North Midlands Health Service

Annual Report 2001/2002

Department of Health
Government of Western Australia

Statement of Compliance

To the Hon Bob Kucera MLA

MINISTER FOR HEALTH

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

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

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

ANNUAL REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mike Daube
DIRECTOR GENERAL

Contents

Contents

Address and Location

North Midlands Health Service
North Midlands District Hospital
Thomas St
THREE SPRINGS WA 6519

PO Box 138
THREE SPRINGS WA 6519

☎ *(08) 9954 1101*
(08) 9954 1054

Mission Statement

Our Mission
To work with the Community to provide services which enable people to achieve their best possible health and wellbeing.

Broad Objectives

The objectives of the North Midlands Health Service are:

- To provide an appropriate mix of services within the North Midlands district to meet the needs of the Community.
- To improve quality of care for health and aged care clients within the North Midlands district.
- To provide an appropriate level and mix of district service delivery in a cost effective and coordinated manner.
- To provide a service delivery model to encompass preventative, curative, rehabilitative and palliative health needs of rural people.
- To provide health promotion and early detection through screening and education programs to address lifestyle factors that significantly contribute to poor health.
- To provide service delivery in a Primary Health Care Model.

Enabling Legislation

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

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

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

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

Ministerial Directives

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

Submission of Annual Report

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

Statement of Compliance with Public Sector Standards

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

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

Such processes include:

- Each health service 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 None
- Number of material breaches found None
- Applications under review None

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

Shane Matthews
ACTING REGIONAL DIRECTOR
MIDWEST AND MURCHISON REGION
6 December 2002

Advertising and Sponsorship — Electoral Act 1907

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

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies			
— Minginew	–	0	0
— Carnamah Matt	–	34	0
— Midwest Times	–	360	124
— Geraldton Newspaper Ltd	–	585	0
— Dongara	–	30	0
— Coorow	–	20	0
Market Research Organisations	–	0	0
Polling Organisations	–	0	0
Direct Mail Organisations	–	0	0
Media Advertising Organisations	–	0	0
TOTAL	**–**	**$1029**	**$124**

Freedom of Information Act 1992

The North Midlands Health Service received and dealt with no formal applications under the Freedom of Information guidelines during 2001/2002.

Formal applications are defined as requests which:

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

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

The types of documents held by the North Midlands Health Service include:

- Patient medical records.
- Staff employment records.
- Department of Health reports, plans and guidelines.
- Other health-related agency reports.
- Agreements with the Department of Health.
- Epidemiology and morbidity reports.
- 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 Service Manager/ Director of Nursing
North Midlands Health Service
Thomas St
PO Box 138
THREE SPRINGS WA 6519

☎ *(08) 9954 1101*

North Midlands Health Service

Key Operations and Achievements

- North Midlands Health Service continued to provide a wide variety of services including acute care and accident and en=mergency services.
- An activities coordinator was appointed for Aged Care Services.
- A community seminar was held on arthritis education.
- The Health Service has appointed an asthma educator.
- Health Service activities were publicised locally.
- A district-wide needs analysis was conducted.

Multi Purpose Service

North Midlands Health Service provides acute medical care, accident and emergency, paediatric care, antenatal and postnatal cares, emergency obstetric care, permanent and respite care, physiotherapy, podiatry and medical imaging. A visiting Primary Health Care service is provided by the Midwest Primary Health Care team. This includes occupational therapy, speech pathology and social work. A Westlink service operates from within the hospital but it is under utilised. All members of the community are encouraged to utilise this facility. Telehealth operates from the health service and is utilised for meetings, education sessions and allied health assessments. The opening of the Telehealth via videoconference was attended by invited guests and staff.

Activities Coordinator

The Health Service continues to increase its aged care services by the appointment of an activities coordinator.

Community Seminar

Health Promotion activities remain a high priority. A very successful community seminar was held on arthritis education. Approximately 40 people attended. A dementia seminar was held and again was well attended by approximately 30 people.

Asthma Educator

The Health Service has appointed an asthma educator. The hours of the therapy assistant are to increase to 10 hours per week.

Health Service Activities Publicised

News of activities and pending events is placed in the local newspapers. Displays of current health issues are placed in local shop fronts in the main streets of Three Springs, Carnamah and Coorow. A resource library is established for use by all community members. Items such as health videos, health publications and books may be used as a reference or borrowed. Meetings with Shire and community parties arise on an ad hoc requested basis.

Needs Analysis

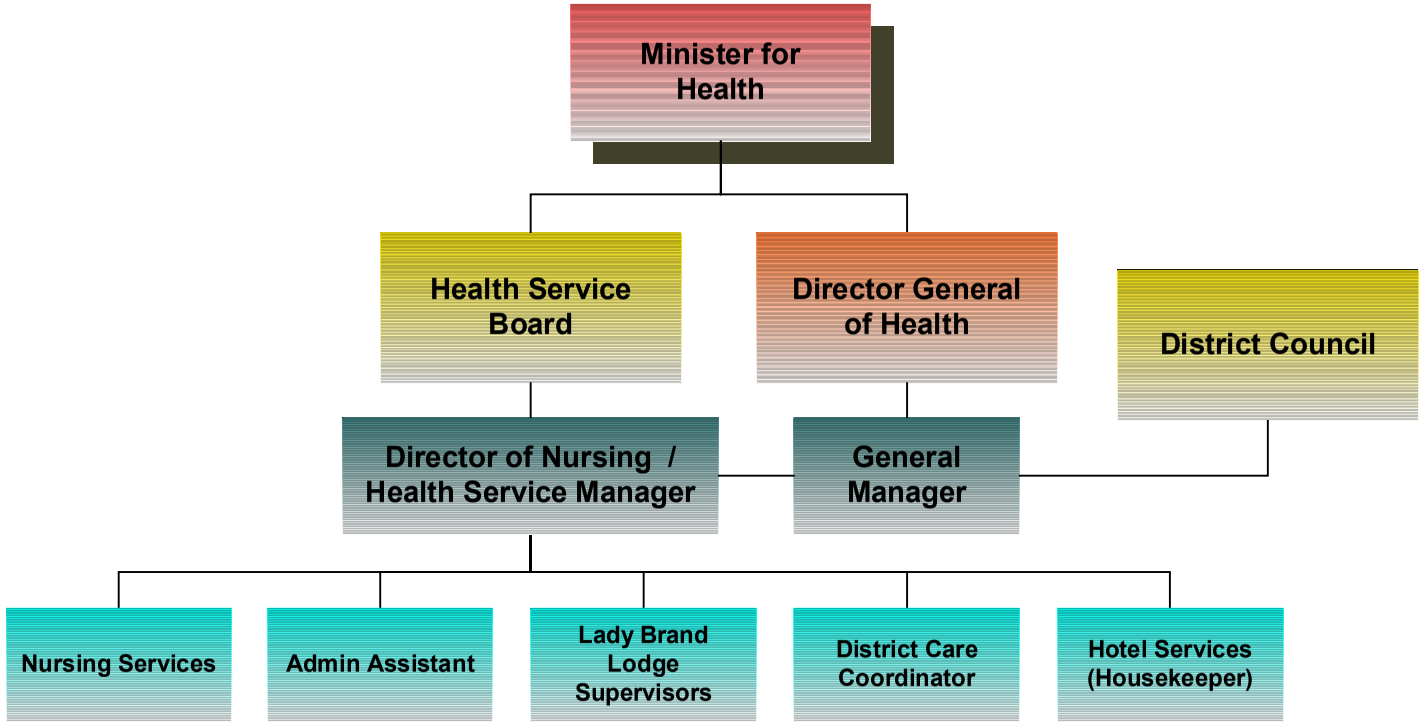
A district-wide needs analysis was conducted and a focus group held giving community members an opportunity for input.

Major Capital Projects

The North Midlands Health Service did not complete or make progress on any major capital projects during 2001/2002.

Management Structure

Organisational Chart



Accountable Authority

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

Name	Position	Term of Office Expires
Inez Davies	Chairperson	30 June 2002
James Lane	Deputy Chairperson	30 June 2002
Rhonda Roberts	Member	30 June 2002
Kathleen Grover	Member	30 June 2002
Joan Newton	Member	30 June 2002
Jacki Catto	Member	30 June 2002
Moira Girando	Member	30 June 2002

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

Senior Officers

The senior officers of the North Midlands Health Service Board and their areas of responsibility are listed below:

Area of Responsibility	Title	Name	Basis of Appointment
Health Service and Corporate Management	General Manager	Jan Hall	Acting
Nursing Services	Director of Nursing/HSM	Muriel Heartfield	Acting

Pecuniary Interests

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

Demography

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

- Three Springs Shire
- Carnamah Shire
- Coorow Shire

The following table shows population figures for each local authority within the North Midlands region:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Three Springs	**838**	**745**	797
Carnamah	**999**	**808**	902
Coorow	**1447**	**1393**	1650

*Data sources:

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

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

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

Available Services

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

Direct Patient Services
Accident and Emergency
Acute Medical
Domiciliary Nursing
Extended Care Services
Obstetrics
Paediatric

Community Services
Asthma Educator
Child Development
Health Promotion
Home Help and Maintenance
Immunisation
Meals on Wheels
Palliative Care
Primary Health Care

Medical Support Services
Dietetics
Drug and Alcohol Counsellor
Medical Imaging
Mental Health
Occupational Therapy
Pathology
Pharmacy
Physiotherapy
Podiatry
Speech Pathology

Other Support Services
Gardening and Maintenance
Hotel Services

Specialist Services
None

Other Services
None

Disability Services

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

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

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

- Upgrading of facilities where such tools as the Access Resource Kit developed by the Disability Services Commission are utilised to ensure compliance with our disability services plan. Strategies currently in place include the development of a specific policy for customers with disabilities and ensuring that all publications and printed information, web sites and audio facilities meet the needs of this client group.

Outcome 2: Access to buildings and facilities is improved.

- Midwest Health Service provides disabled parking bays for clients, with appropriate signage. The corporate office has relocated in this reporting period and the issue of access to its premises will be taken up with the building management. Access audits are planned throughout the Midwest Health Service to ensure that we meet the requirements of the Access Resource Kit developed by the Disability Services Commission.

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

- Midwest Health Service has put in place strategies including adopting the promotion of our services in alternative formats such as large print pamphlets, audio tapes and captioned videos. Our web site is still under development and will include information for customers with disabilities.

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

- Performance management processes will now include provision of advice and resources for staff to enhance their skills in assisting customers with disabilities. Our code of conduct and customer charter are under review to reflect the changing needs of people with disabilities. Information concerning disability services will be made available to all staff through our newsletters on a regular basis so that staff are more aware of the requirements of people with disabilities.

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

- Midwest Health Service is addressing this outcome by including targeted questions in future customer satisfaction surveys to ascertain what types of difficulties people with disabilities are experiencing when accessing services provided. Policies, procedures and systems relating to complaints handling will be adapted to enable capturing and reporting of complaints from people with disabilities. Consultation with our social worker concerning development of processes for consultation with people with disabilities will also be introduced to enhance this outcome further.

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

Cultural Diversity and Language Services

Our Policy
The North Midlands Health Service strives to ensure there is no discrimination against members of the public based upon race, ethnicity, religion, language or culture.

Midwest Health Service supports the principles of incorporating diversity into mainstream service planning, delivery and evaluation for culturally and linguistically diverse people. Negotiations are progressing to formalise relevant partnerships that will assist and support services that facilitate care and remove barriers based on race, ethnicity, religion, language and culture.

Programs and Initiatives
The North Midlands Health Service has not yet developed any strategies or programs specific to the *Western Australian Government Language Services Policy*.

Youth Services

The Midwest Health Service is cognisant of many of the youth issues within the area, and is in the process of developing a strategic direction, based on the 2002 Midwest Needs Analysis, in partnership with local stakeholders, particularly the Shires, to address these.

The population profile of the Midwest indicates the age group 16–20 is relatively small (approximately five per cent of total Midwest population) due to many in this age group being schooled outside of their area and leaving the area for work opportunities.

Our Policy
The North Midlands Health Service acknowledges the rights and special needs of youth, and endeavours to provide appropriate services, supportive environments and opportunities for young people.

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

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

Programs and Initiatives
Throughout the 2001/2002 period, the Midwest Health Service participated with other organisations and agencies to support specific programs such as the development of a youth advisory council in Dongara, curriculum support programs (such as safety, nutrition, activity and self-management programs) and young mothers groups. Services through the schools are well covered with facilitation of StarCap programs and Asthma Friendly Schools programs being well supported. Additionally, close association and support of a two-year nutrition program through Mullewa District High School continues with great success during this period.

