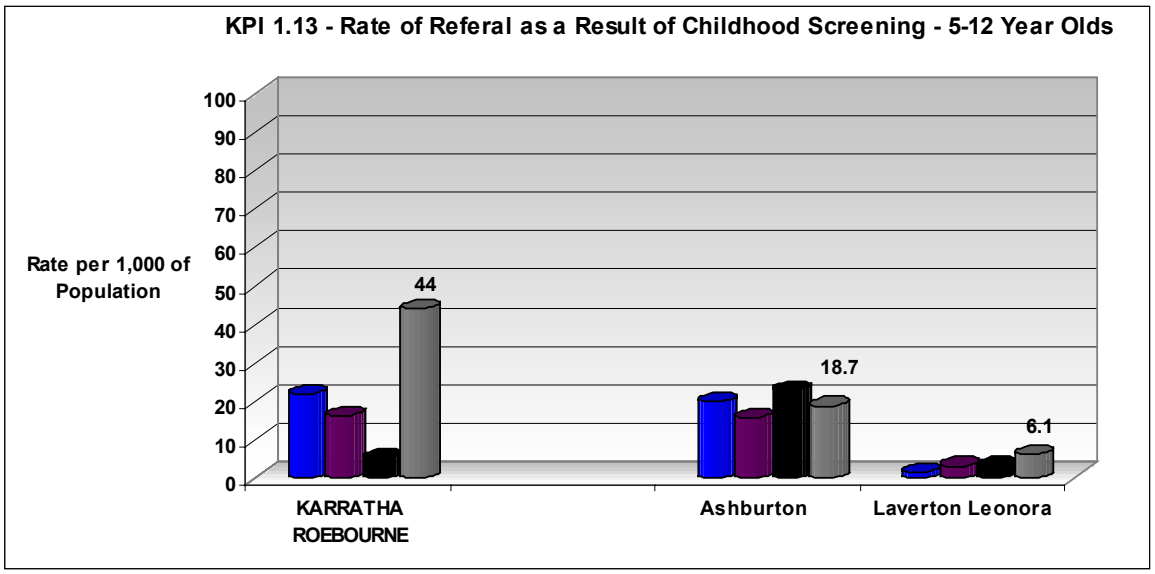
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill but also to maintain a state of 'wellness' that allows them to develop to full potential.

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.

Child and community health services are provided through West Pilbara Community Health.





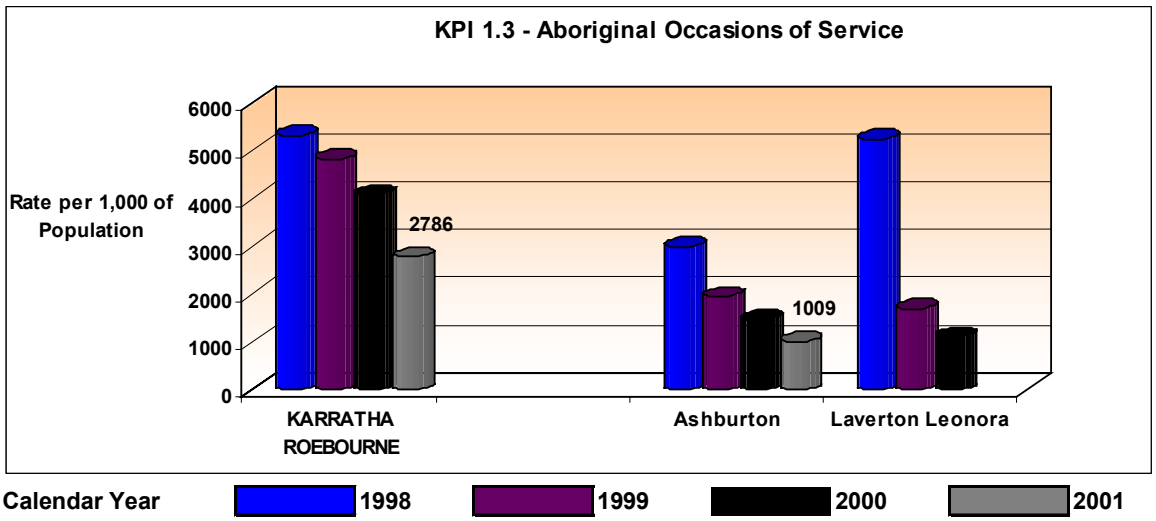
RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

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.

Community health services are provided through West Pilbara Community Health.



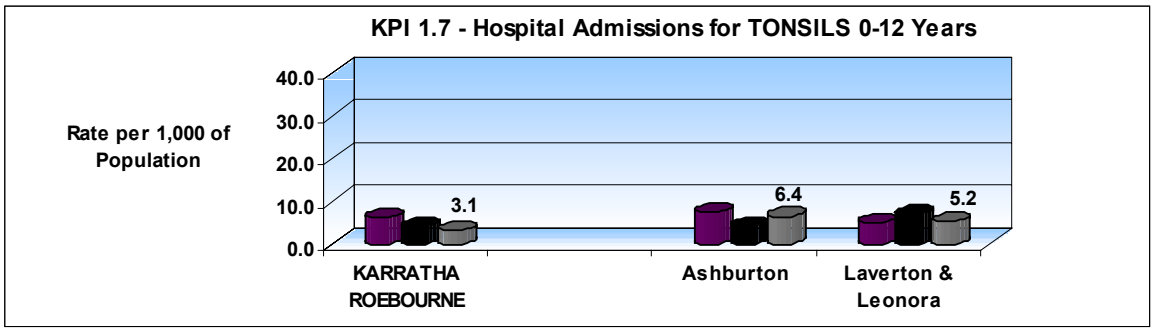
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS | KPI 1.7

