Northampton Kalbarri Health Services

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 Northampton Kalbarri Health Services for the year ended 30 June 2002.

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

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

ANNUAL REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mike Daube
DIRECTOR GENERAL

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Address and Location

Northampton Kalbarri Health Service
Northampton Hospital
Stephen St
NORTHAMPTON WA 6535

☎ *(08) 9934 1002*
℻ *(08) 9934 1414*

The Northampton Kalbarri Health Service also includes the following health care unit:

Kalbarri Health Centre
Corner of Glass St and Kaiber St
KALBARRI WA 6536

☎ *(08) 9937 0100*
℻ *(08) 9937 0105*

Mission Statement

Our Mission
To work with the community to provide services which enable the people to achieve their best possible health and well being

Broad Objectives

The objectives of the Northampton Kalbarri Health Service are:

- To increase the number of Aged Care Units at Northampton by four and commence planning strategies to build a unit attached to the Kalbarri Health Centre.
- To expand palliative care and outreach services by providing extensive staff cover and resources.
- To enhance the volunteer program by providing more carers for home and palliative care.
- To raise community awareness of family and domestic violence.

Enabling Legislation

The Northampton Kalbarri 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 Northampton Kalbarri 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 Northampton Kalbarri Health Service operations during 2001/2002.

Submission of Annual Report

Approval was sought under the *Financial Administration and Audit Act 1985* to extend the Northampton Kalbarri 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 Northampton Kalbarri 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 Northampton Kalbarri 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 Northampton Kalbarri Health Service published in accordance with Section 175ZE of the *Electoral Act 1907*.

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies			
— Midwest Times	–	180.00	–
— WA Newspapers	–	353.80	1000.00
— Beemac Printers	–	2053.70	–
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations	–	–	–
Media Advertising Organisations	–	–	–
TOTAL	**–**	**$2587.50**	**$1000.00**

Freedom of Information Act 1992

The Northampton Kalbarri 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 Northampton Kalbarri 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
Northampton Hospital
Stephen St
PO Box 400
NORTHAMPTON WA 6535

☎ *(08) 9934 1002*

Northampton Kalbarri Health Service

Key Operations and Achievements

- The Health Service is entering its third term as a Multi Purpose Site.
- The Aged Care Unit located at Northampton has remained fully occupied.
- A positive independent assessment was received for Aged Care Services (Brookview Aged Care Unit).
- Community Health Nurses have achieved community awareness with various programs.
- Data collection for the State Injury Surveillance Survey has been completed.
- A commitment to student placement continues.

Third Term as a Multi Purpose Site

The Northampton Kalbarri Health Service commences its third term as a Multi Purpose Site with the renewal of the agreement due in July 2002. Volunteer activity assistants have been utilised in the Aged Care Unit four days a week to assist residents with activities and an exercise program. In-hospital respite care continues to increase. An admission package and agreement has been developed for respite clients. A therapy assistant has been employed in Kalbarri following a positive appraisal of the Therapy Assistant Program.

Northampton Aged Care Unit Fully Occupied

The Aged Care Unit located at Northampton has remained fully occupied as well as providing for Care Awaiting Placement patients in the acute section of the Hospital for most of the year. A respite bed has been occupied a third of the year with the occasional emergency respite occupying a second bed. Planning meetings continue to address the short- and long-term needs for extra aged care beds at both Northampton and Kalbarri. Funding is required for access to Community Aged Care Packages. The waiting list for aged care placement continues with three or four clients awaiting placement in Brookview. Several Northampton residents have been placed in Geraldton beds and wish to return to Northampton. Several Kalbarri residents have sought placement in other locations. Four units are needed at Northampton of which one bed will be utilised for respite care, and six new units attached to the Centre at Kalbarri are required.

Positive Independent Assessment for Brookview

A positive report was received from an independent assessor for Aged Care Services (Brookview Aged Care Unit). Recommendations made have been implemented with several under review for implementation. The Health Service continues to strive to provide the best possible care for its residents. The Northampton Seniors Liaison Group has made application for land adjacent to the hospital for a joint venture with the Shire and Homeswest to build units for seniors. The Minister has approved the transfer of land. Palliative care admissions and home care services have increased markedly. Home care services have been introduced for palliative care patients with the assistance of Home and Community Care, Outreach Services and volunteers.

Community Awareness Programs
Community health nurses have achieved community awareness with various programs, including Positive Parenting, forming a Family and Domestic Violence Group in Northampton, with ambitions of obtaining a 'safe house', Men's Health Days at both sites, Mums and Bubs Day in conjunction with Mental Health — self-esteem and weight loss after childbirth. A *Beach and Bush Safety* brochure for the treatment of bites and stings was published and widely distributed. Workshops for community health nurses have been attended following the New Vision for Community Health release.

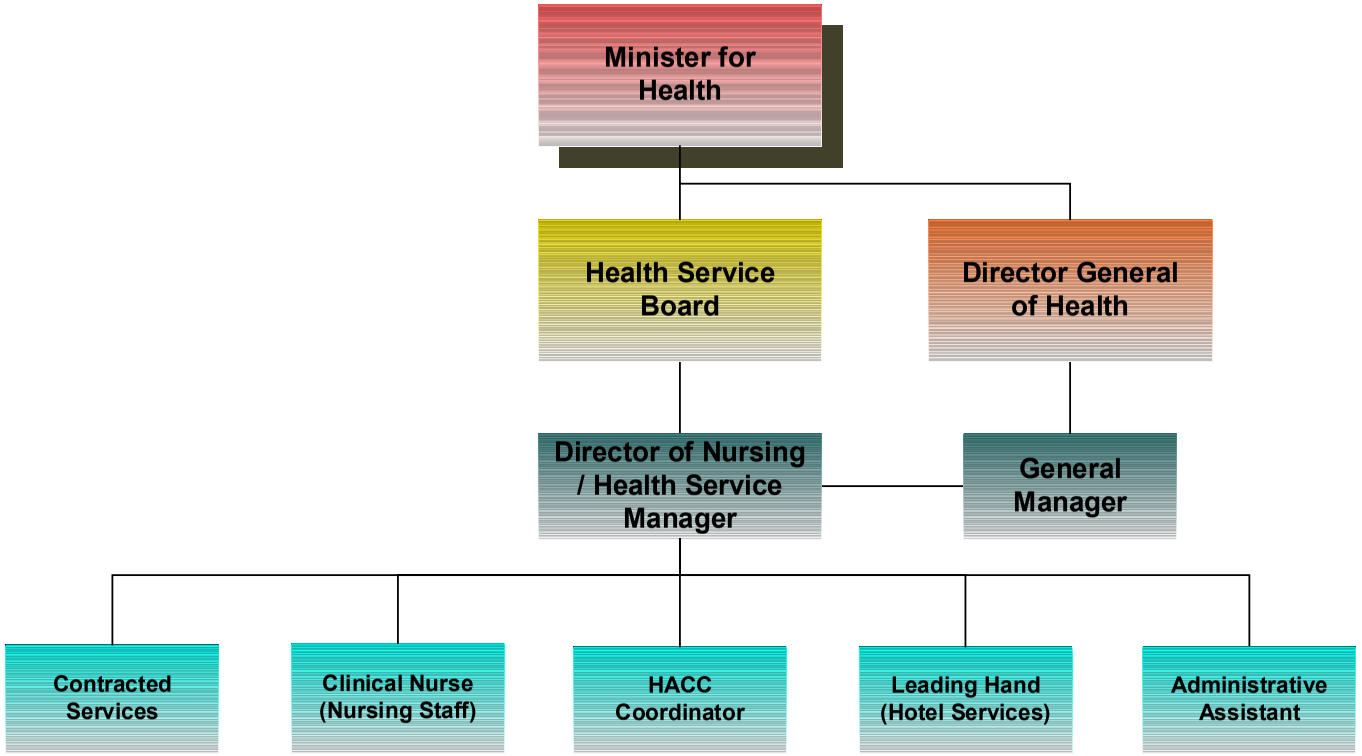
State Injury Surveillance Survey
Data collection for the State Injury Surveillance Survey to determine alcohol-related injuries in the community has been completed, the Alcohol and Other Drugs Module was introduced and Telehealth ports are installed at both sites. Access via Telehealth to specialist health services for the rural areas will increase quality of care and efficiency of health services. Education and training will be easily accessed and planning and management through video conferencing will decrease time spent travelling.