Employee Profile

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	13.03	12.02	12.44
Administration and Clerical*	2.57	2.60	2.80
Medical Support*	–	0.14	0.09
Hotel Services*	9.85	11.21	11.31
Maintenance	–	–	–
Medical (salaried)	–	–	–
Other	–	2.98	2.21
TOTAL	**25.45**	28.95	28.85

*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

North Midlands Health Service has recruited a part-time Activities Coordinator. Agency nurses have been employed since May due to one long-term permanent staff member resigning and another on workers' compensation.

Staff Development

Staff had the opportunity to attend workshops, seminars and conferences held locally and in the metropolitan area. Patient Care Assistants, Carers and nursing staff attended an education session on dementia care presented by the Alzheimer's Association. Mandatory **updates** continue in the areas of Fire and Safety, Cardio-Pulmonary Resuscitation and Manual Handling.

Industrial Relations Issues

A senior enrolled nurse has been employed as part of the Enrolled Nurses and Nursing Assistants (North Midlands Health Service) Enterprise Agreement 1999.

Workers' Compensation and Rehabilitation

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

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

*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.

North Midlands Health Service has a very good record in relation to injury prevention over the last three financial years. North Midlands Health Service has a Safety and Quality Activities Committee, which covers Occupational Safety and Health. This Committee focuses on education of staff in safe work practices.

Equity and Diversity Outcomes

Integration of EEO Outcomes

- North Midlands Health Service advertises as an equal opportunity employer.
- Equal Employment Opportunity knowledge and awareness are part of all Job Descriptions.
- North Midlands Health Service has a multicultural workforce.
- Policies and Procedures regarding Human Resources reflect public sector standards.

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

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

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

- All policies and procedures, planning documents and job descriptions reflect EEO principles and practice.

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

- Regular staff meetings provide a forum for discussion of issues and foster team building and good relationships.

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

- The Equal Employment Opportunity target group of women is well represented at North Midlands Health Service.
- Currently North Midlands has three people employed from non-English speaking backgrounds.

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 North Midlands Health Service has been able to meet these goals:

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

Marketing

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

- Advertisements in the local papers.
- Membership on Community Committees.
- Community Liaison.
- Interagency Liaison.

Publications

There were no publications issued by the Health Service during 2001/2002.

Research and Development

North Midlands Health Service participated in the Midwest Health Needs Analysis during December 2001 and January 2002. The purpose of the research was to establish the perception of the community in relation to their own health, the general health of the community and what health services are needed to enhance service provision.

Evaluations

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

Risk Management

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

Strategies and Initiatives
The North Midlands Health Service has a risk management strategy in place. The Safety and Quality Activities Committee oversees the risk management plan and its implementation.

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

Internal Audit Controls

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

Waste Paper Recycling

The Shires of Three Springs, Carnamah or Coorow do not have any local recycling facilities.

Shredded paper is used as mulch in the hospital gardens and staff are permitted to take the shredded paper home.

Pricing Policy

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

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

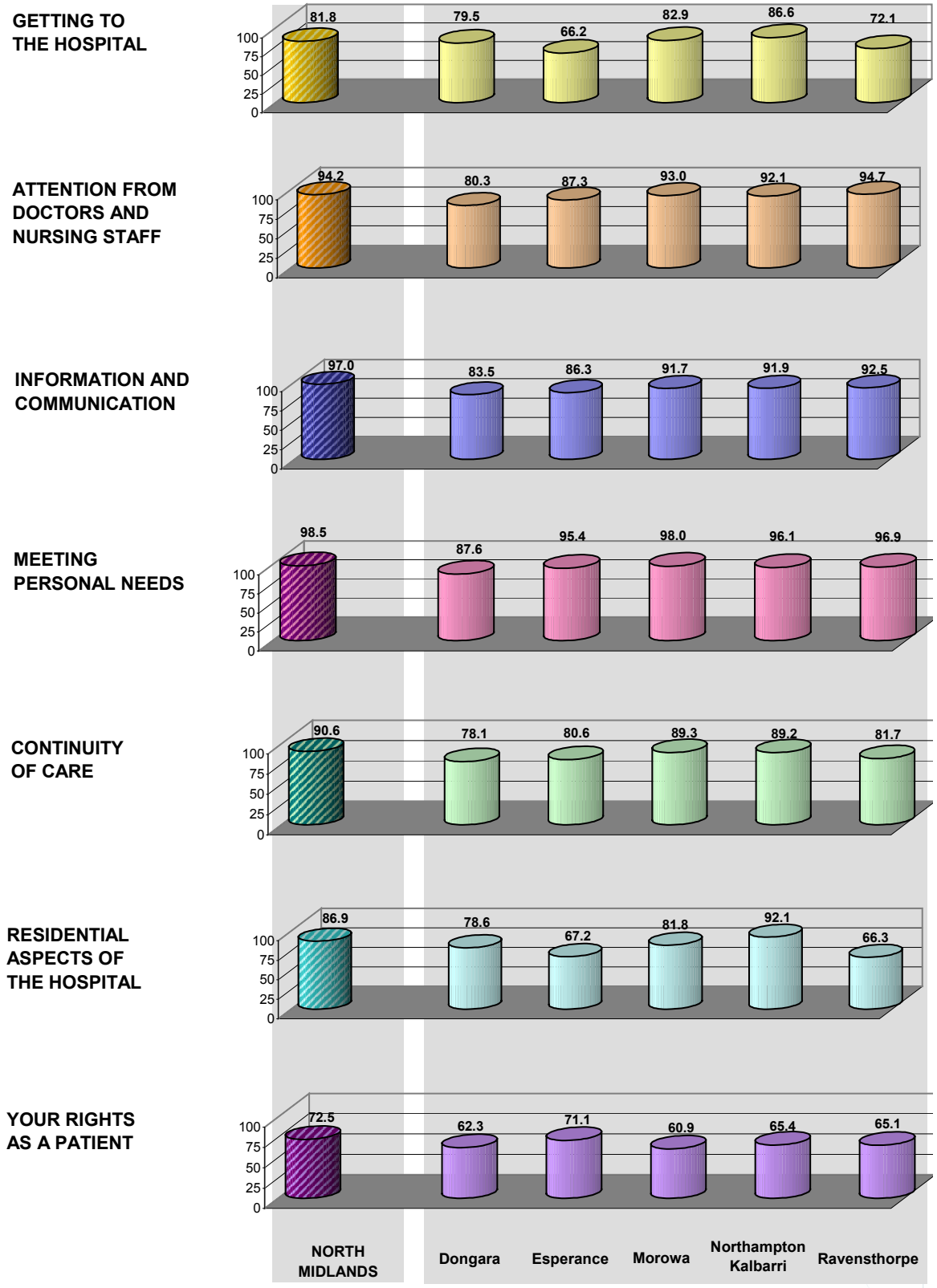
No fees are raised against registered public and private outpatients of the hospital.

Client Satisfaction Surveys

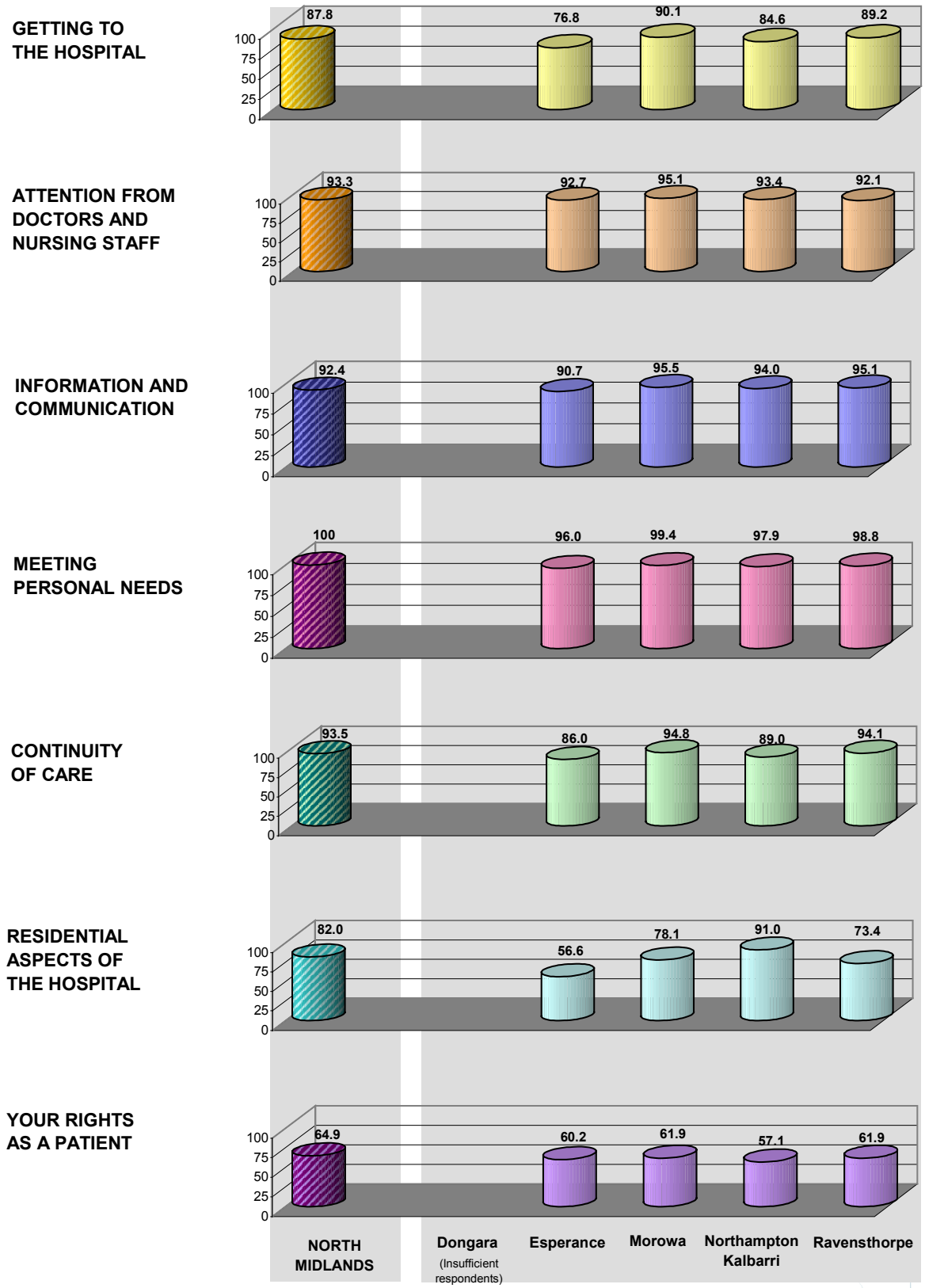
Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey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

Each year a number of client groups are selected to answer questions about their experiences within the health system. The survey process is managed by the Department of Health with questionnaires being posted to patients during a specified survey period. Details of the responses to individual questions are shown below and audited aggregate results of these surveys are shown in the Key Performance Indicator section (page 43) of this report.

KPI 2.2: EMERGENCY PATIENTS — RURAL



KPI 2.2: OUTPATIENTS — RURAL



AUDITOR GENERAL

To the Parliament of Western Australia

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

Scope

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

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

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

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

Audit Opinion

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

D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

AUDITOR GENERAL

INTERIM REPORT

To the Parliament of Western Australia

NORTH MIDLANDS HEALTH SERVICE

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

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

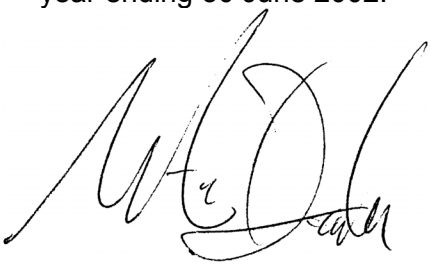
It is anticipated that the opinions will be issued by March 31, 2003.

D D R PEARSON
AUDITOR GENERAL
February 28, 2003

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

NORTH MIDLANDS HEALTH SERVICE
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2002

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



Mike Daube
ACCOUNTABLE AUTHORITY
Director General of Health

November 2002

Table of Contents

Background

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

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

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

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

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

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

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

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

Output 1: *Prevention and Promotion*

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

Output 2: *Diagnosis and Treatment*

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

Output 3: *Continuing Care*

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

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

General Approach

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

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

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

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

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

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

Comparative Results

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

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

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

Output Measures

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

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

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

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

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

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

Assessing the Performance of the Health Service

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

Glossary of Terms

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

MEDIAN WAITING TIMES FOR COMMUNITY AND ALLIED HEALTH SERVICES (HOSPITAL & 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.