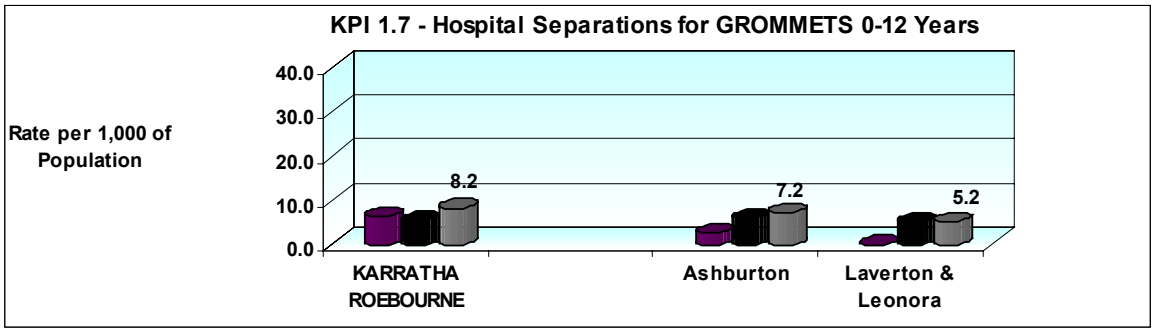
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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

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

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





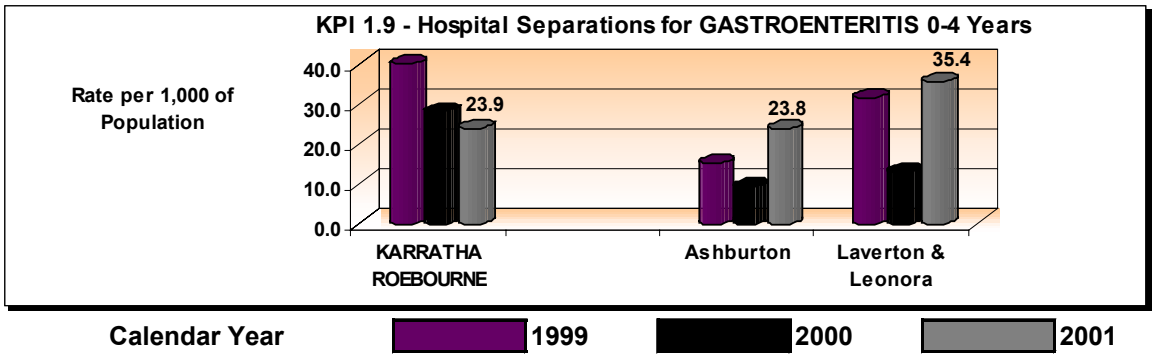
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN | KPI 1.9

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

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

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

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



HOSPITAL SEPARATIONS FOR RESPIRATORY CONDITIONS | KPI 1.10

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

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

Bronchiolitis

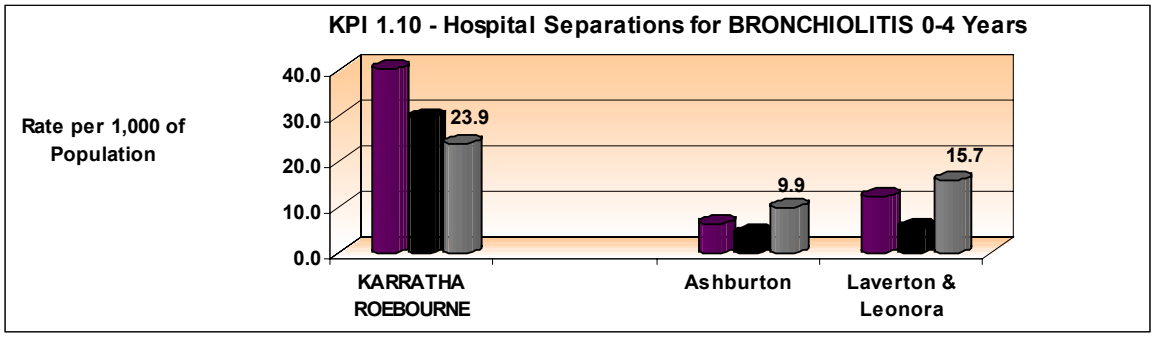
The graph shows individuals aged 0-4. Of those individuals aged 5-12 and 13-18, none were hospitalised this year.