Student Placement
A commitment to student placement continues. This currently includes medical students (John Flynn Scholarship) and registered nurses — postgraduates from Geraldton Regional Hospital and students from TAFE, Curtin and Edith Cowan Universities — with Kalbarri now able to participate due to availability of accommodation.

Major Capital Projects

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

Organisational Chart



Accountable Authority

The Northampton Kalbarri 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
Allan Putland	Chairperson	30 June 2002
Jenny Teakle	Deputy Chairperson	30 June 2002
Iris Annear	Member	30 June 2002
Brian Baldock	Member	30 June 2002
Joyce Lennard	Member	30 June 2002
Dennis O'Brien	Member	30 June 2002
Gordon Patrick	Member	30 June 2002
Dorothy Shepherd	Member	30 June 2002

Note: The Governor in Executive Council approved the amalgamation of several hospital boards including the Northampton Kalbarri 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 Northampton Kalbarri Health Service 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	Marie Grant	Acting

Pecuniary Interests

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

Demography

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

- Northampton Shire
- Chapman Valley Shire

The following table shows population figures for each local authority within the Northampton Kalbarri region:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Northampton Shire	3021	3325	3299
Chapman Valley Shire	837	883	1199

*Data sources:

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

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

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

The Northampton Kalbarri Health Service covers the Shire of Northampton. Its major sites are Northampton and Kalbarri. Minor town sites include Horrocks Beach, Port Gregory, Binnu and Ajana. Yuna and Nabawa in the Shire of Chapman Valley also use the Health Service.

Northampton is reported as having one of the greatest increasing aged populations in the State, and Kalbarri is one of the fastest growing towns with a high percentage of retirees. This is reflected in the demand on services for the aged.

The shire covers 13,513 square kilometres and its core businesses are farming, fishing and tourism.

Available Services

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

Direct Patient Services
Aboriginal Health (Northampton)
Accident and Emergency
Child Health
Continence Services
Diabetic Services
General Medical
General Paediatric
Immunisation
Mental Health
Obstetric Care (Level 1)
Outpatient Services
Palliative Care
Residential Aged Care (Northampton)
Respite Care

Medical Support Services
ACAT
Asthma Education
COMPARI
Dental (Kalbarri) – Private
Dietetics
Family Children's Services
Medical Imaging
Occupational Therapy
Pathology (Geraldton)
Pharmacy (Geraldton)
Physiotherapy
Podiatry – Private
Social Work
Speech Pathology
Therapy Assistants

Community Services
Aboriginal Health
Child Development
Community Health
Exercise Programs
Extended Care
Health Promotion
Home Care
Meals on Wheels
Outreach Services
Palliative Care
Primary Health Care
School Health

Other Support Services
CSSD (Geraldton)
Hotel Services
Medical Records

Specialist Services
None

Other Services
None

Customer Group Outcomes

- All staff wear name badges.
- Development of Outpatient Satisfaction Surveys. Inpatient and Outpatient surveys presented in a user-friendly pamphlet form for feedback on services.
- Inpatient information booklets published.
- Publication of information brochures for both Northampton and Kalbarri centres.

- Newsletter articles are provided for the *Northampton News* and the *Kalbarri Town Talk.*
- A quarterly newsletter is produced for Brookview Aged Care Residents and their relatives/carers.
- Flexible service delivery is provided relating to community needs.

Disability Services

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

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

- The Health Service has continued to adapt to accommodate the needs of people with disabilities, particularly with 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.

- The 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 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.

- The 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 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 also under review to reflect the changing needs of people with disabilities. Information concerning disability services are 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.

- The 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 the development of processes for consultation with people with disabilities has been introduced to enhance this outcome further.

Future Direction
The Northampton Kalbarri 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

The Northampton Kalbarri Health Service supports the principles of incorporating diversity into mainstream service planning, delivery and evaluation for culturally and linguistically diverse people.

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

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

- 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.

Youth Services

The Northampton Kalbarri 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 that 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 the area and leaving the area for work opportunities.

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

The Northampton Kalbarri 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 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 continues with great success during this period.

Employee Profile

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	19.28	20.46	22.32
Administration and Clerical*	2.68	2.84	3.01
Medical Support*	4.02	4.11	3.96
Hotel Services*	10.71	11.15	11.55
Maintenance	–	–	–
Medical (salaried)	–	–	–
Other	–	–	–
TOTAL	**36.69**	**38.56**	**40.84**

*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, HACC
- **Hotel Services** -— cleaners, caterers and patient service assistants.

Recruitment Practices

Recruitment and retainment of staff have been adequate to maintain service delivery in all areas. Gratuity payments have been continued in the new Australian Nursing Federation EBA for Registered Nurses as an incentive.

A part-time Therapy Assistant position was introduced at Kalbarri.

Staff Development

All Staff have completed mandatory education sessions.

- Patient Care Assistant training courses are ongoing at both sites.
- First Aid Courses for non-nursing staff, were conducted at Northampton and Kalbarri.
- Palliative Care Education Course for staff at both sites were completed.
- A Graduate Registered Nurse was employed at Northampton Kalbarri for 10 weeks.
- Telehealth training for all staff is ongoing.
- Defibrillation training is ongoing for all new staff.
- Health Care And Related Information Systems' Ambulatory, Other Patient and Domiciliary training is conducted for administration and nursing staff.

Industrial Relations Issues

- The Registered Nurses EBA was accepted. Gratuity Payment will continue.
- Hospital Salaried Officers Association negotiations were completed.
- There were no industrial issues this term.

Workers' Compensation and Rehabilitation

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	0	2	2
Administration and Clerical*	0	0	0
Medical Support*	0	0	0
Hotel Services*	0	2	2
Maintenance	0	0	0
Medical (salaried)	0	0	0
Other	0	1	0
TOTAL	**0**	**5**	**4**

*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, HACC.
- **Hotel Services** — cleaners, caterers and patient service assistants.

Manual handling and occupational safety and health sessions are compulsory for all staff. Risk management is incorporated into work practices and hazard identification is in place. The Occupational Safety and Health committee continues to assess all injuries and take action wherever possible. Equipment has been purchased for a No Lift policy to be implemented. Work site inspections are conducted on a regular basis and maintenance programs ensure a safe work environment for all areas of the Health Service. Immunisation is made available to all staff.

Three Lost Time Injuries occurred. Two were due to patient handling and one to domestic duties.

Equity and Diversity Outcomes

Integration of EEO Outcomes

The Health Service has worked towards the integration of outcomes as contained in the Management Plan. It has ensured that the workplace is free from sexual and racial harassment and free from employment practices that discriminate unlawfully against employees or potential employees. Job description forms have been amended to incorporate this. Education sessions have been attended by relevant staff.