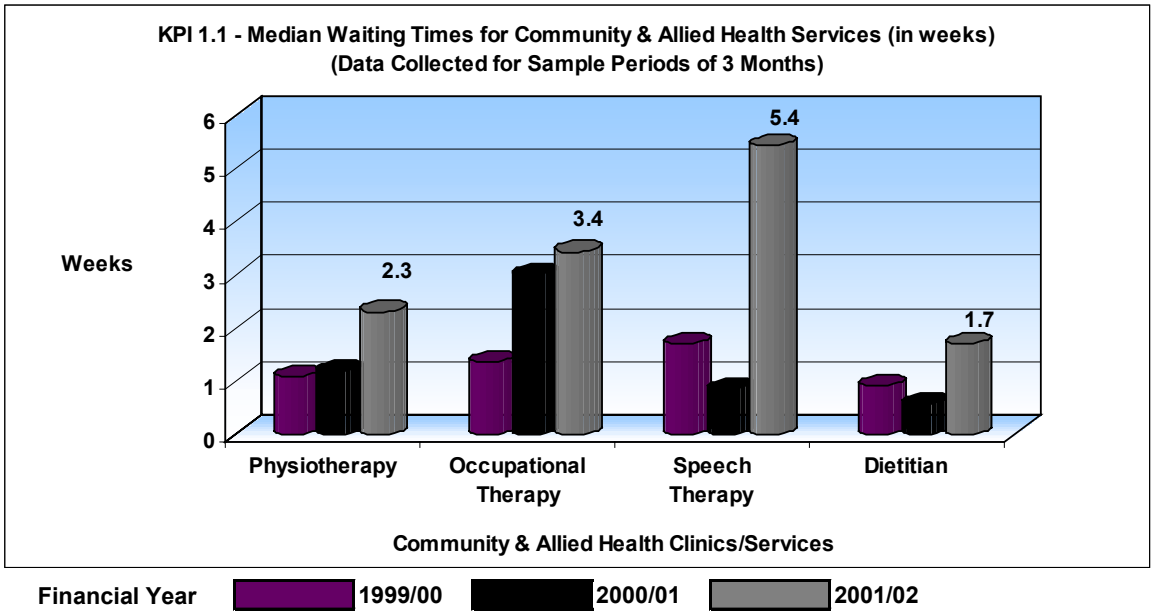
Access to health services are provided on the basis of clinical need but situations where clients are waiting longer than the average may reflect sub-optimal practices or under-resourcing within the organisation.

This indicator measures the median (middlemost) waiting time in days 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.

Community and allied health services are provided by Midwest Health Services. The increase in waiting times is a result of staff shortages in allied health.



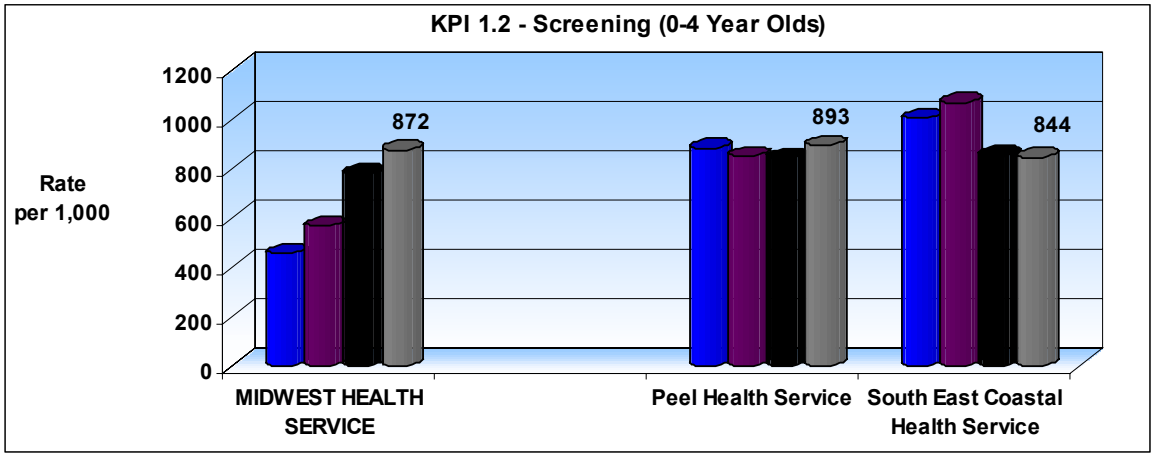
RATE OF SCREENING IN CHILDREN	KPI 1.2

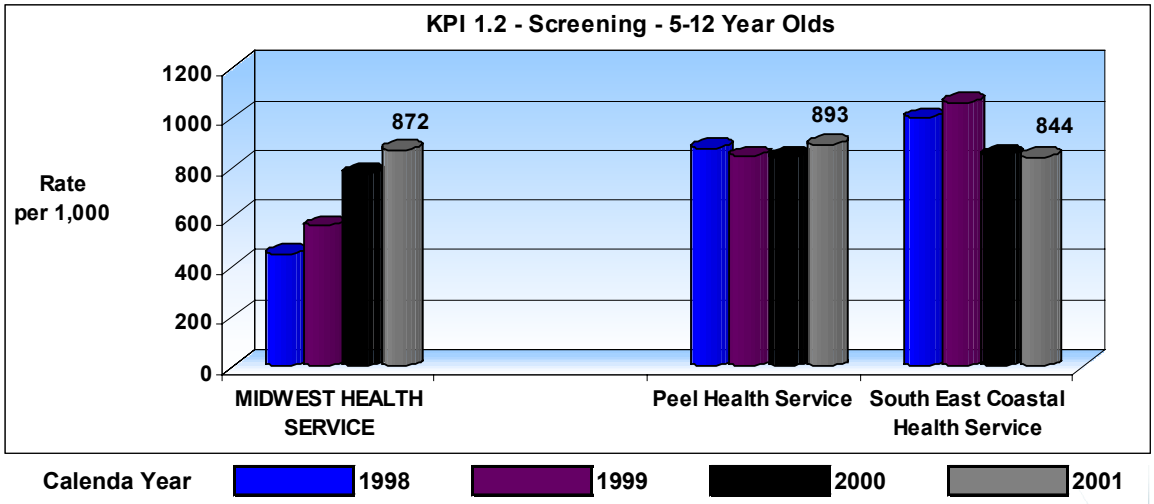
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good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

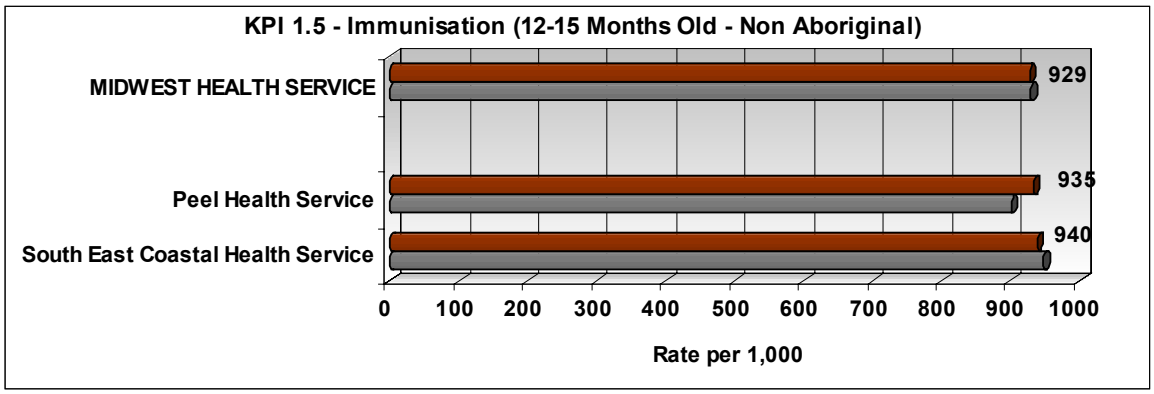
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

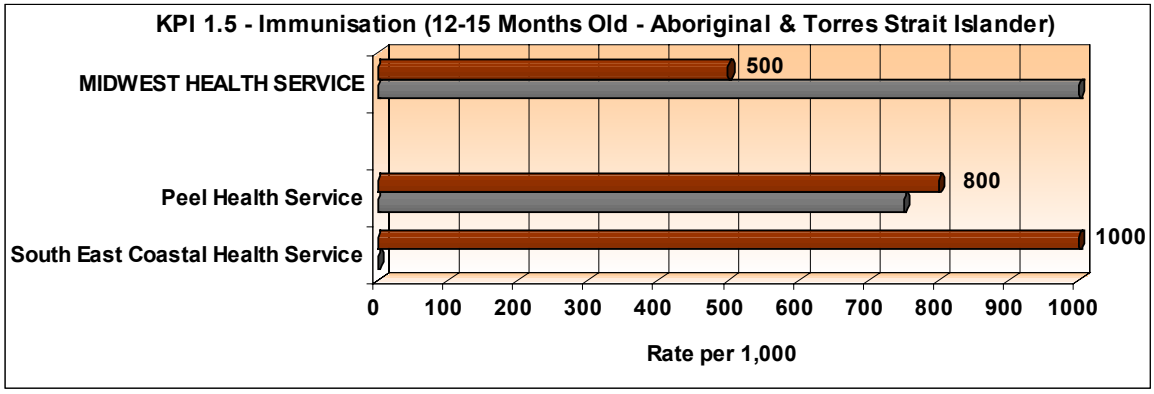
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

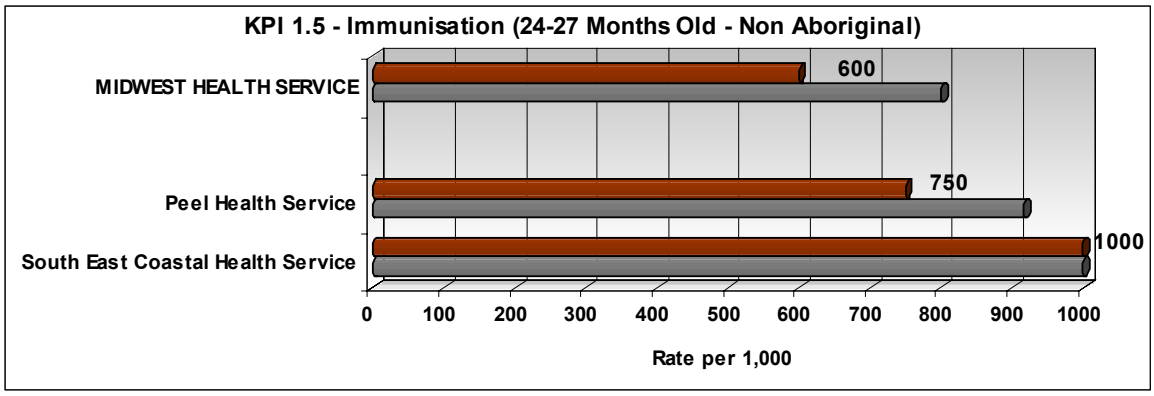
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

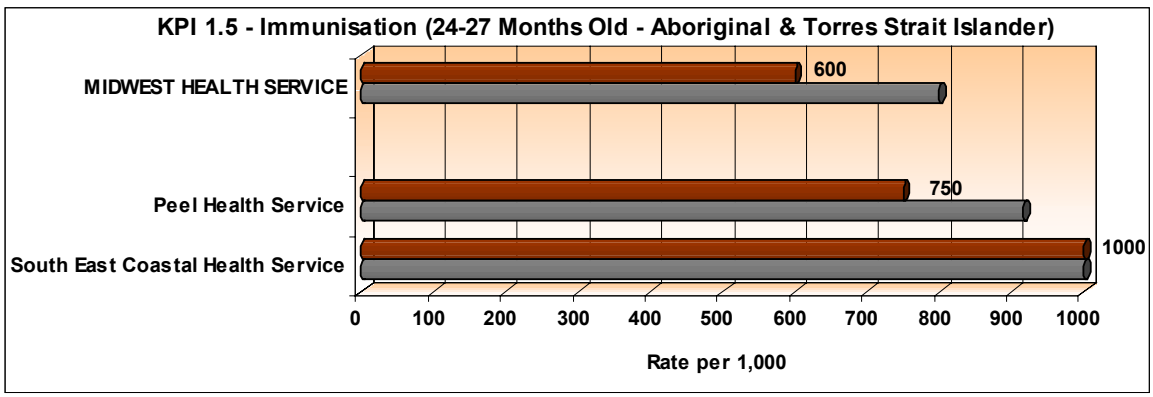
All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the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

The rate of immunisation of 24-27 month old Aboriginal and Torres Strait Islander children has dropped, however, the small numbers of children involved make this variation non-significant.