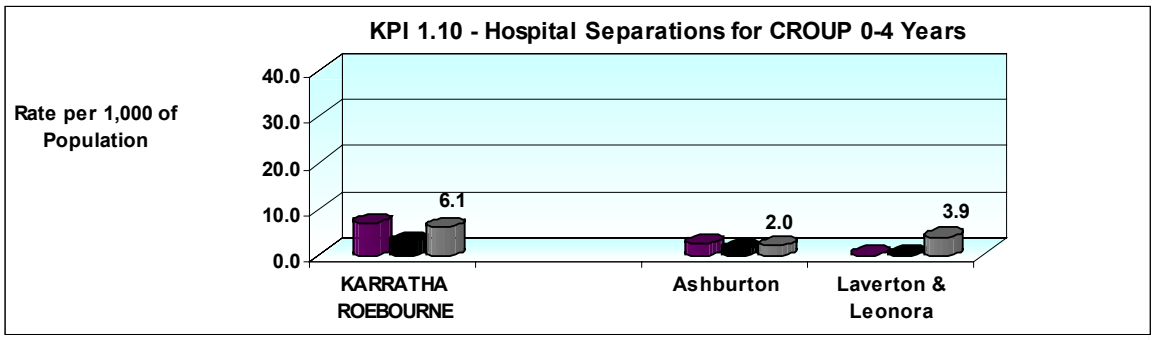
Croup

The graph shows individuals aged 0-4. Of those individuals aged 5-12, only 2 were hospitalised this year, a rate of 0.4 per thousand and of those aged 13-18, none were hospitalised this year.

Acute Bronchitis

5 individuals aged 0-4 at a rate of 3.4 per thousand were hospitalised this year, with 1 individual being admitted aged 5-12 at a rate of 0.4 per thousand and no individuals aged 13-18 years were admitted.





Calendar Year 1999 2000 2001

HOSPITAL ADMISSIONS FOR ASTHMA	KPI 3.7

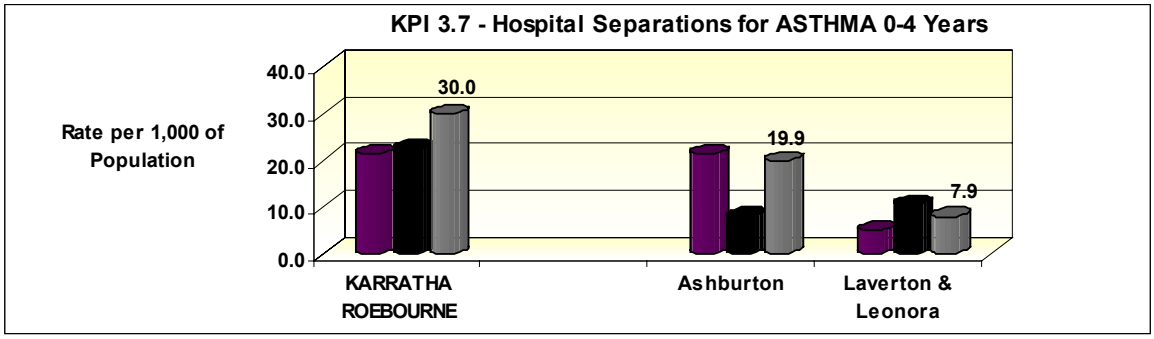
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

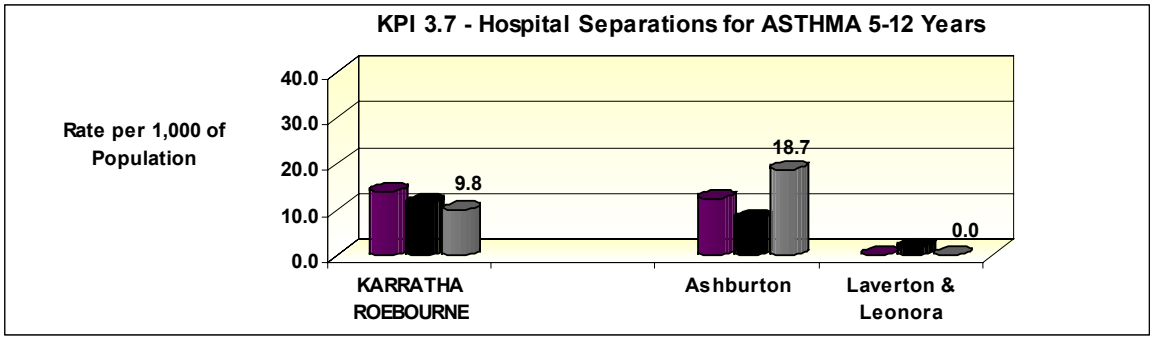
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

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

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

The graphs show individuals aged 0-4 and 5-12. Only 3 individuals aged 13-18 at a rate of 2.1 per thousand were hospitalised this year, with 15 individuals being admitted aged 19-34 at a rate of 3.2 per thousand and 33 individuals aged 35 years and over at a rate of 5.2 per thousand.





Calendar Year 1999 2000 2001

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.

Community health services are provided through West Pilbara Community Health.

HEALTH SERVICE	COST PER OCCASION OF COMMUNITY HEALTH SERVICE
West Pilbara	$39.84

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.

Roebourne District Hospital achieved an overall satisfaction score of 82 for emergency patients with a standard error of 2.34 on a 95% confidence interval. The estimated population of individuals surveyed for Emergency Services was 1221.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Emergency Patients	34	20	59%

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.