Recruitment protocols ensure there is no discrimination in employment. The Health Service adheres to human resource policies.

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

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

- The Health Service has continued to ensure that discrimination and harassment do not exist in the workplace. No reports have been received of such occurrences. A positive attitude exists.

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

- The Health Service ensures that recruitment and selection procedures are fair and unbiased at all times.

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

- The EEO target group of women is well represented in the Health Service as women are employed in a high percentage of positions as well as in senior management positions. Of the currently employed staff members, one is of Aboriginal or Torres Strait Islander origin, two have disabilities and three are 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 Northampton Kalbarri 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	In Progress
Diversity	Under Review

Marketing

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

- Open public forums were held at Northampton and Kalbarri.
- Auxiliary Committee meetings at both sites were attended by management staff.
- Health Promotion Days were held at both sites.
- Monthly local newsletter articles appeared at both sites.
- Inpatient and Outpatient Satisfaction Surveys were made available.
- Pamphlets were distributed to accommodation outlets on services available.
- The Health Service participated at state MPS network meetings.
- Health Service events were advertised in the community.

Publications

Publications of health services provided at Northampton and Kalbarri sites have been distributed to major outlets, tourist information centres and major accommodation providers, as well as being accessible through the centres.

These brochures are convenient items to provide people with an overview of the Northampton Kalbarri Health Service and have been given to other service providers and bodies such as universities for assistance to students.

Research and Development

Northampton Kalbarri 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 Northampton Kalbarri Health Service carried out no major evaluations during 2001/2002.

Risk Management

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

Strategies and Initiatives
Successful risk management strategies initiated during 2001/2002 include:

- A risk management policy and committee have been established.
- A risk management plan has been developed and is updated on a regular basis.

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

Internal Audit Controls

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

An Audit Committee has been established to oversee the operation of internal audit functions and to ensure that management addresses any findings made by the Health Service's internal and external audits.

Waste Paper Recycling

There is no recycling facility in the Shire. Aluminium cans are collected and taken to Geraldton. Paper is shredded on site and used by staff for mulch and garden compost. Tree trunks and branches are mulched and used in the garden. Disposable napkins are not used. Items for incineration are sent to the plant in Perth. General waste and waste for specialised land fill are dealt with locally.

Pricing Policy

The Northampton Kalbarri 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.

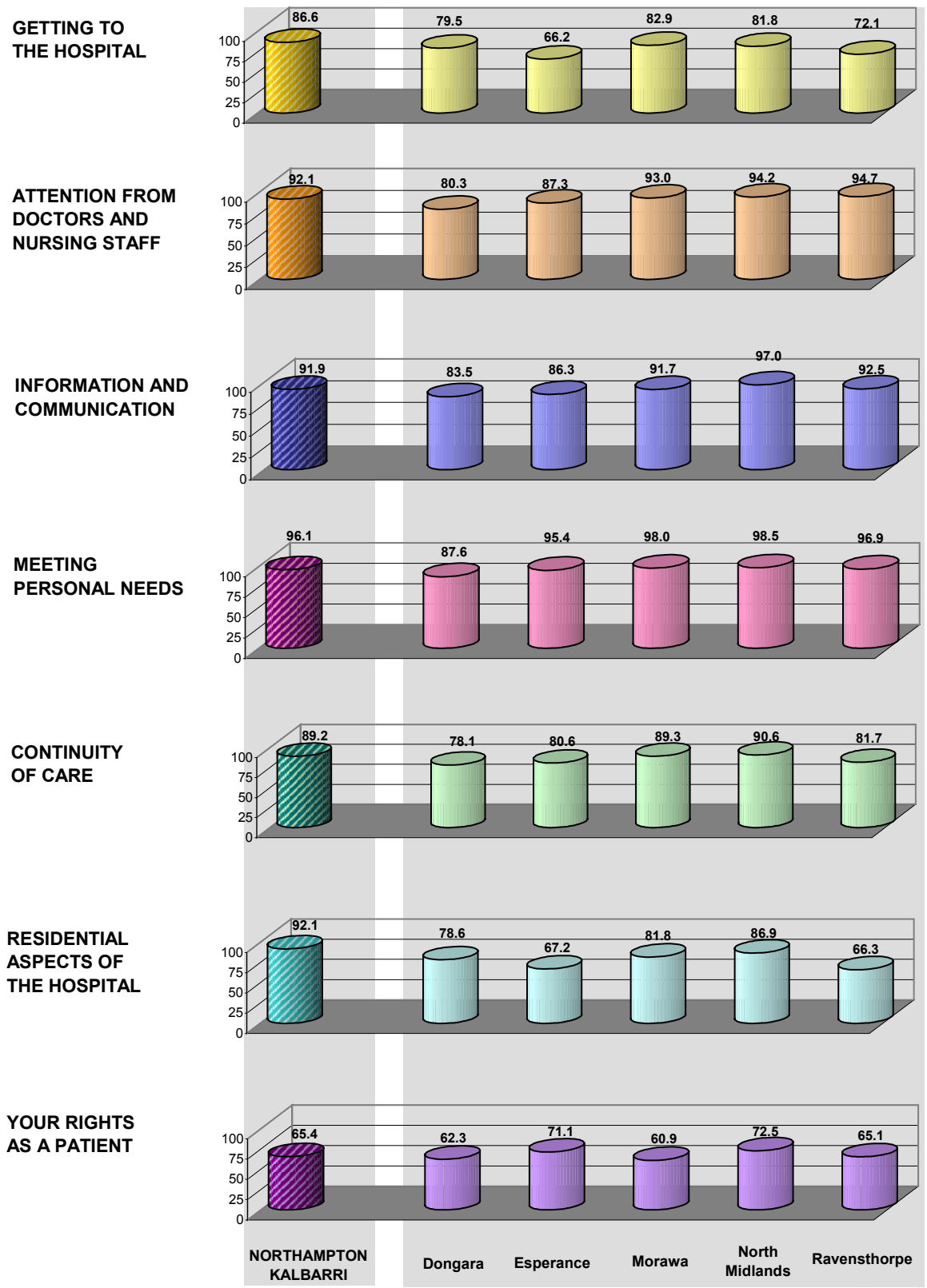
No fees are raised against registered public and private outpatients of the hospital.