Calendar Year 2001 2002

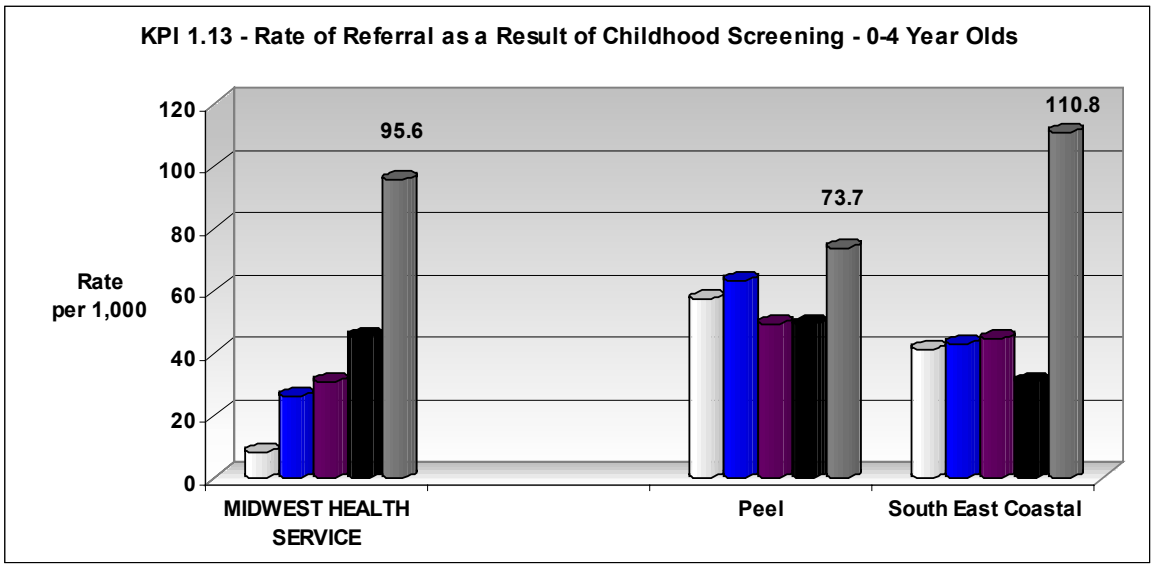
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

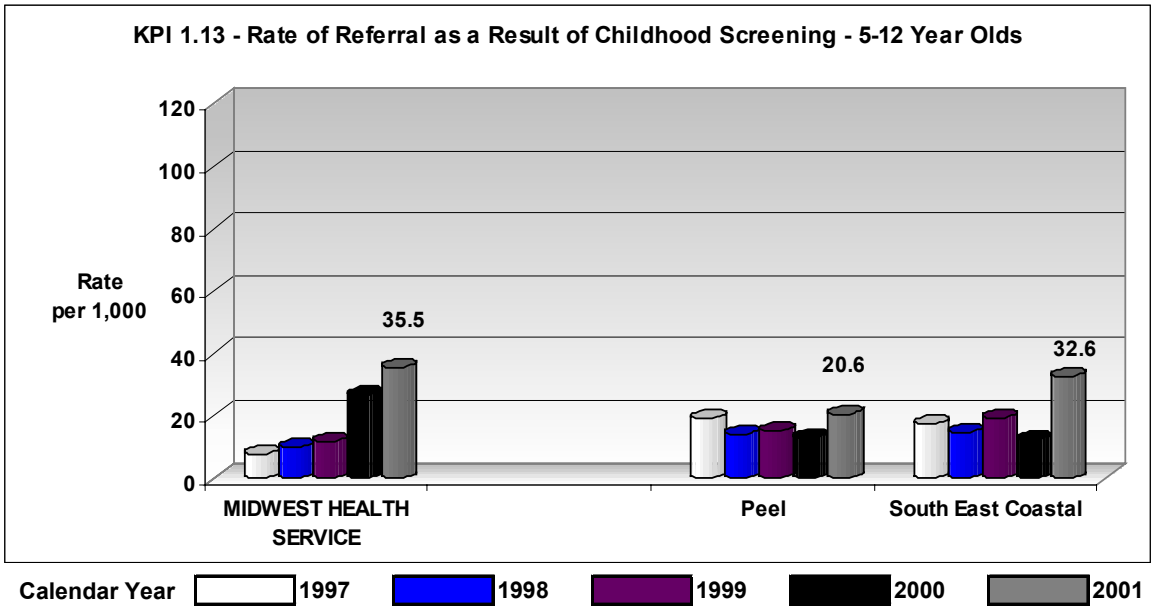
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only to restore children to good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

The rate of childhood screening has steadily increased over the years. The rate of referral as a result of screening has increased dramatically due to a change in screening methods and education of staff.





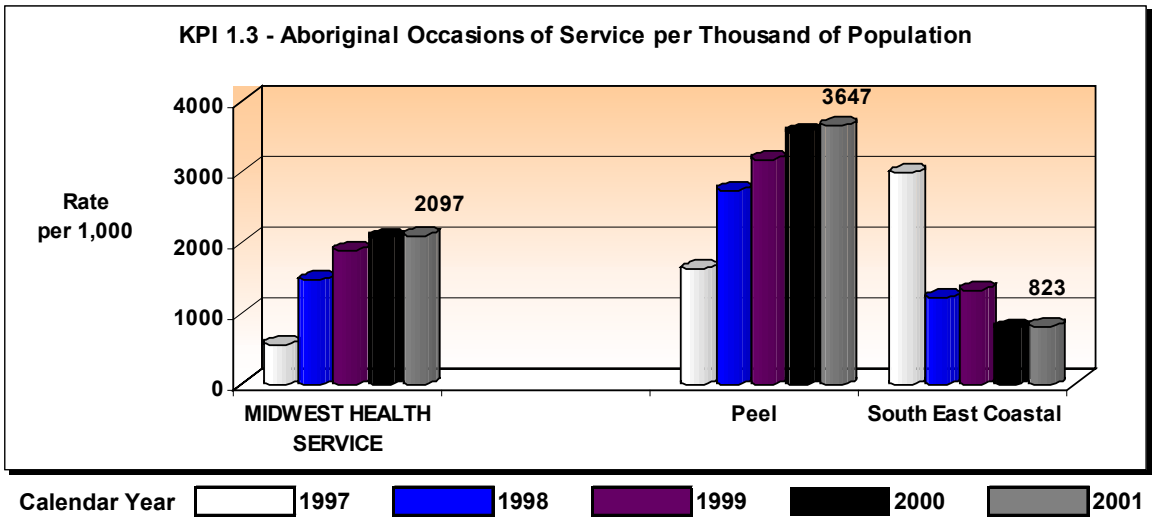
RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

The lower standard of health experienced by the Aboriginal population 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.

This indicator measures the rate of provision of service per thousand members of this special needs group in the catchment area of the health service.



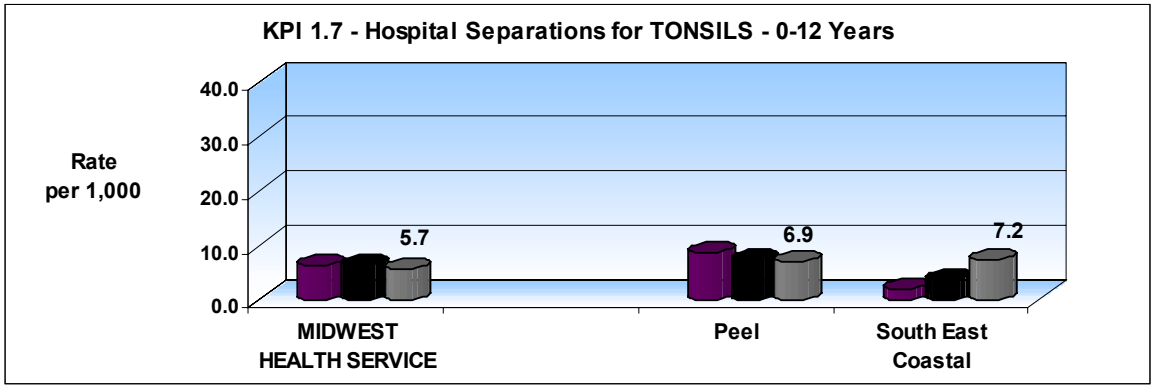
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS — KPI 1.7

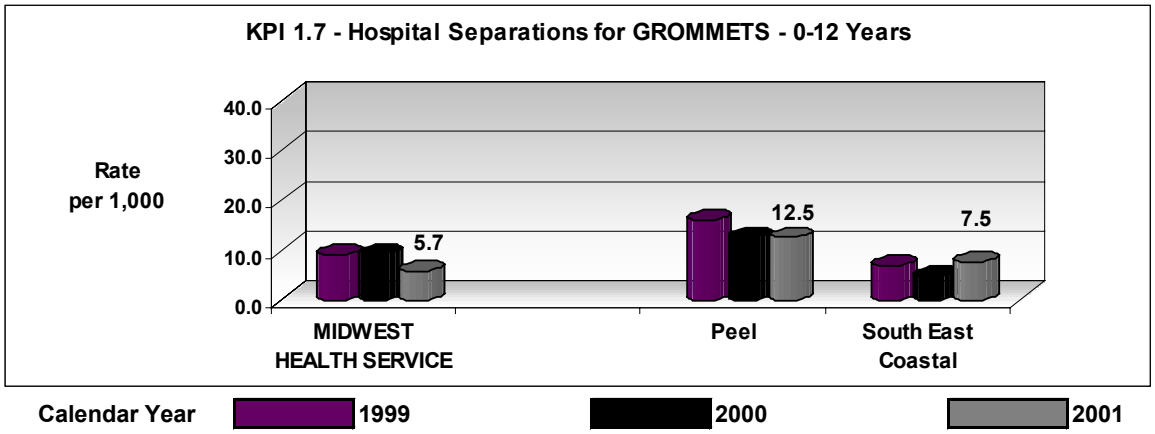
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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.





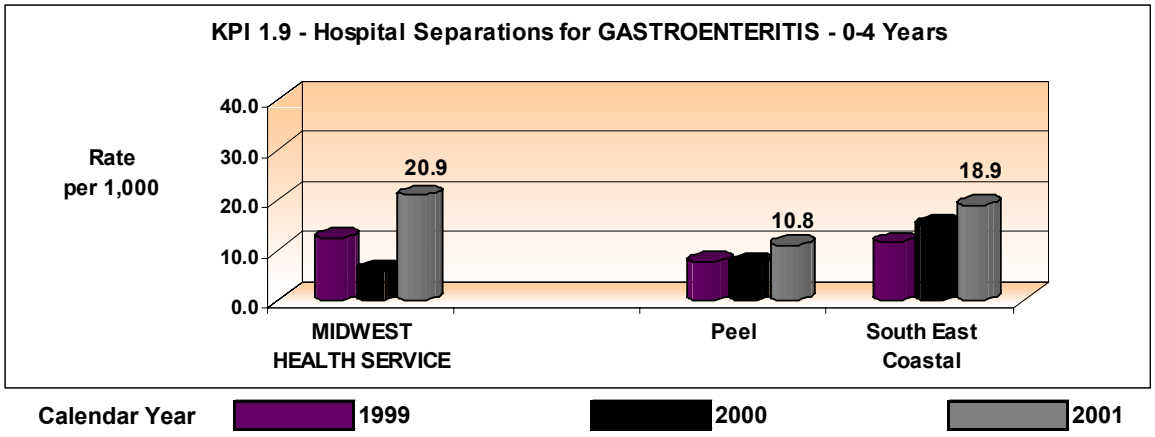
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN | KPI 1.9

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

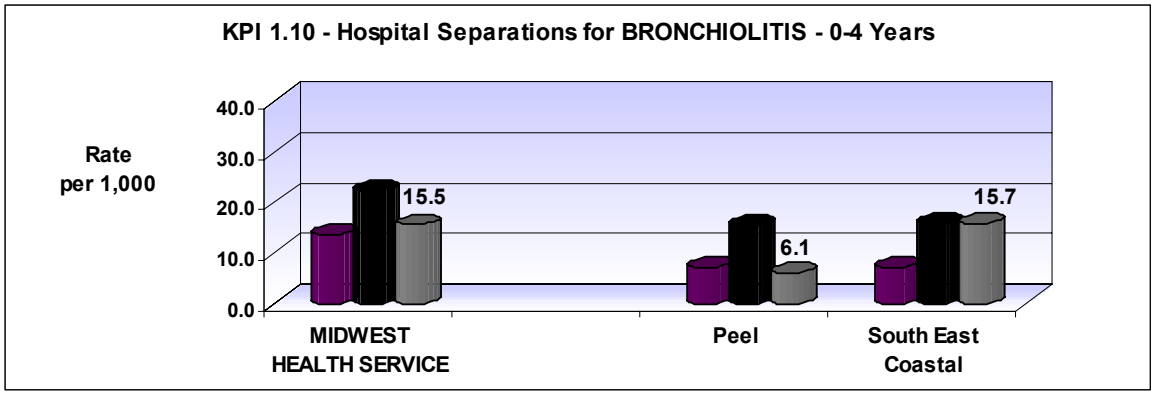
Respiratory illness is one of the most common reasons for hospital admission in children and young adults. Improved primary health and community health strategies, such as health monitoring, education and risk prevention can assist in reducing the incidence and prevalence of conditions such as acute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