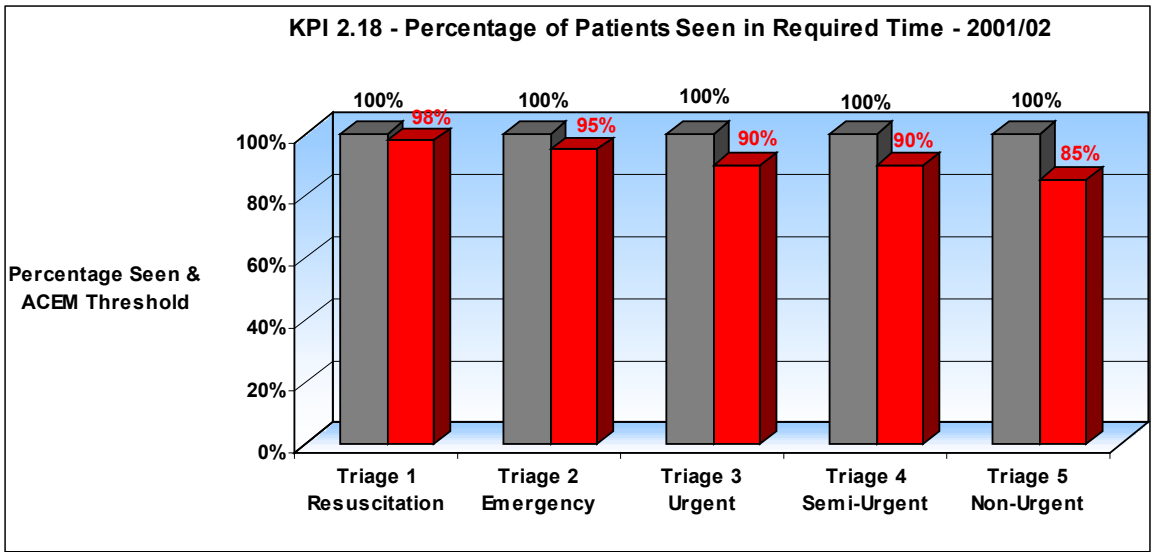
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

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 - 2001/02
Percentage Seen & ACEM Threshold
100%
80%
60%
40%
20%
0%
100%
98%
100%
95%
100%
90%
100%
90%
100%
85%
Triage 1 Resuscitation
Triage 2 Emergency
Triage 3 Urgent
Triage 4 Semi-Urgent
Triage 5 Non-Urgent

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.

There were no unplanned readmissions at Roebourne District Hospital.

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.

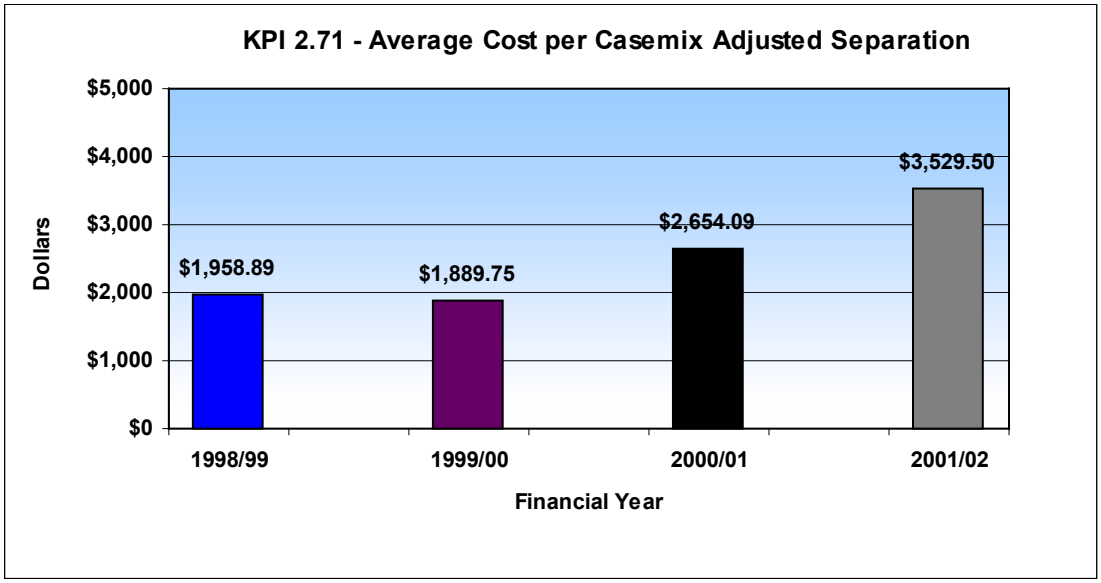
There were no unplanned readmissions at Roebourne District Hospital.

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.