Client Satisfaction Surveys

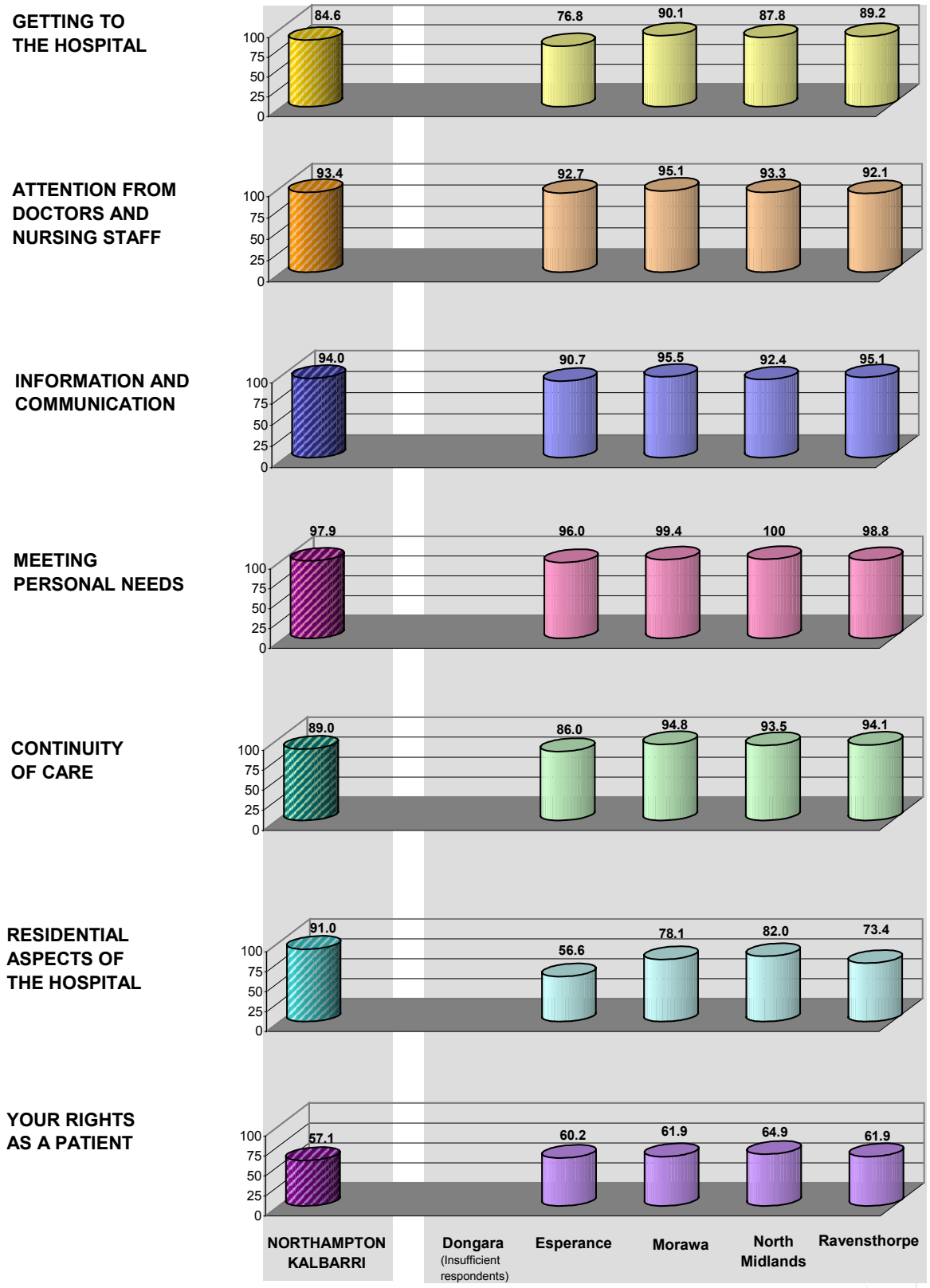
Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey 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 45) of this report.

KPI 2.2: EMERGENCY PATIENTS — RURAL



KPI 2.2: OUTPATIENTS — RURAL



AUDITOR GENERAL

To the Parliament of Western Australia

NORTHAMPTON KALBARRI HEALTH SERVICES
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the key effectiveness and efficiency performance indicators of the Northampton Kalbarri Health Services 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 Northampton Kalbarri Health Services.

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 Northampton Kalbarri Health Services 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

NORTHAMPTON KALBARRI HEALTH SERVICES

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 Northampton Kalbarri Health Services for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Northampton Kalbarri Health Services 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.

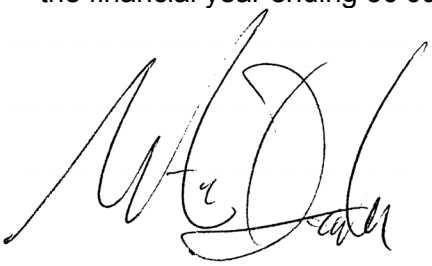
It is anticipated that the opinions will be issued by March 31, 2003.

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

NORTHAMPTON KALBARRI HEALTH SERVICES
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 Northampton Kalbarri Health Services 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.

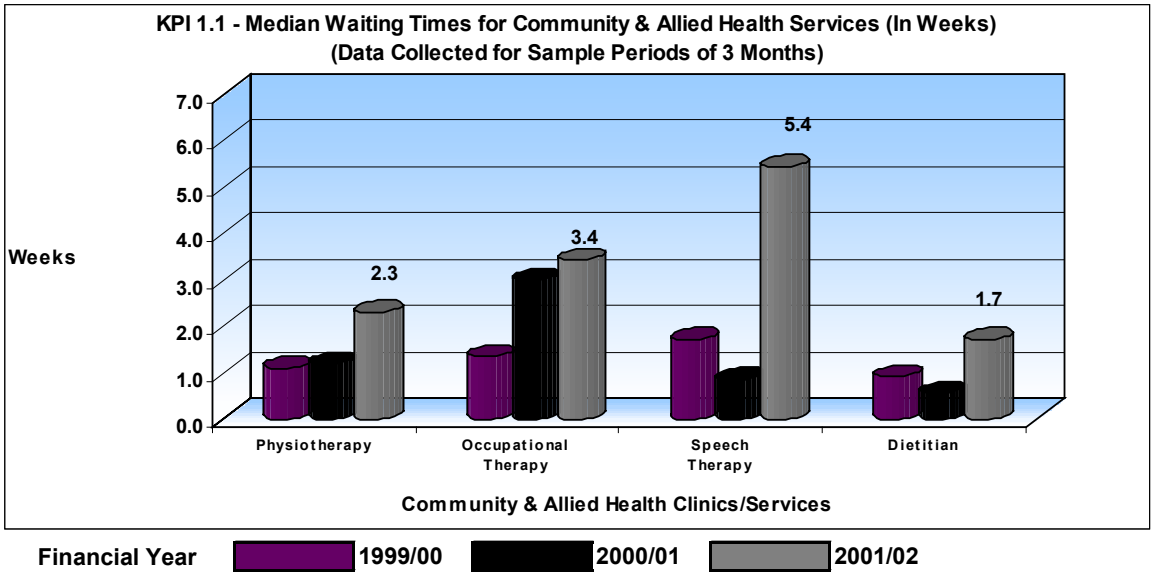
Access to health services are provided on the basis of clinical need but situations where clients are waiting longer than the average may reflect sub-optimal practices or under-resourcing within the organisation.

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

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

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

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

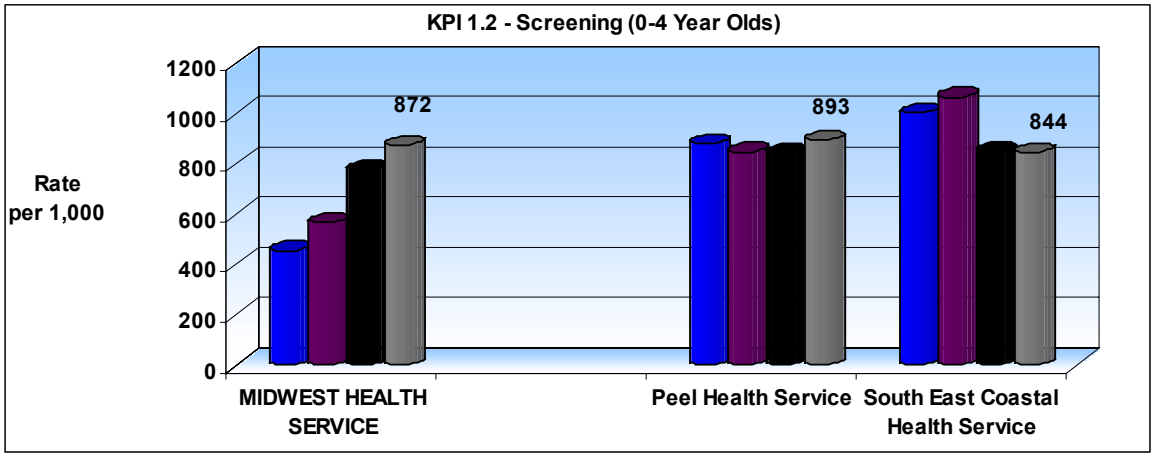
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good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