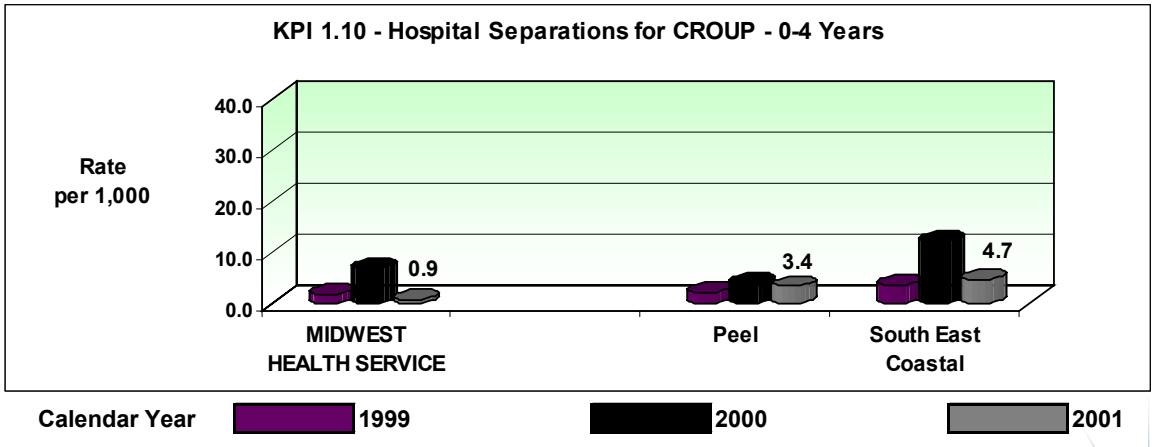
Improved primary management will reflect a decrease in the number of admissions for these conditions. Comparison of the rate of hospitalisation for respiratory illness with other comparable areas can help identify those areas where improvements in primary care could be necessary.

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

Croup
The graphs shows individuals aged 0-4. Of those individuals aged 5-12, only 1 was hospitalised this year, a rate of 1.1 per thousand. Of those aged 13-18, none were hospitalised this year.

Acute Bronchitis
No individuals aged 0-4 were hospitalised this year, with 1 individual being admitted aged 5-12 at a rate of 0.5 per thousand and no individuals aged 13-18 were admitted.





HOSPITAL ADMISSIONS FOR ASTHMA	KPI 3.7

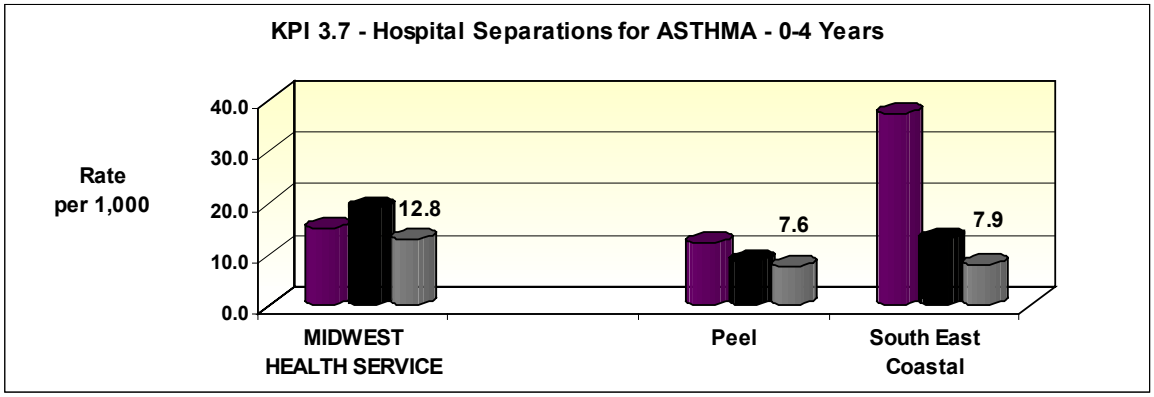
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

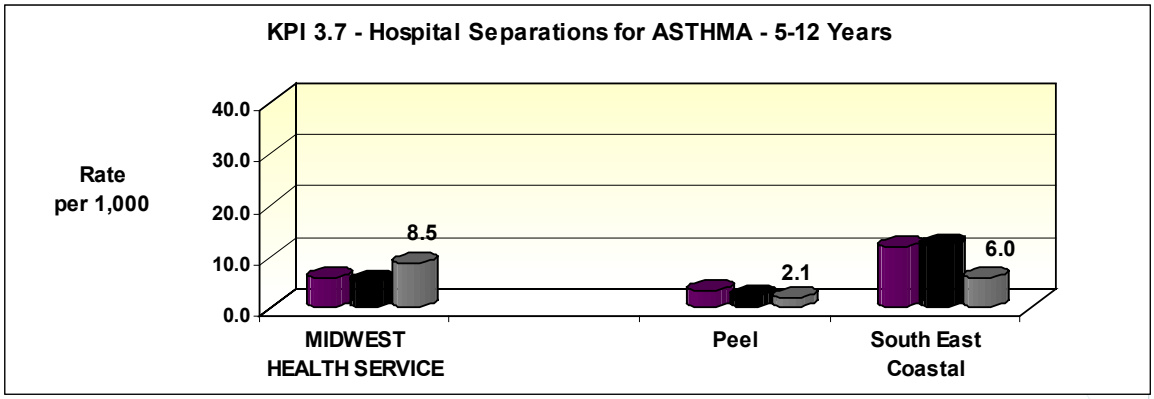
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

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 2 individuals aged 13-18 at a rate of 2.1 per thousand were hospitalised this year, with 6 individuals being admitted aged 19-34 at a rate of 2.2 per thousand and 11 individuals aged 35 years and over at a rate of 1.5 per thousand.





Calendar Year 1999 2000 2001

COST PER OCCASION OF SERVICE OF COMMUNITY HEALTH SERVICE	KPI 1.14

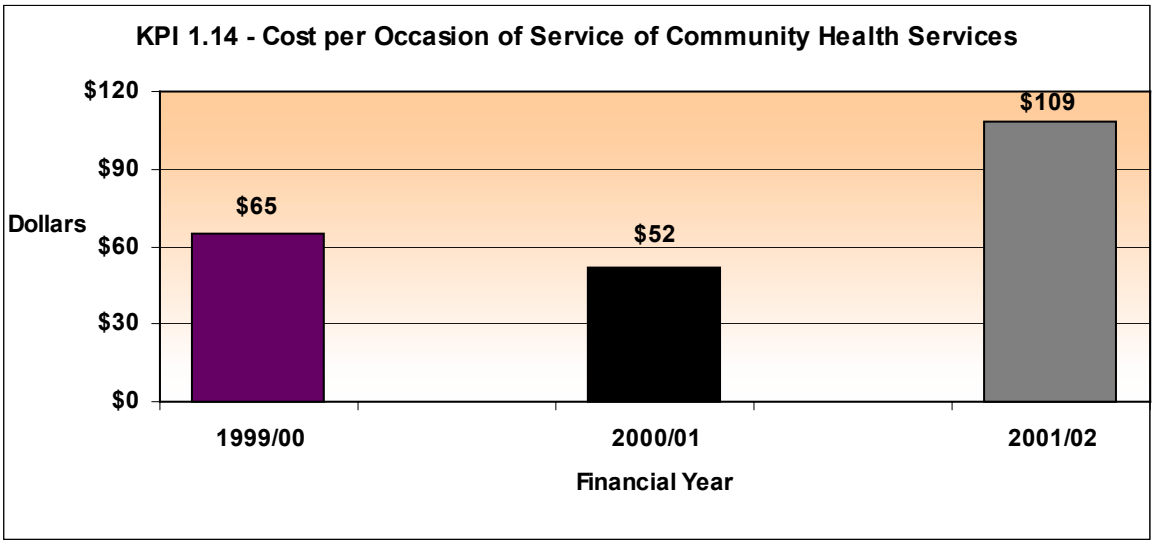
Community health occasions of service measure the provision of primary and community health services undertaken by a range of health service professionals in a community setting, with a focus on improving the overall health of the State population. Child health nursing, clinical psychology, occupational 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.

NOTE:

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



CLIENT SATISFACTION	KPI 2.2

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

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

The North Midlands District Hospital achieved an overall satisfaction score of 89 for emergency services and 88 for outpatients' services over the last financial year.

The standard error for each is 1.58 and 2.04 respectively.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Same-day Patients	4	3	75%
Emergency Patients – Centrally Administered	50	14	28%
Emergency Patients – Centrally Administered*	60	6	10%
Outpatients – Centrally Administered	48	22	46%
Outpatients – Hospital Administered*	60	3	5%

* *Response rates for hospital administered surveys are estimates.*

EMERGENCY DEPARTMENT WAITING TIMES	KPI 2.18

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

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

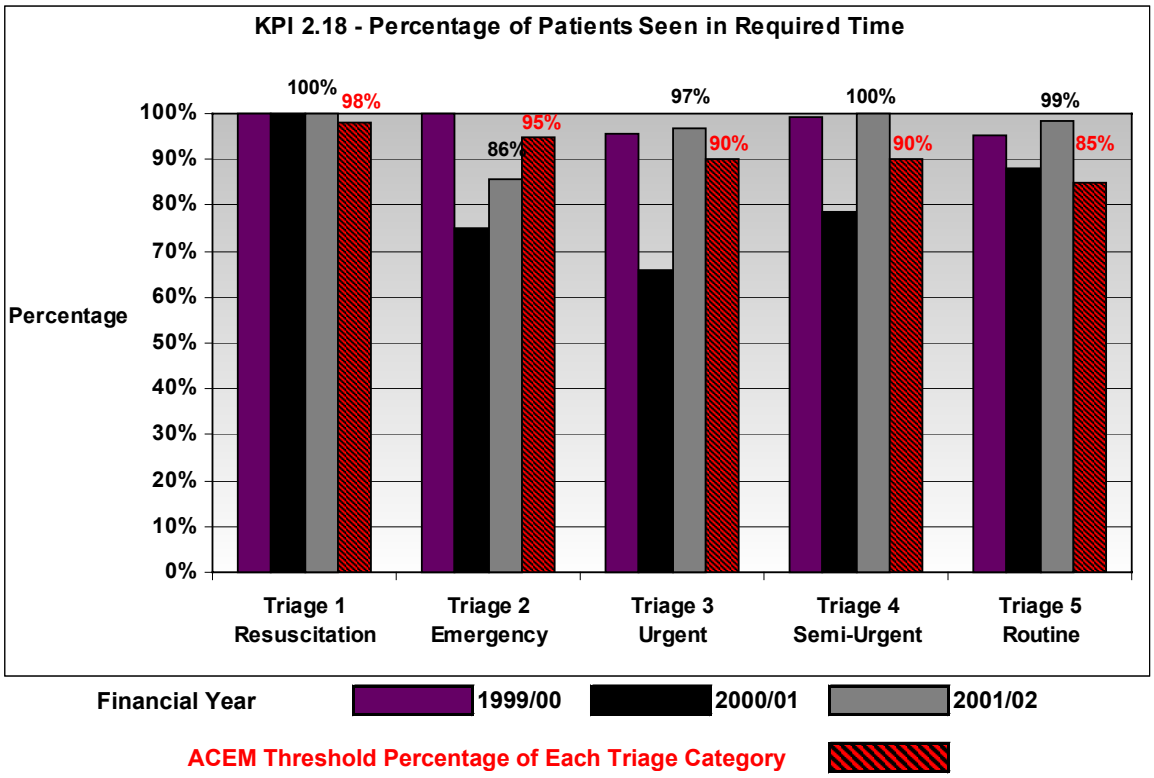
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