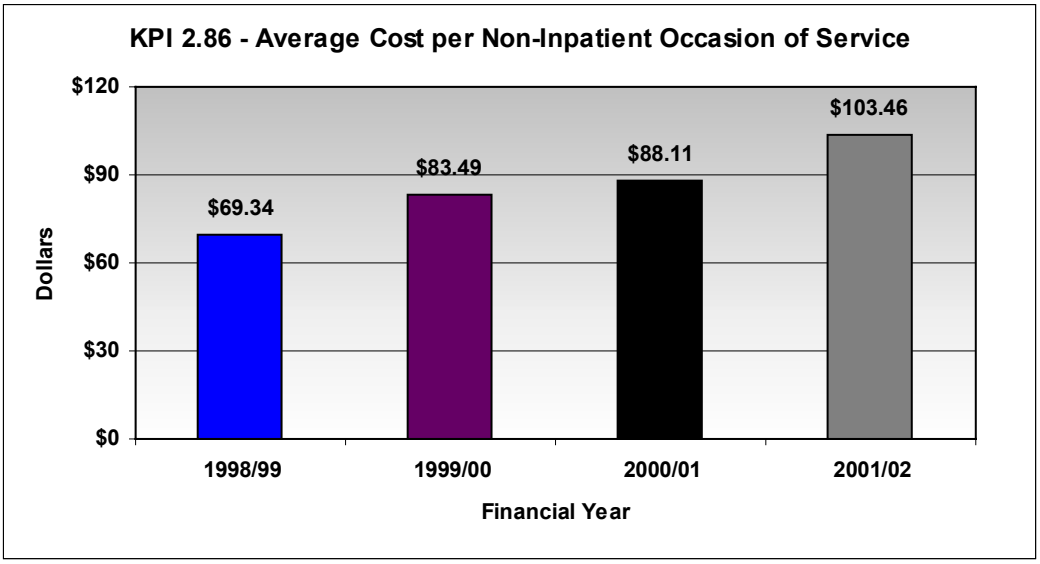


AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

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.



KPI 3.7 : Hospital separations for Asthma

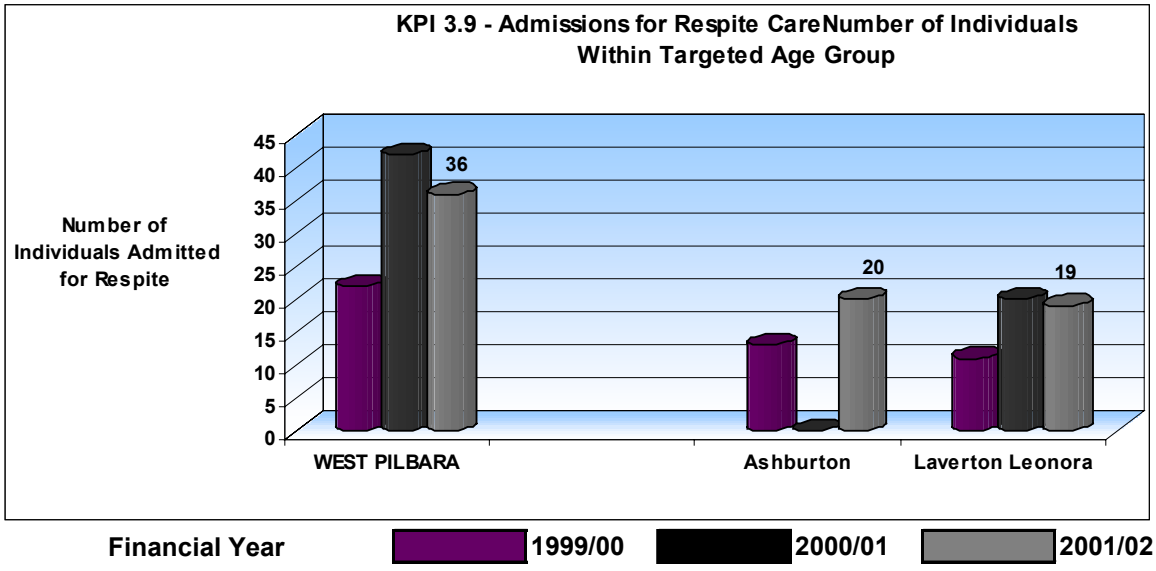
Hospitalisation for acute Asthma is part of managing chronic conditions. The indicator has been moved to Output 1 from Output 3 in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

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

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

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

The number of individuals admitted for respite is reported as part of the overall data for the West Pilbara Health Service.



AUDITOR GENERAL

To the Parliament of Western Australia

ROEBOURNE DISTRICT HOSPITAL
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Scope
I have audited the accounts and financial statements of the Roebourne District Hospital for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

The Director General, Department of Health 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 Director General.

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 Hospital 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 Hospital'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

Roebourne District Hospital
Financial Statements for the year ended June 30, 2002

Audit Opinion
In my opinion,

(i) the controls exercised by the Roebourne District Hospital 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 Hospital at June 30, 2002 and its financial performance and its cash flows for the year then ended.

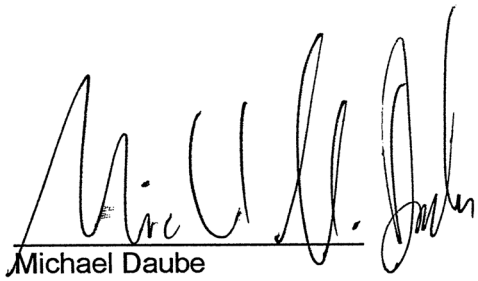
D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

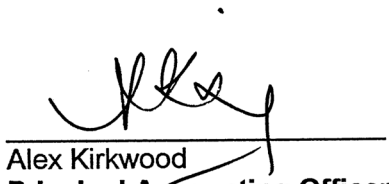
The accompanying financial statements of the Roebourne District Hospital have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002 and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