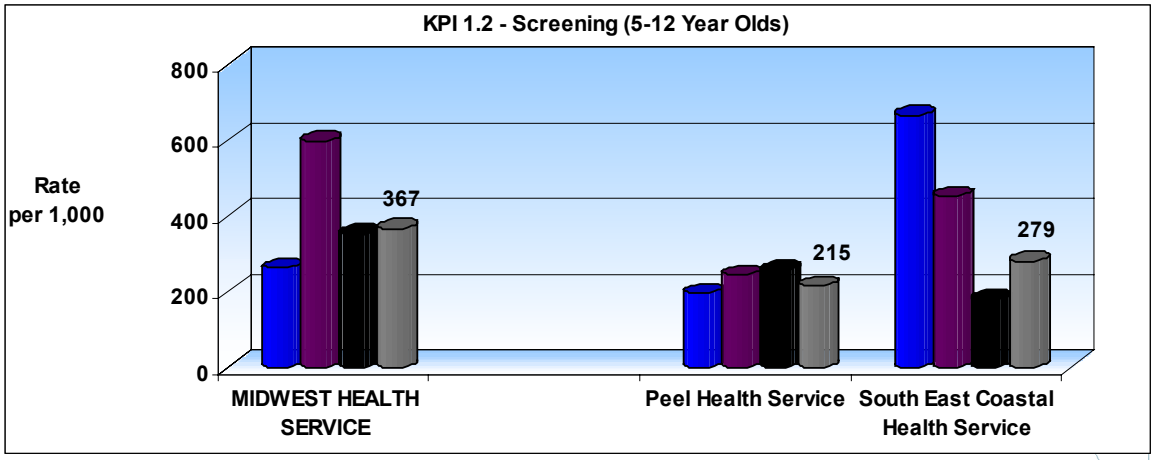
The consequences of any illness or disability not detected by routine screening programs for children are more likely to be permanently disabling or even contribute to their premature death.

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

The rate of childhood screening has steadily increased over the years.

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





Calendar Year 1998 1999 2000 2001

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.

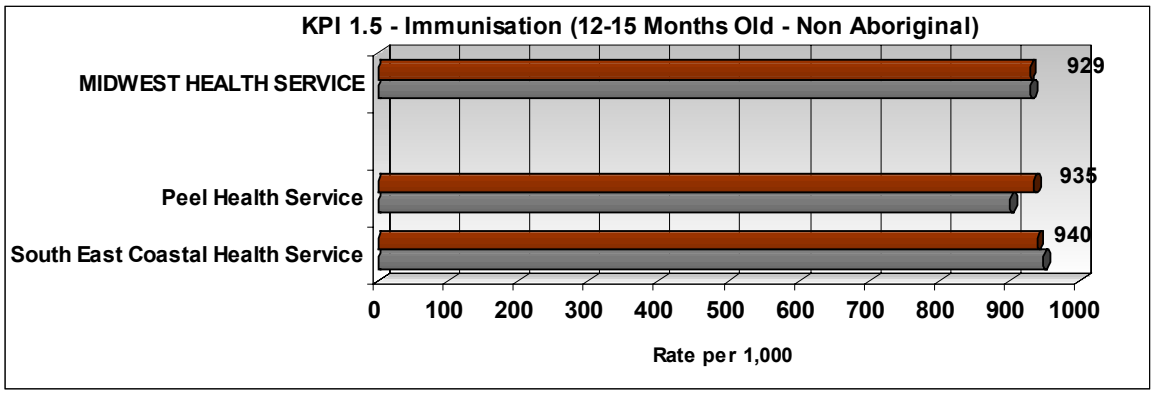
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

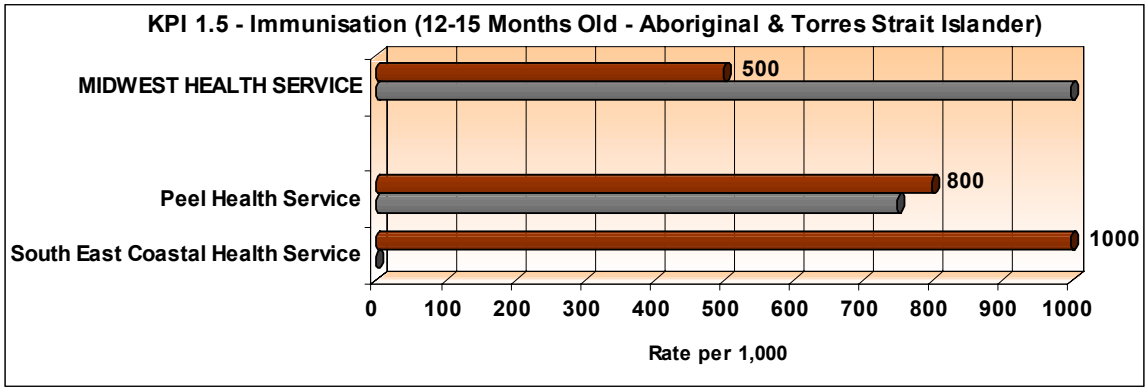
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

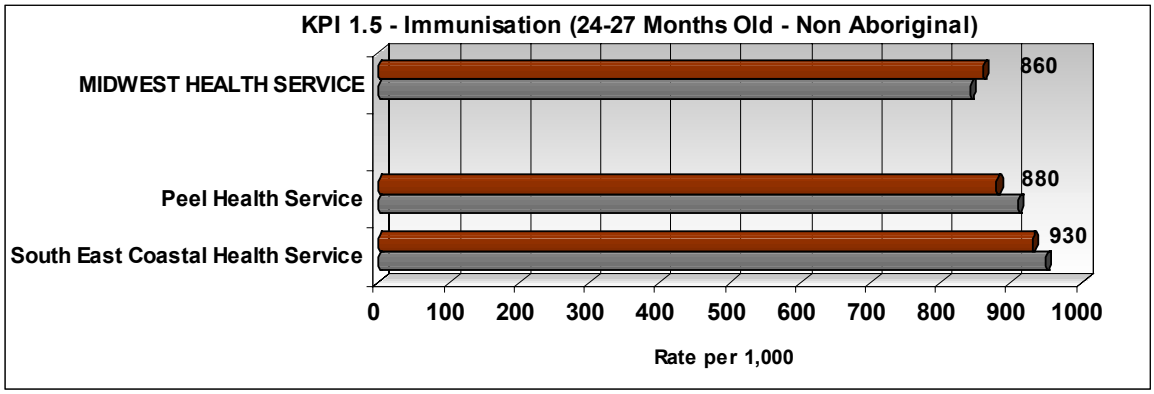
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