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

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

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

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

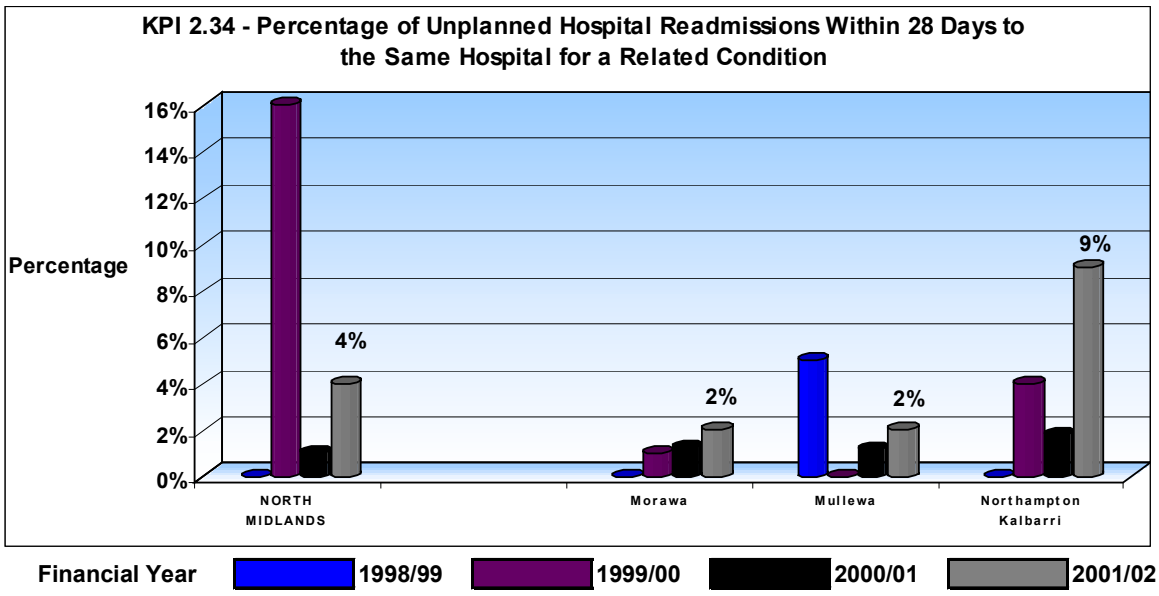

KPI 2.18 - Percentage of Patients Seen in Required Time
Percentage
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
98%
86%
95%
97%
90%
100%
90%
99%
85%
Triage 1 Resuscitation
Triage 2 Emergency
Triage 3 Urgent
Triage 4 Semi-Urgent
Triage 5 Routine
Financial Year
1999/00
2000/01
2001/02
ACEM Threshold Percentage of Each Triage Category

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

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

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

The unplanned readmission rate for the North Midlands Health Service is within the ACHS threshold.



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.

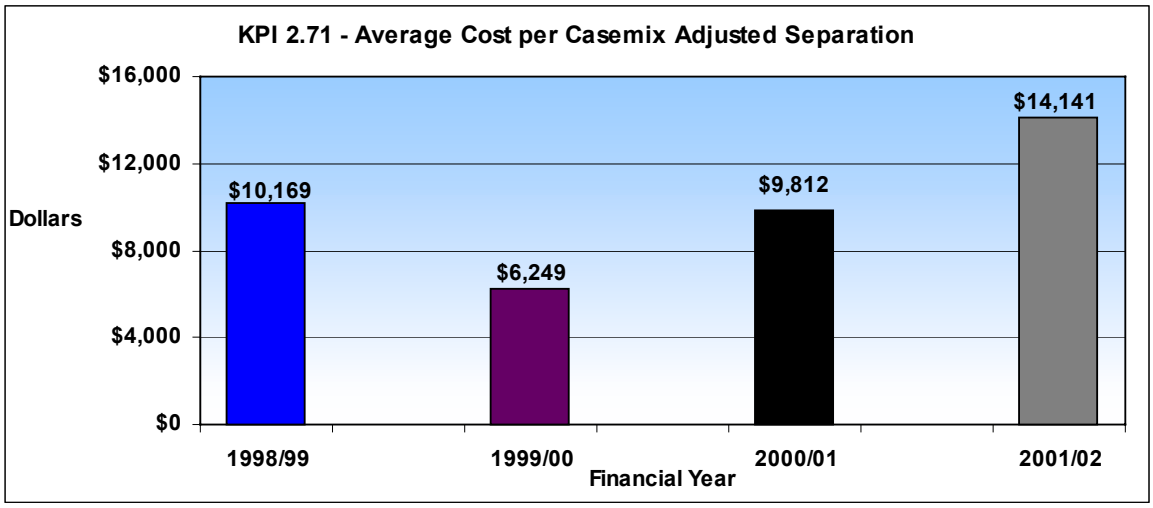
There were no unplanned readmissions reported at the North Midlands Health Service this year, comparisons with previous years have therefore not been provided.

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.



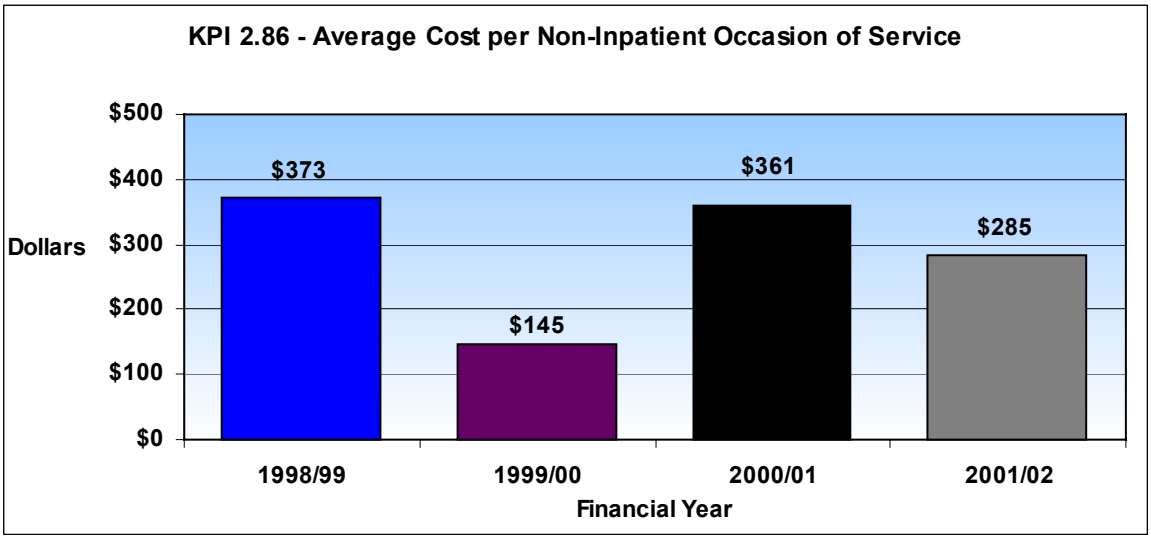
AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

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.

The decrease in average cost per non-inpatient occasion of service is due to an increase in occasions of service for this year.



KPI 3.7 : Hospital separations for Asthma

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

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

Number of Individuals Admitted as a Nursing Home Type Patient

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

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

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

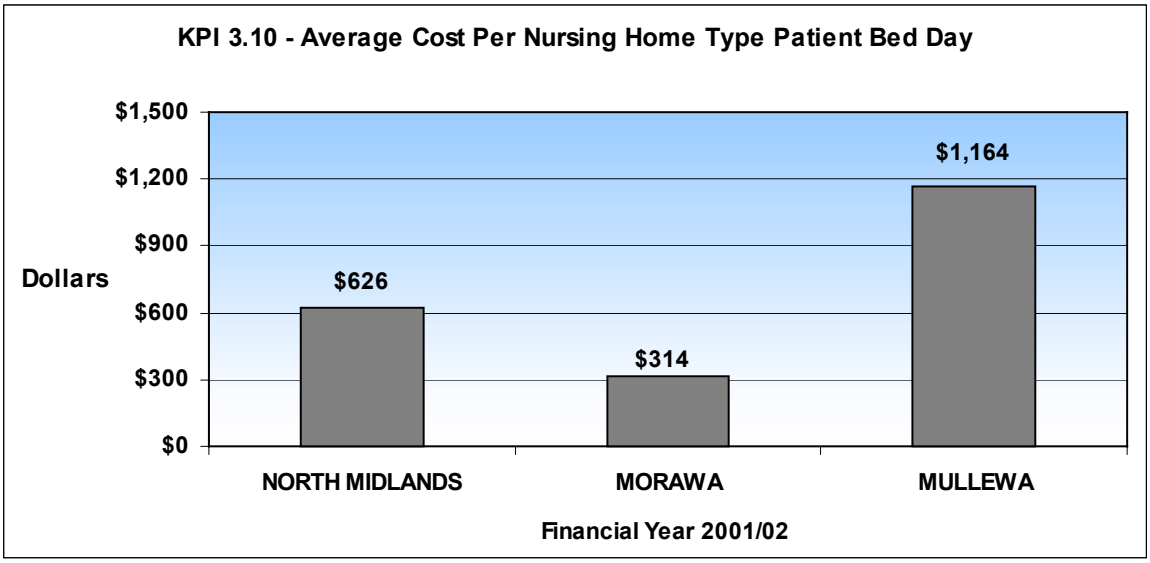
There was one Nursing Home Type Patient aged 70+ admitted in the North Midlands Health Service in 2001/02, and no Aboriginal or Torres Strait Islander patients.

Average Cost per Nursing Home Type Patient Bed Day

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

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

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



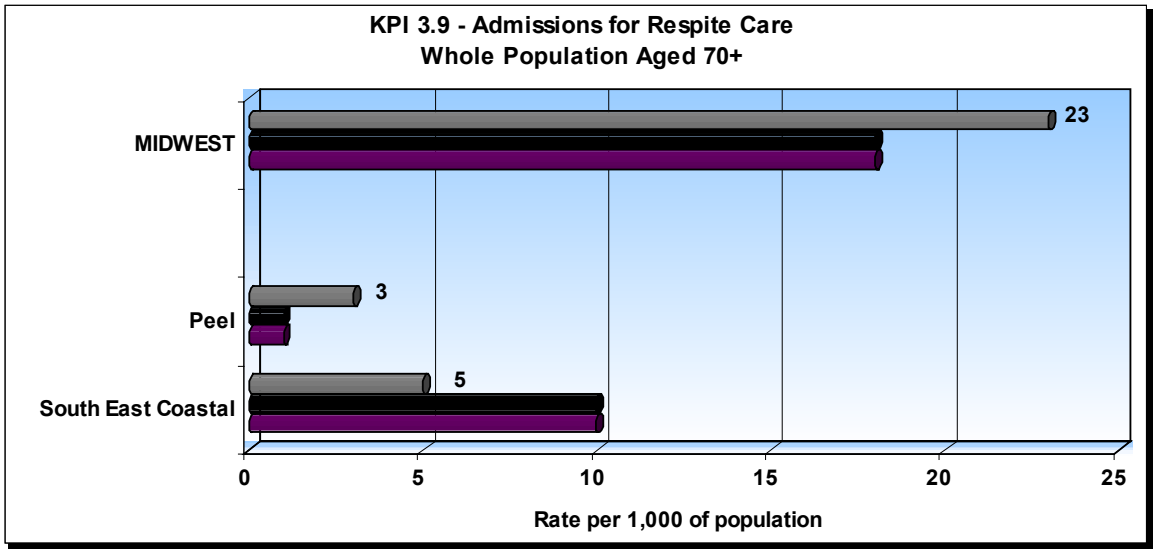
NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

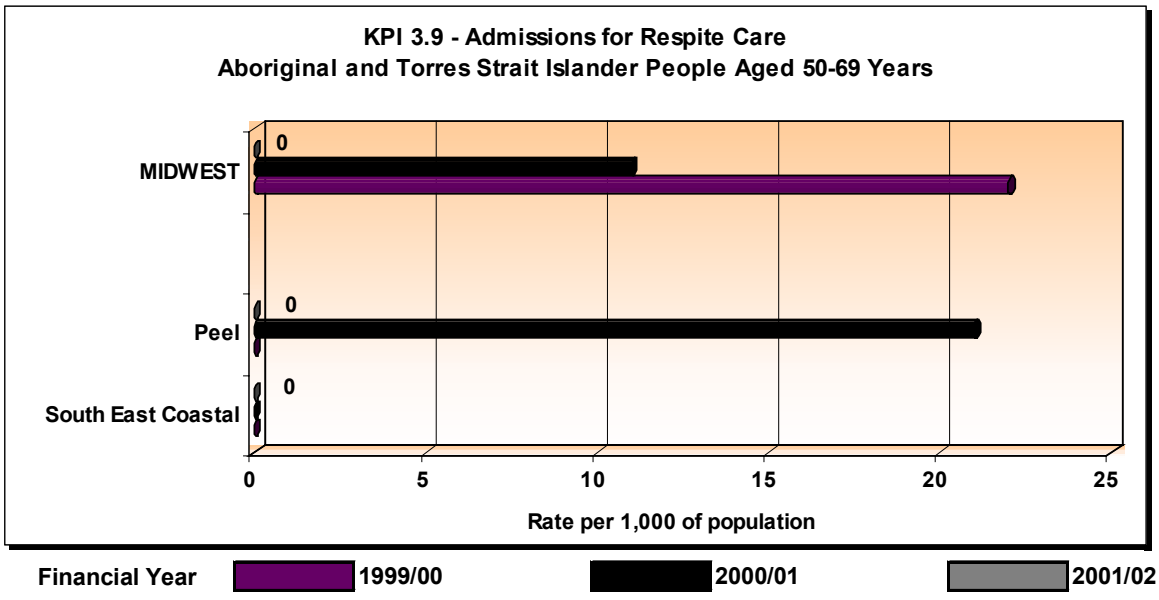
Some people with chronic illness and disability are cared for at home or in a family member's home with the support of local community services including Home & Community Care (HACC). To enable the carer to have a break from the continual carer role, short-term care may be provided in country facilities.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

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

An increase in the availability of home based nursing services in the area has decreased the need for respite care.