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Roebourne District Hospital

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		1,079,291	1,143,165
Fees for visiting medical practitioners		53,532	82,747
Superannuation expense		77,839	71,399
Patient support costs	3	159,926	186,031
Patient transport costs		117,995	103,664
Repairs, maintenance and consumable equipment expense		33,402	58,591
Depreciation expense	4	69,926	73,585
Net loss on disposal of non-current assets	5	404	8,879
Capital user charge	6	148,542	0
Other expenses from ordinary activities	7	107,314	146,532
Total cost of services		1,848,171	1,874,593
Revenues from Ordinary Activities			
Patient charges	8	2,224	270
Donations revenue	9	0	100
Other revenues from ordinary activities	10	23,167	42,685
Total revenues from ordinary activities		25,391	43,055
NET COST OF SERVICES		**1,822,780**	**1,831,538**
Revenues from Government			
Output appropriations	11	1,929,790	1,567,400
Capital appropriations	11	0	28,986
Assets assumed / (transferred)	12	(28,976)	0
Liabilities assumed by the Treasurer	13	0	71,399
Resources received free of charge	14	10,000	5,500
Total revenues from government		1,910,814	1,673,285
Change in net assets		**88,034**	**(158,253)**
Net decrease in asset revaluation reserve	22	0	(87,325)
Total revenues, expenses and valuation adjustments recognised directly in equity		0	(87,325)
Total changes in equity other than those resulting from transactions with WA State Government as owners		**88,034**	**(245,578)**

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	(2,733)	(8,156)
Receivables	16	3,187	6,263
Inventories	18	25,972	9,500
Total current assets		26,426	7,607
NON-CURRENT ASSETS			
Amounts receivable for outputs	17	124,400	0
Property, plant and equipment	19	1,978,962	2,081,392
Total non-current assets		2,103,362	2,081,392
Total assets		**2,129,788**	**2,088,999**
CURRENT LIABILITIES			
Payables		49,278	110,968
Accrued salaries	20	41,560	53,863
Provisions	21	163,016	135,895
Total current liabilities		253,854	300,726
NON-CURRENT LIABILITIES			
Provisions	21	24,693	25,066
Total non-current liabilities		24,693	25,066
Total liabilities		**278,547**	**325,792**
Net Assets		**1,851,241**	**1,763,207**
EQUITY			
Asset revaluation reserve	22	117,749	117,749
Accumulated surplus	23	1,733,492	1,645,458
Total Equity		**1,851,241**	**1,763,207**

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	24(c)	1,656,848	1,567,400
Capital contributions (2000/01 appropriation)	24(c)	0	27,100
Net cash provided by Government		1,656,848	1,594,500
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(584,116)	(571,459)
Employee costs		(1,092,094)	(1,091,337)
GST payments on purchases		(27,428)	(25,251)
Receipts			
Receipts from customers		2,175	1,428
Donations		0	100
Interest received		0	2
GST receipts on sales		556	871
GST receipts from taxation authority		26,093	23,657
Other receipts		23,389	45,415
Net cash used in operating activities	24(b)	(1,651,425)	(1,616,574)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	19	0	(2,800)
Net cash used in investing activities		0	(2,800)
Net increase / (decrease) in cash held		5,423	(24,874)
Cash assets at the beginning of the reporting period		(8,156)	16,718
Cash assets at the end of the reporting period	24(a)	(2,733)	(8,156)

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 Hospital gains control of the appropriated funds. The Hospital gains control of appropriated funds at the time those funds are deposited into the Hospital'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

Land and buildings are reported at 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 Hospital 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 Hospital 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 Hospital 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 Hospital considers the carrying amount approximates net fair value.

(m) Provisions

Employee Entitlements

i) Annual and Long Service Leave

The liability for annual leave represents the amount which the Hospital 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 Hospital 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 Hospital. Accordingly, deriving the information for the Hospital is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

(n) Revenue Recognition

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

(o) Grants and Other Contributions Revenue

Grants, donations, gifts and other non-reciprocal contributions are recognised as revenue when the Hospital 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.

(p) 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.

(q) Comparative Figures

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

Note 2 Administered trust accounts	**2001/02 $**	**2000/01 $**

Funds held in these trust accounts are not controlled by the Hospital and are therefore not recognised in the financial statements.

a) The Hospital 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	120	0
Add Receipts		
- Patient Deposits	30	120
	150	120
Less Payments		
- Patient Withdrawals	115	0
- Interest / Charges	4	0
Closing Balance	31	120

		2001/02 $	2000/01 $
Note 3	**Patient support costs**		
	Medical supplies and services	21,524	47,548
	Domestic charges	18,231	15,134
	Fuel, light and power	88,605	88,438
	Food supplies	27,987	30,751
	Purchase of external services	3,579	4,160
		159,926	186,031
Note 4	**Depreciation expense**		
	Buildings	58,876	63,538
	Computer equipment and software	1,160	1,670
	Furniture and fittings	2,790	2,666
	Other plant and equipment	7,100	5,711
		69,926	73,585
Note 5	**Net 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 directly into the Consolidated Fund	32,000	0
	Gross proceeds from sale of non-current assets	32,000	0
b)	**Net loss on disposal of non-current assets:**		
	Land and buildings	7,890	0
	Computer equipment and software	(439)	(2,248)
	Furniture and fittings	(2,856)	(444)
	Other plant and equipment	(4,999)	(6,187)
		(404)	(8,879)
Note 6	**Capital user charge**		
		148,542	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 Hospital 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 Hospital.