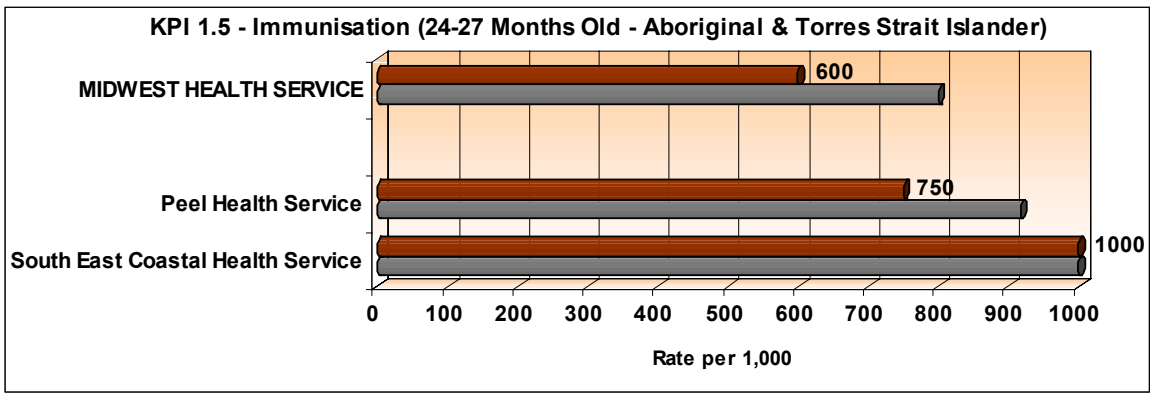
All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the 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 has dropped, however, the small numbers of children involved does not make this variation significant.









Calendar Year 2001 2002

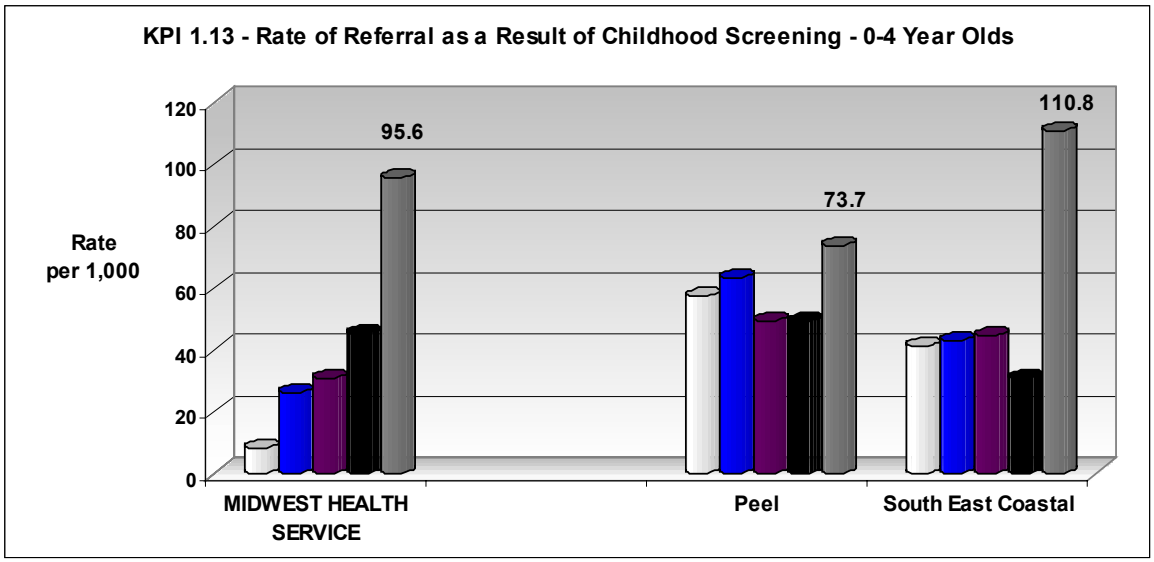
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

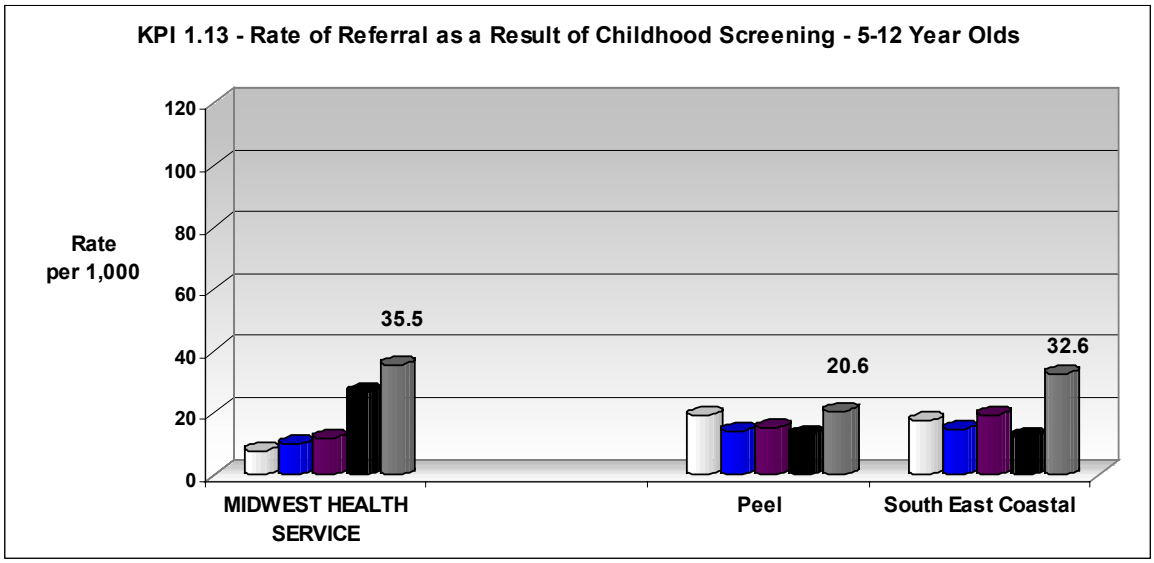
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill but also to maintain a state of 'wellness' that allows them to develop to full potential.

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

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

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.


KPI 1.13 - Rate of Referral as a Result of Childhood Screening - 0-4 Year Olds
Rate per 1,000
120
100
80
60
40
20
0
95.6
73.7
110.8
MIDWEST HEALTH SERVICE
Peel
South East Coastal


KPI 1.13 - Rate of Referral as a Result of Childhood Screening - 5-12 Year Olds
Rate per 1,000
120
100
80
60
40
20
0
35.5
20.6
32.6
MIDWEST HEALTH SERVICE
Peel
South East Coastal

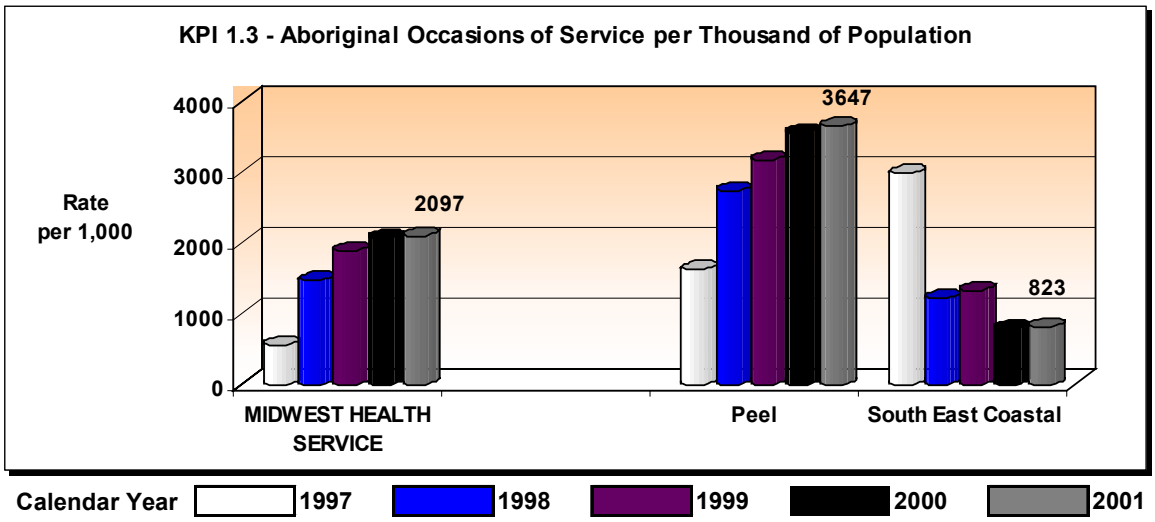

Calendar Year
1997
1998
1999
2000
2001

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

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

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

A rate in excess of 1,000 occurs when individuals attend more than once in a year.