There was no Aboriginal or Torres Strait Islander people within the targeted age group admitted for respite care this year.





AUDITOR GENERAL

To the Parliament of Western Australia

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

Scope
I have audited the accounts and financial statements of the North Midlands Health Service for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

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

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

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

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

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

Audit Opinion
In my opinion,

(i) the controls exercised by the North Midlands Health Service provide reasonable assurance that the receipt, expenditure and investment of moneys and the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions; and

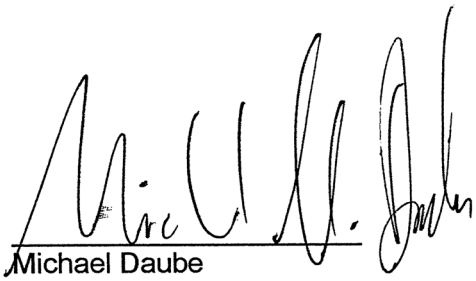
(ii) the Statement of Financial Performance, Statement of Financial Position and Statement of Cash Flows and the Notes to and forming part of the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Health Service at June 30, 2002 and its financial performance and its cash flows for the year then ended.

D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

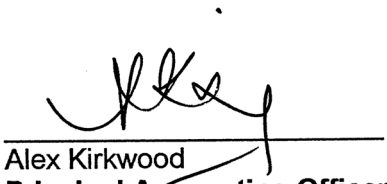
The accompanying financial statements of the North Midlands Health Service have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002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

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



Michael Daube
Director General of Health
Accountable Authority for
North Midlands Health
Service

30 August 2002



Alex Kirkwood
Principal Accounting Officer
North Midlands Health
Service

30 August 2002

Statement of Financial Performance
For the year ended 30 June 2002

	Note	2001/02 $	2000/01 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses		1,267,582	1,246,179
Fees for visiting medical practitioners		21,800	29,683
Superannuation expense		122,039	96,257
Patient support costs	3	175,403	210,805
Patient transport costs		38,211	41,943
Borrowing costs expense		126,470	131,560
Repairs, maintenance and consumable equipment expense		62,390	157,301
Depreciation expense	4	156,667	119,468
Net loss on disposal of non-current assets	5	28,830	16,007
Asset revaluation decrement	25	10,900	0
Capital user charge	6	96,680	0
Other expenses from ordinary activities	7	91,599	90,608
Total cost of services		2,198,571	2,139,811
Revenues from Ordinary Activities			
Patient charges	8	168,874	209,770
Commonwealth grants and contributions	9	0	760
Donations revenue	10	2,847	502
Interest revenue		1,519	2,824
Other revenues from ordinary activities	11	45,697	38,490
Total revenues from ordinary activities		218,937	252,346
NET COST OF SERVICES		**1,979,634**	**1,887,465**
Revenues from Government			
Output appropriations	12	1,971,601	1,498,063
Capital appropriations	12	0	43,936
Assets assumed	13	623,409	73,181
Liabilities assumed by the Treasurer	14	23,285	95,687
Resources received free of charge	15	5,500	5,000
Total revenues from government		2,623,795	1,715,867
Change in net assets		**644,161**	**(171,598)**
Net increase in asset revaluation reserve	25	106,473	0
Total revenues, expenses and valuation adjustments recognised directly in equity		106,473	0
Total changes in equity other than those resulting from transactions with WA State Government as owners		**750,634**	**(171,598)**

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

Statement of Financial Position
As at 30th June 2002

	Note	2001/02 $	2000/01 $
CURRENT ASSETS			
Cash assets	16	23,667	22,830
Receivables	17	19,915	37,541
Inventories	19	8,864	12,073
Total current assets		52,446	72,444
NON-CURRENT ASSETS			
Amounts receivable for outputs	18	122,200	0
Property, plant and equipment	20	3,192,015	2,531,082
Total non-current assets		3,314,215	2,531,082
Total assets		**3,366,661**	**2,603,526**
CURRENT LIABILITIES			
Payables		29,214	59,598
Interest-bearing liabilities	21	43,739	29,480
Accrued salaries	22	21,661	18,962
Provisions	23	211,575	210,107
Total current liabilities		306,189	318,147
NON-CURRENT LIABILITIES			
Interest-bearing liabilities	21	1,191,864	1,247,938
Provisions	23	52,794	42,758
Total non-current liabilities		1,244,658	1,290,696
Total liabilities		**1,550,847**	**1,608,843**
Net Assets		**1,815,814**	**994,683**
EQUITY			
Contributed equity	24	70,498	0
Asset revaluation reserve	25	106,473	0
Accumulated surplus	26	1,638,843	994,683
Total Equity		**1,815,814**	**994,683**

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	27(c)	1,635,258	1,356,590
Capital contributions (2000/01 appropriation)	27(c)	28,184	13,441
Net cash provided by Government		1,663,442	1,370,031
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(541,992)	(486,841)
Employee costs		(1,253,225)	(1,179,774)
GST payments on purchases		(39,344)	(35,252)
GST payments to taxation authority		0	579
Receipts			
Receipts from customers		178,072	197,431
Commonwealth grants and contributions		0	760
Donations		249	502
Interest received		1,519	3,117
GST receipts on sales		429	455
GST receipts from taxation authority		36,054	29,909
Other receipts		79,983	45,082
Net cash (used in) / provided by operating activities	27(b)	(1,538,255)	(1,424,032)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	20	(124,350)	(52,818)
Net cash (used in) / provided by investing activities		(124,350)	(52,818)
Net increase / (decrease) in cash held		837	(106,819)
Cash assets at the beginning of the reporting period		22,830	129,649
Cash assets at the end of the reporting period	27(a)	23,667	22,830

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

Note 1 SIGNIFICANT ACCOUNTING POLICIES

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

(a) General Statement

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

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

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

(b) Output Appropriations

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

(c) Contributed Equity

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

(d) Acquisition of Assets

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

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

(e) Valuation of Non-Current Assets

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

i) Land and Non-Clinical Buildings

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

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

Recent valuations on this basis are equivalent to fair value.

ii) Clinical Buildings

The valuations of clinical buildings (eg hospitals) have been carried out at five yearly intervals by the Department of Health in conjunction with the Department of Housing and Works using "as constructed" drawings. The clinical buildings are valued at "Replacement Capital Value", which is defined as the cost to replace buildings constructed at

current building costs with current materials on a greenfield site. All building costs are Perth based and include elements of electrical, mechanical and plumbing services. Loose and free standing furniture and equipment together with specialised medical equipment are excluded from this valuation. Buildings are depreciated using weighted average age to determine the net carrying values. Recent valuations on this basis are equivalent to fair value.

(f) Depreciation of Non-current Assets

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

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

Buildings	33 years
Computer equipment	5 years
Furniture and fittings	7 to 40 years
Motor vehicles	4 years
Other plant and equipment	7 to 30 years

(g) Leases

The Health Service has no contractual obligations under finance leases.

(h) Cash

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

(i) Receivables

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

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

(j) Inventories

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

(k) Payables

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

(l) Accrued Salaries

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

(m) Interest-bearing liabilities

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

(n) Provisions

Employee Entitlements

i) Annual and Long Service Leave

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

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

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

ii) Superannuation

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

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

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

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

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

iii) Deferred Salary Scheme

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

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

(o) Revenue Recognition

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

(p) Grants and Other Contributions Revenue

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

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

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

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

(r) Comparative Figures

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

	2001/02 $	2000/01 $
Note 2 Administered trust accounts		
Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.		
a) The Health Service administers a trust account for the purpose of holding patients' private moneys.		
A summary of the transactions for this trust account is as follows:		
Opening Balance	375	465
Add Receipts		
- Patient Deposits	1,140	1,080
	1,515	1,545
Less Payments		
- Patient Withdrawals	1,331	1,170
Closing Balance	184	375
Note 3 Patient support costs		
Medical supplies and services	33,720	43,829
Domestic charges	27,445	48,547
Fuel, light and power	50,035	52,438
Food supplies	38,842	38,856
Purchase of external services	25,361	27,135
	175,403	210,805
Note 4 Depreciation expense		
Buildings	86,671	69,417
Computer equipment and software	4,041	3,030
Furniture and fittings	7,653	7,870
Motor vehicles	41,845	25,896
Other plant and equipment	16,457	13,255
	156,667	119,468
Note 5 Net profit / (loss) on disposal of non-current assets		
a) **Profit / (Loss) on disposal of non-current assets:**		
Computer equipment and software	(1,238)	0
Furniture and fittings	(26,622)	0
Motor vehicles	4,363	(16,007)
Other plant and equipment	(5,333)	0
	(28,830)	(16,007)
Note 6 Capital user charge		
	96,680	0
A capital user charge rate of 8% has been set by the Government for 2001/02 and represents the opportunity cost of capital invested in the net assets of the Health Service used in the provision of outputs. The charge is calculated on the net assets adjusted to take account of exempt assets. Payments are made to the Department of Treasury and Finance on a quarterly basis by the Department of Health on behalf of the Health Service.		
Note 7 Other expenses from ordinary activities		
Workers compensation insurance	17,291	13,558
Other employee expenses	2,846	3,461
Motor vehicle expenses	23,376	26,457
Insurance	8,283	7,486
Communications	19,384	17,468
Printing and stationery	4,714	6,594
Rental of property	260	242
Audit fees - external	8,450	8,882
Other	6,995	6,460
	91,599	90,608

	2001/02 $	2000/01 $
Note 8 Patient charges		
Inpatient charges	165,352	205,244
Outpatient charges	3,522	4,526
	168,874	209,770
Note 9 Commonwealth grants and contributions		
Immunisation Recoup	0	760
Note 10 Donations revenue		
General public contributions	2,847	502
Note 11 Other revenues from ordinary activities		
Rent from properties	1,773	3,948
Recoveries	12,351	11,337
Use of hospital facilities	362	1,472
Other	31,211	21,733
	45,697	38,490
Note 12 Government appropriations		
Output appropriations (I)	1,971,601	1,498,063
Capital appropriations (II)	0	43,936
	1,971,601	1,541,999

(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 13 Assets assumed

The following assets have been assumed from other government agencies during the year:

Lady Brand Lodge/HACC/MOW	623,409	73,181
Total assets assumed	623,409	73,181

Note 14 Liabilities assumed by the Treasurer

Superannuation	23,285	95,687

Note 15 Resources received free of charge

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

Office of the Auditor General		
- Audit services	5,500	5,000

Where assets or services have been received free of charge or for nominal consideration, the Health Service recognises revenues equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable.