Note 7	**Other expenses from ordinary activities**		
	Other employee expenses	5,123	19,284
	Motor vehicle expenses	8,514	10,147
	Insurance	14,841	26,019
	Communications	13,458	16,722
	Printing and stationery	1,154	7,187
	Rental of property	27,301	54,178
	Audit fees - external	10,000	5,500
	Bad and doubtful debts expense	(450)	42
	Other	27,373	7,453
		107,314	146,532
Note 8	**Patient charges**		
	Inpatient charges	2,040	0
	Outpatient charges	184	270
		2,224	270
Note 9	**Donations revenue**		
	General public contributions	0	100
Note 10	**Other revenues from ordinary activities**		
	Rent from properties	2,862	13,260
	Recoveries	20,155	29,356
	Other	150	69
		23,167	42,685

Note 11 Government appropriations	2001/02 $	2000/01 $
Output appropriations (I)	1,929,790	1,567,400
Capital appropriations (II)	0	28,986
	1,929,790	1,596,386

(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	(28,976)	0
Total assets assumed/(transferred)	(28,976)	0

Note 13 Liabilities assumed by the Treasurer

	0	71,399

The change in funding arrangement for the Gold State Superannuation Scheme and the West State Superannuation Scheme has resulted in "Liabilities assumed by the Treasurer".

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	10,000	5,500

Where assets or services have been received free of charge or for nominal consideration, the Hospital 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	1,050	1,050
Cash at bank - general	(4,231)	(9,654)
Cash at bank - donations	448	448
	(2,733)	(8,156)

Note 16 Receivables

GST receivable	3,156	3,665
Other receivables	781	3,798
	3,937	7,463
Less: Provision for doubtful debts	(750)	(1,200)
	3,187	6,263

Note 17 Amounts receivable for outputs

Non-current	124,400	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	2001/02 $	2000/01 $
Supply stores - at cost	17,611	6,500
Pharmaceutical stores - at cost	8,361	3,000
	25,972	9,500

Note 19 Property, plant and equipment

Land		
At fair value	27,400	32,400
	27,400	32,400
Buildings		
Clinical:		
At fair value (i)	5,440,000	5,440,000
Accumulated depreciation	(3,566,692)	(3,508,752)
	1,873,308	1,931,248
Non-Clinical:		
At fair value (i)	14,900	40,000
Accumulated depreciation	(449)	(5,403)
	14,451	34,597
Computer equipment and software		
At cost	6,970	8,686
Accumulated depreciation	(4,660)	(4,777)
	2,310	3,909
Furniture and fittings		
At cost	38,355	48,625
Accumulated depreciation	(15,129)	(19,753)
	23,226	28,872
Other plant and equipment		
At cost	77,267	101,550
Accumulated depreciation	(39,000)	(51,184)
	38,267	50,366
Total of property, plant and equipment	1,978,962	2,081,392

Land and buildings

(i) Land, clinical buildings and non-clinical buildings have been subject to a recent revaluation and are carried at their 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 Hospital from output appropriations	0	2,800
Paid by the Department of Health	0	26,168
Gross payments for purchases of non-current assets	0	28,968

Note 19 Property, plant and equipment - continued

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	32,400
Disposals	(5,000)
Carrying amount at end of year	27,400
Buildings	
Carrying amount at start of year	1,965,845
Disposals	(19,210)
Depreciation	(58,876)
Carrying amount at end of year	1,887,759
Computer equipment and software	
Carrying amount at start of year	3,909
Disposals	(439)
Depreciation	(1,160)
Carrying amount at end of year	2,310
Furniture and fittings	
Carrying amount at start of year	28,872
Disposals	(2,856)
Depreciation	(2,790)
Carrying amount at end of year	23,226
Other plant and equipment	
Carrying amount at start of year	50,366
Disposals	(4,999)
Depreciation	(7,100)
Carrying amount at end of year	38,267

Note 20 Accrued salaries	2001/02 $	2000/01 $
Amounts owing for: All staff 10 working days from 17 June to 30 June 2002 (2001:10 working days from 18 June to 30 June 2001)	41,560	53,863

Note 21 Provisions

Current liabilities:		
Annual leave	141,940	112,266
Long service leave	21,076	23,629
	163,016	135,895
Non-current liabilities:		
Long service leave	24,693	25,066
	24,693	25,066
Total employee entitlements	187,709	160,961

The Hospital considers the carrying amount of employee entitlements approximates the net fair value.

Note 22 Asset revaluation reserve	2001/02 $	2000/01 $
Balance at beginning of the year	117,749	205,074
Net revaluation increments / (decrements) :		
Land	0	1,400
Buildings	0	(88,725)
Balance at end of the year	117,749	117,749

(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 23 Accumulated surplus		
Balance at beginning of the year	1,645,458	1,803,711
Change in net assets	88,034	(158,253)
Balance at end of the year	1,733,492	1,645,458

Note 24 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)	(2,733)	(8,156)

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)	(1,651,425)	(1,616,574)
Increase / (decrease) in assets:		
GST receivable	(509)	3,663
Other receivables	(31,993)	(6,612)
Inventories	16,472	273
Decrease / (increase) in liabilities:		
Doubtful debts provision	450	0
Payables	61,690	(34,190)
Accrued salaries	12,303	(29,075)
Provisions	(26,748)	(13,941)
Non-cash items:		
Depreciation expense	(69,926)	(73,585)
Loss from disposal of non-current assets	(404)	(8,879)
Capital user charge paid by Department of Health	(148,542)	0
Superannuation liabilities assumed by the Treasurer	0	(71,399)
Resources received free of charge	(10,000)	(5,500)
Other	25,852	24,281
Net cost of services (Statement of Financial Performance)	(1,822,780)	(1,831,538)