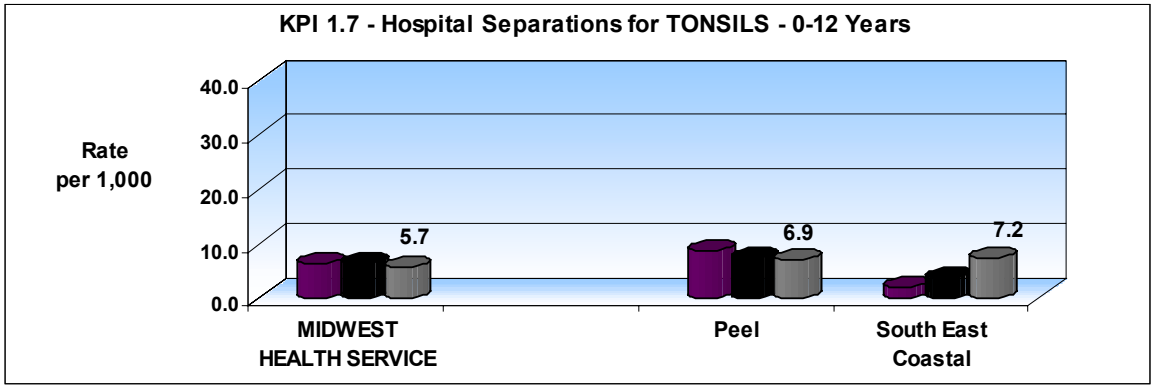
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS — KPI 1.7

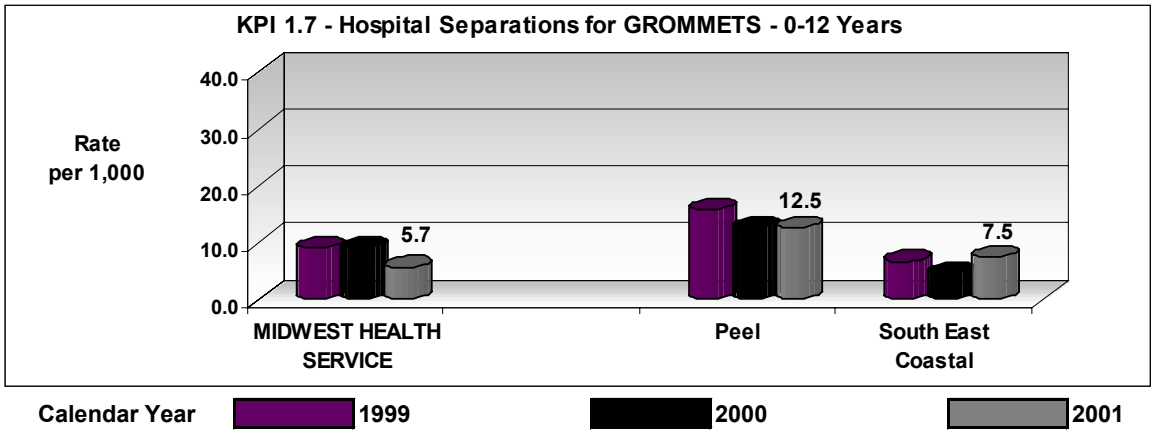
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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

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

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





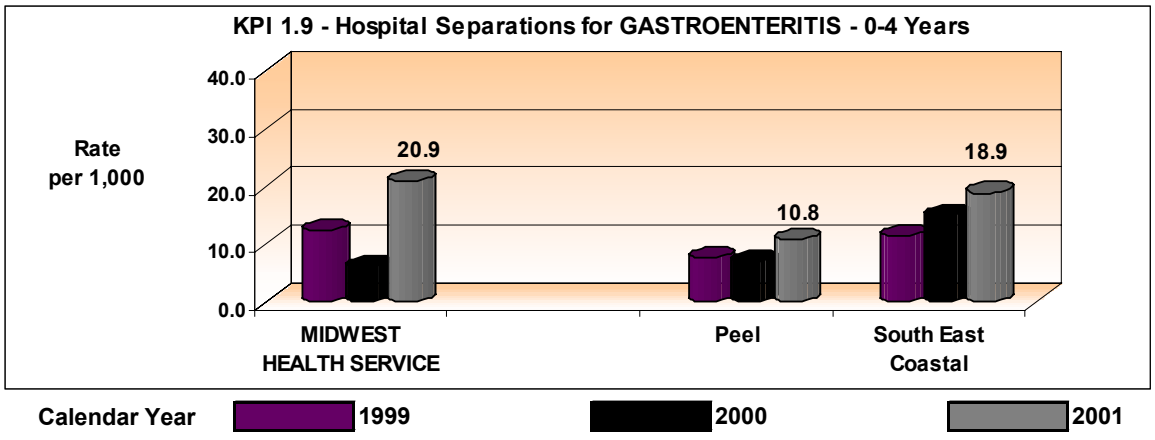
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN | KPI 1.9

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

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

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

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



HOSPITAL SEPARATIONS FOR RESPIRATORY CONDITIONS | KPI 1.10

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

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

Bronchiolitis

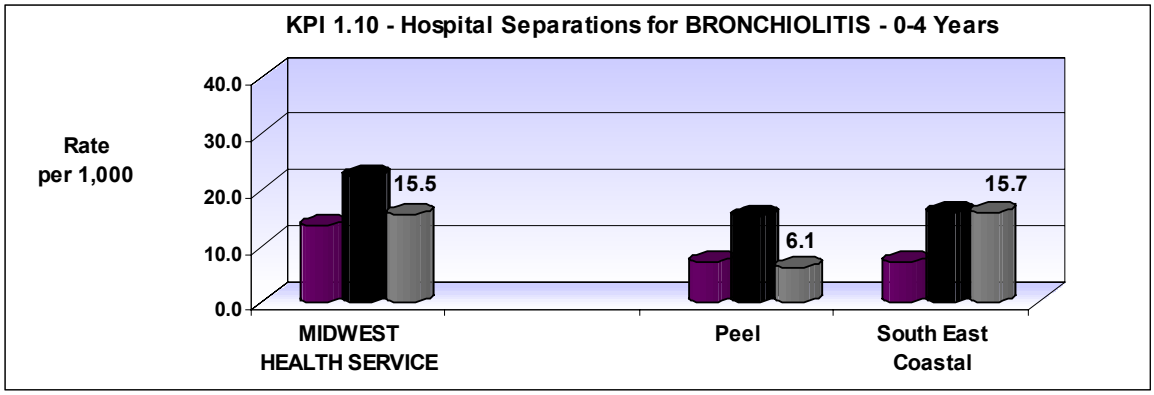
The graph shows individuals aged 0-4. Of those individuals aged 5-12 and 13-18, none were hospitalised this year.