Note 16 Cash assets

Cash on hand	170	170
Cash at bank - general	1,995	2,136
Cash at bank - donations	21,502	20,524
	23,667	22,830

Note 17 Receivables	2001/02 $	2000/01 $
GST receivable	7,093	7,347
Other receivables	12,822	30,193
	19,915	37,540

Note 18 Amounts receivable for outputs

Non-current	122,200	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 19 Inventories

Supply stores - at cost	5,589	3,657
Pharmaceutical stores - at cost	3,275	8,416
	8,864	12,073

Note 20 Property, plant and equipment

Land		
At cost (i)	0	3,500
At valuation - 30 June 2002 (ii)	12,100	19,500
	12,100	23,000
Buildings		
At cost (i)	0	136,099
At valuation - 30 June 2002 (ii)	6,414,409	5,341,300
Accumulated depreciation	(3,526,792)	(3,232,993)
	2,887,617	2,244,406
Computer equipment and software		
At cost	26,475	30,196
Accumulated depreciation	(17,277)	(15,719)
	9,198	14,477
Furniture and fittings		
At cost	150,642	264,996
Accumulated depreciation	(95,705)	(178,382)
	54,937	86,614
Motor vehicles		
At cost	180,424	70,459
Accumulated depreciation	(46,299)	(21,782)
	134,125	48,677
Other plant and equipment		
At cost	245,858	264,455
Accumulated depreciation	(151,820)	(150,547)
	94,038	113,908
Total of property, plant and equipment	3,192,015	2,531,082

Land and buildings

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

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

Payments for non-current assets

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

Paid as cash by the Health Service from capital contributions	28,184	52,818
Paid as cash by the Health Service from other funding sources	96,166	0
Paid by the Department of Health	500	30,495
Gross payments for purchases of non-current assets	124,850	83,313

Note 20 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 $	2000/01 $
Land		
Carrying amount at start of year	23,000	23,000
Revaluation increments / (decrements)	(10,900)	0
Carrying amount at end of year	12,100	23,000
Buildings		
Carrying amount at start of year	2,244,406	2,313,823
Additions	623,409	0
Revaluation increments / (decrements)	106,473	0
Depreciation	(86,671)	(69,417)
Carrying amount at end of year	2,887,617	2,244,406
Computer equipment and software		
Carrying amount at start of year	14,477	9,044
Additions	0	8,463
Depreciation	(4,041)	(3,030)
Write-off of assets	(1,238)	0
Carrying amount at end of year	9,198	14,477
Furniture and fittings		
Carrying amount at start of year	86,614	83,105
Additions	2,598	11,379
Depreciation	(7,653)	(7,870)
Write-off of assets	(26,622)	0
Carrying amount at end of year	54,937	86,614
Motor vehicles		
Carrying amount at start of year	48,677	0
Additions	140,680	74,573
Disposals	(13,387)	0
Depreciation	(41,845)	(25,896)
Carrying amount at end of year	134,125	48,677
Other plant and equipment		
Carrying amount at start of year	113,908	84,591
Additions	1,920	42,572
Depreciation	(16,457)	(13,255)
Write-off of assets	(5,333)	0
Carrying amount at end of year	94,038	113,908

Note 21 Interest-bearing liabilities

a) **Department of Treasury and Finance loans**

Balance at beginning of year	1,277,418	1,287,331
Less repayments this year	(41,815)	(9,913)
Balance at end of year	1,235,603	1,277,418
Amount repayable within the next 12 months	43,739	29,480
Amount repayable after 12 months	1,191,864	1,247,938
Balance at end of year	1,235,603	1,277,418

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

Total interest-bearing liabilities:

Balance at beginning of year	1,277,418	1,287,331
Less repayments this year	(41,815)	(9,913)
Balance at end of year	1,235,603	1,277,418
Amount repayable within the next 12 months	43,739	29,480
Amount repayable after 12 months	1,191,864	1,247,938
Balance at end of year	1,235,603	1,277,418

Note 22 Accrued salaries	2001/02 $	2000/01 $
Amounts owing for:	21,661	18,962
Nursing staff		
7 days from 24th June to 30 June 2002		
(2001: 6 days from 25 June to 30 June 2001)		
Non-nursing staff		
7 days from 24th June to 30 June 2002		
(2001: 6 days from 25 June to 30 June 2001)		

Note 23 Provisions

Current liabilities:		
Annual leave	145,560	143,653
Long service leave	66,015	66,454
	211,575	210,107
Non-current liabilities:		
Long service leave	52,794	42,758
	52,794	42,758
Total employee entitlements	264,369	252,865

The superannuation liability has been established from data supplied by the Government Employees Superannuation Board.

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

Note 24 Contributed equity

Balance at beginning of the year	0	0
Capital contributions (i)	70,498	0
Balance at end of the year	70,498	0

(i) From 1 July 2001, capital appropriations, termed Capital Contributions, have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

Note 25 Asset revaluation reserve

Balance at beginning of the year	0	0
Net revaluation increments:		
Buildings	106,473	0
Balance at end of the year	106,473	0
Asset revaluation decrements recognised as an expense (iii):		
Land	10,900	0
	10,900	0

(i) Revaluation increments and decrements are offset against one another within the same class of non-current assets.

(ii) Any net increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement previously recognised as an expense.

(iii) Any net decrement is recognised as an expense in the Statement of Financial Performance, except to the extent that any decrement reverses a revaluation increment previously credited to the asset revaluation reserve.

Note 26 Accumulated surplus

Balance at beginning of the year	994,683	1,166,281
Change in net assets	644,161	(171,598)
Balance at end of the year	1,638,844	994,683

	2001/02 $	2000/01 $
Note 27 Notes to the statement of cash flows		
a) **Reconciliation of cash**		
Cash assets at the end of the reporting period as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:		
Cash assets (Refer note 16)	23,667	22,830
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)	(1,538,255)	(1,424,032)
Increase / (decrease) in assets:		
GST receivable	(254)	7,347
Other receivables	(17,371)	(9,491)
Inventories	(3,209)	(11,502)
Prepayments	0	(473)
Decrease / (increase) in liabilities:		
Payables	30,384	(21,048)
Accrued salaries	(2,699)	403
Provisions	(11,504)	(60,949)
Non-cash items:		
Depreciation expense	(156,667)	(119,468)
Profit / (loss) from disposal of non-current assets	(28,830)	(16,007)
Interest paid by Department of Health	(117,462)	(131,560)
Capital user charge paid by Department of Health	(96,680)	0
Donation of non-current assets	2,598	0
Asset revaluation decrements	(10,900)	0
Superannuation liabilities assumed by the Treasurer	(23,285)	(95,687)
Resources received free of charge	(5,500)	(5,000)
Other	0	2
Net cost of services (Statement of Financial Performance)	(1,979,634)	(1,887,465)
c) **Notional cash flows**		
Output appropriations as per Statement of Financial Performance	1,971,601	1,498,063
Capital appropriations as per Statement of Financial Performance	0	43,936
Capital appropriations credited directly to Contributed Equity	70,498	0
	2,042,099	1,541,999
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest paid to Department of Treasury & Finance	(117,462)	(131,560)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(41,815)	(9,913)
Capital user charge	(96,680)	0
Other non cash adjustments to appropriations	(122,700)	(30,495)
	(378,657)	(171,968)
Output appropriations as per Statement of Cash Flows	1,663,442	1,370,031
Note 28 Revenue, public and other property written off or presented as gifts		
a) Public and other property written off.	28,830	0

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

Note 29 Remuneration of members of the accountable authority and senior officers

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

	2001/02	2000/01
$60,001 - $70,000	1	1
Total	1	1

	$	$
The total remuneration of senior officers is:	60,636	60,530

Note 30 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 $
Expenditure			
Fees for visiting medical practitioners	21,800	29,683	(7,883)
Superannuation expense	122,039	96,257	25,782
Patient support costs	175,403	210,805	(35,402)
Repairs, maintenance and consumable equipment expense	62,390	157,301	(94,911)

Explanation of Variances	
Fees for visiting medical practitioners	Reduced inpatient and outpatient activity.
Superannuation expense	Increase rate of non-contributions.
Patient support costs	Reduced inpatient and outpatient activity, resulting in reduced consumables.
Repairs, maintenance and consumable equipment expense	Prior year expenditure on Lady Brand Lodge, auto doors, security system nurse call system and upgrade to supervisors flat.

Revenue			
Patient charges	168,874	209,770	(40,896)
Interest revenue	1,519	2,824	(1,305)
Other revenues from ordinary activities	45,697	38,490	7,207

Explanation of Variances	
Patient charges	Reduced private inpatient activity and reduced no of bed days at Lady Brand Lodge.
Interest revenue	Reduced amount of cash held at bank.
Other revenues from ordinary activities	Final transfer of funds from Lady Brand Lodge.

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

	2001/02 Actual $	2001/02 Estimate $	Variation $
Expenditure			
Visiting medical officers	21,800	27,000	(5,200)
Superannuation	122,039	90,000	32,039
Patient support costs	175,403	146,000	29,403
Repairs and mainenance	62,390	45,000	17,390
Other expenses	96,434	85,000	11,434

Explanation of Variances	
Fees for visiting medical practitioners	Reduced inpatient and outpatient activity.
Superannuation expense	Increase rate of non-contributions.
Patient support costs	The estimate was reduced due to the expectation of reduced costs with the integration of the Lady Brand Lodge
Repairs, maintenance and consumable equipment expenses	Required to replace the Hot water rings on Hospital, cost $21,000.
Other Expenses	The estimate was reduced due to the expectation of reduced costs with the integration of the Lady Brand Lodge.

	2001/02 Actual $	2001/02 Estimate $	Variation $
Revenue			
Patient charges	168,874	210,000	(41,126)
Other revenue	45,697	20,000	25,697

Explanation of Variances

Patient charges	Reduced private inpatient activity and reduced no of bed days at Lady Brand Lodge.
Other revenues from ordinary activities	Final transfer of funds from Lady Brand Lodge

Note 31 Commitments for Expenditure

	2001/02 $	2000/01 $
b) **Operating lease commitments:** Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	9,459	4,037
Later than one year, and not later than five years	381	0
	9,840	4,037

These commitments are all inclusive of GST.

Note 32 Contingent liabilities

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

Note 33 Events occurring after reporting date

The North Midlands Health Service 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 34 Related bodies

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

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

Note 35 Affiliated bodies

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

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

Note 36 Financial instruments

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

	Weighted average effective interest rate %	Variable interest rate $000	Fixed interest rate maturities: Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2002							
Financial Assets							
Cash assets	2.5%	24	0	0	0	0	24
Receivables	0.0%	0	0	0	0	20	20
		24	0	0	0	20	44
Financial Liabilities							
Payables	0.0%	0	0	0	0	29	29
Interest-bearing liabilities							
- Department of Treasury & Finance	8.6%	0	44	1,192	0	0	1,236
Accrued salaries	0.0%	0	0	0	0	22	22
Provisions	0.0%	0	0	0	0	264	264
		0	44	1,192	0	315	1,551
Net financial assets / (liabilities)		24	(44)	(1,192)	0	(295)	(1,507)

Note 36 Financial instruments (continued)

	Weighted average effective interest rate %	Variable interest rate $000	Fixed interest rate maturities: Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2001							
Financial Assets							
Cash assets	0.0%	23	0	0	0	0	23
Receivables	0.0%	0	0	0	0	38	38
		23	0	0	0	38	61
Financial Liabilities							
Payables	0.0%	0	0	0	0	60	60
Interest-bearing liabilities							
- Department of Treasury & Finance	8.9%	0	29	1,248	0	0	1,277
Accrued salaries	0.0%	0	0	0	0	19	19
		0	29	1,248	0	79	1,356
Net financial assets / (liabilities)		23	(29)	(1,248)	0	(41)	(1,295)

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 37 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	190	187	697	685	380	374	1,268	1,246
Fees for visiting medical practitioners	3	4	12	16	7	9	22	30
Superannuation expense	18	14	67	53	37	29	122	96
Patient support costs	26	32	96	116	53	63	175	211
Patient transport costs	6	6	21	23	11	13	38	42
Borrowing costs expense	19	20	70	72	38	39	126	132
Repairs, maintenance and consumable equipment	9	24	34	87	19	47	62	157
Depreciation expense	23	18	86	66	47	36	156	119
Net loss on disposal of non-current assets	5	2	15	9	8	5	28	16
Asset revaluation decrement	2	0	6	0	3	0	11	0
Capital user charge	15	0	53	0	29	0	97	0
Other expenses from ordinary activities	14	14	50	50	28	27	92	91
Total cost of services	331	321	1,208	1,177	659	642	2,198	2,140
Revenues from Ordinary Activities								
Patient charges	25	31	93	115	51	63	169	210
Commonwealth grants and contributions	0	0	0	0	0	0	0	1
Donations revenue	0	0	2	0	1	0	3	1
Interest revenue	0	0	1	2	0	1	2	3
Other revenues from ordinary activities	7	6	25	21	14	12	46	38
Total revenues from ordinary activities	33	38	120	139	66	76	219	252
NET COST OF SERVICES	**298**	**283**	**1,087**	**1,038**	**594**	**566**	**1,979**	**1,887**
Revenues from Government								
Output appropriations	296	225	1,084	824	591	449	1,972	1,498
Capital appropriations	0	7	0	24	0	13	0	44
Assets assumed	94	11	343	40	187	22	623	73
Liabilities assumed by the Treasurer	3	14	13	53	7	29	23	96
Resources received free of charge	1	1	3	3	2	2	5	5
Total revenues from government	394	257	1,443	944	787	515	2,624	1,716
Change in net assets	**96**	**(26)**	**356**	**(94)**	**194**	**(51)**	**645**	**(172)**

Note 37 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).