Note 24 Notes to the statement of cash flows - continued	2001/02 $	2000/01 $
c) **Notional cash flows**		
Output appropriations as per Statement of Financial Performance	1,929,790	1,567,400
Capital appropriations as per Statement of Financial Performance	0	28,986
	1,929,790	1,596,386
Less non-cash component of output appropriations (Refer to Note 17)	(124,400)	0
	1,805,390	1,596,386
Less notional cash flows:		
Items paid directly by the Department of Health for the Hospital and are therefore not included in the Statement of Cash Flows:		
Capital user charge	(148,542)	0
Capital subsidy	0	27,100
Other non cash adjustments to output appropriations	0	(28,986)
	(148,542)	(1,886)
Output appropriations as per Statement of Cash Flows	1,656,848	1,594,500

Note 25 Remuneration of 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
$30,001 - $40,000	0	1
Total	1	1
	$	$
The total remuneration of senior officers is:	28,368	37,029

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

Note 26 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 $
Employee expenses Staff working between Wickham & Roebourne Hospitals. Salary costed to Wickham Hospital	1,079,291	1,143,165	(63,874)
Repairs, maintenance and consumable equipment expense Upgrade of staff accommodation completed in 2000/01	33,402	58,591	(25,189)
Net loss on disposal of non-current assets Disposal of assets in previous financial year	404	8,879	(8,475)
Capital user charge Refer to Note 6.	148,542	0	148,542

Note 26 Explanatory statement - continued

b) **Significant variations between estimates and actual results for the financial year.**
Section 42 of the Financial Administration and Audit Act requires the Hospital to prepare annual budget estimates. Details and reasons for significant variations between these estimates and actual results are detailed below. Significant variations are considered to be those greater than 10% of budget .

	2001/02 Actual $	2001/02 Estimate $	Variation $
Employee expenses Staff working between Wickham & Roebourne Hospitals. Salary costed to Wickham Hospital.	1,079,291	1,180,000	(100,709)
Visiting medical practitioners Decrease in fee for service payments. Coverage provided by the Aboriginal Medical Service.	53,532	95,000	(41,468)
Other expenses from ordinary activities Estimates prepared on the basis of prior year costs. Reduction in communication costs, staff travel costs and housing rentals.	107,314	152,000	(44,686)

Note 27 Commitments for Expenditure

	2001/02 $	2000/01 $
a) **Operating lease commitments:** Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	6,210	7,826
Later than one year, and not later than five years	3,664	3,363
	9,874	11,189

These commitments are all inclusive of GST.

Note 28 Contingent liabilities

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

Note 29 Events occurring after reporting date

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

Note 30 Related bodies

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

The Hospital had no related bodies during the reporting period.

Note 31 Affiliated bodies

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

The Hospital had no affiliated bodies during the reporting period.

Note 32 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	0.0%	(4)	0	0	0	1	(3)
Receivables		0	0	0	0	3	3
		(4)	0	0	0	4	0
Financial Liabilities							
Payables		0	0	0	0	49	49
Net financial liabilities		(4)	0	0	0	(45)	(49)
As at 30th June 2001							
Financial Assets							
Cash assets	0.0%	(9)	0	0	0	1	(8)
Receivables		0	0	0	0	6	6
		(9)	0	0	0	7	(2)
Financial Liabilities							
Payables		0	0	0	0	111	111
Net financial liabilities		(9)	0	0	0	(104)	(113)

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 33 Output information

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses from Ordinary Activities								
Employee expenses	0	0	1,079	1,143	0	0	1,079	1,143
Fees for visiting medical practitioners	0	0	54	83	0	0	54	83
Superannuation expense	0	0	78	71	0	0	78	71
Patient support costs	0	0	160	186	0	0	160	186
Patient transport costs	0	0	118	104	0	0	118	104
Repairs, maintenance and consumable equipment expense	0	0	33	59	0	0	33	59
Depreciation expense	0	0	70	74	0	0	70	74
Net loss on disposal of non-current assets	0	0	0	9	0	0	0	9
Capital user charge	0	0	149	0	0	0	149	0
Other expenses from ordinary activities	0	0	108	147	0	0	108	147
Total cost of services	0	0	1,848	1,875	0	0	1,848	1,875
Revenues from Ordinary Activities								
Patient charges	0	0	2	0	0	0	2	0
Other revenues from ordinary activities	0	0	23	43	0	0	23	43
Total revenues from ordinary activities	0	0	25	43	0	0	25	43
NET COST OF SERVICES	**0**	**0**	**1,823**	**1,832**	**0**	**0**	**1,823**	**1,832**
Revenues from Government								
Output appropriations	0	0	1,930	1,567	0	0	1,930	1,567
Capital appropriations	0	0	0	29	0	0	0	29
Assets assumed / (transferred)	0	0	(29)	0	0	0	(29)	0
Liabilities assumed by the Treasurer	0	0	0	71	0	0	0	71
Resources received free of charge	0	0	10	6	0	0	10	6
Total revenues from government	0	0	1,911	1,673	0	0	1,911	1,673
Change in net assets	**0**	**0**	**88**	**(158)**	**0**	**0**	**88**	**(158)**

Note 33 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).