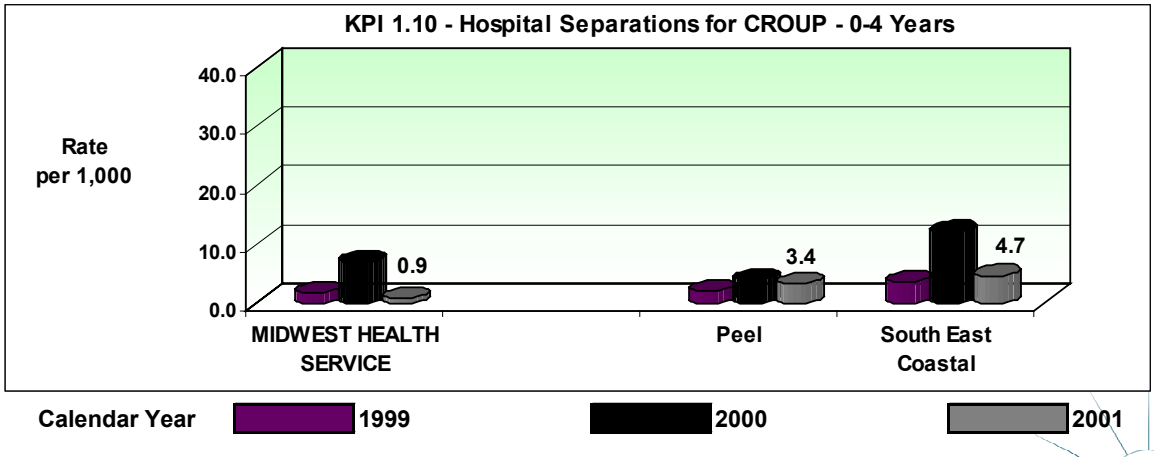
Croup

The graph shows individuals aged 0-4. Of those individuals aged 5-12, only 1 was hospitalised this year, a rate of 1.1 per thousand. Of those aged 13-18 years, 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 being admitted.





HOSPITAL ADMISSIONS FOR ASTHMA	KPI 3.7

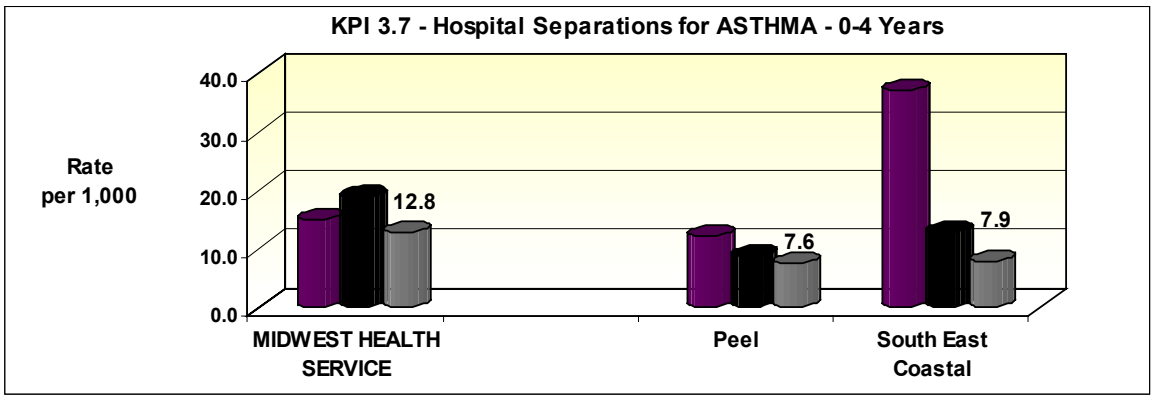
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

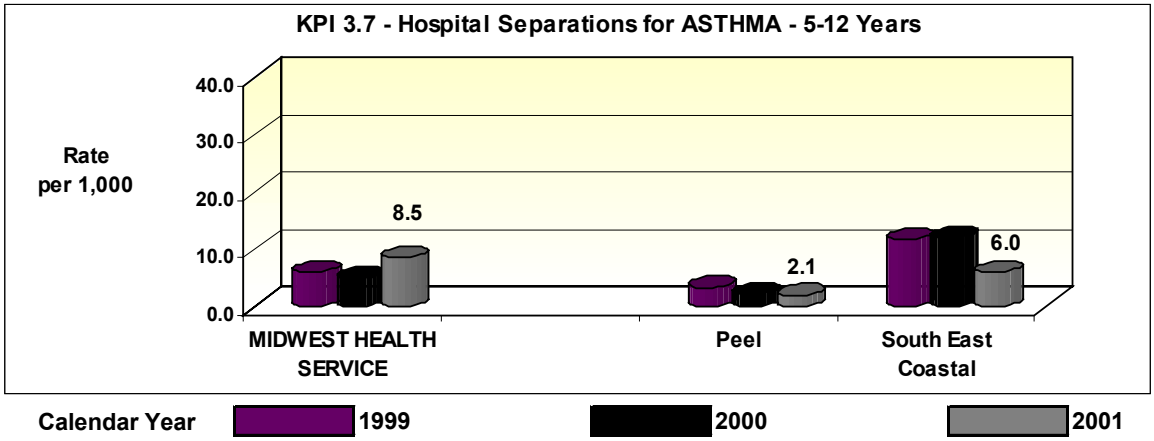
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

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.





COST PER OCCASION OF SERVICE OF COMMUNITY HEALTH SERVICE	KPI 1.14

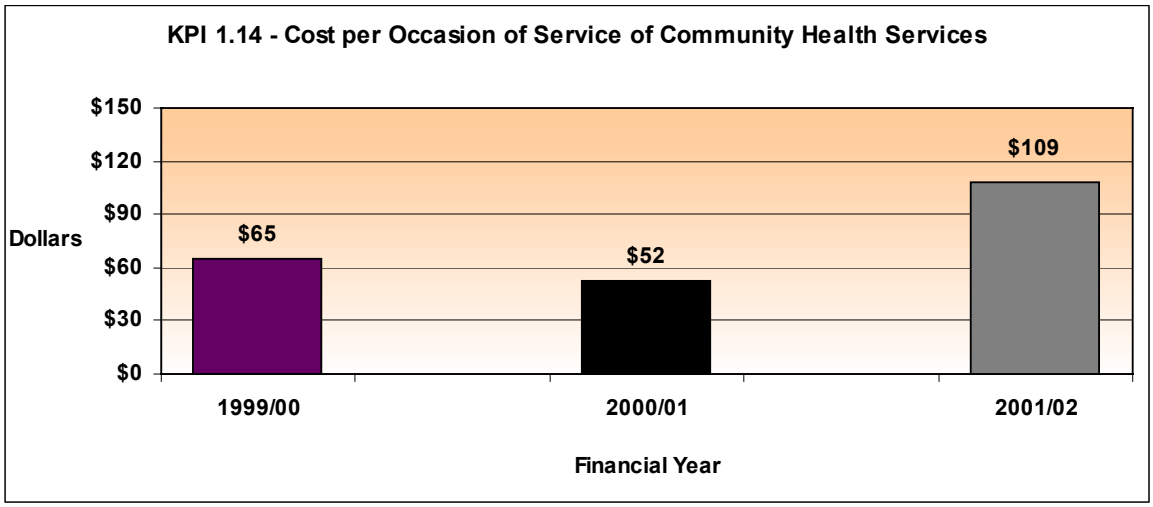
Community health occasions of service measure the provision of primary and community health services undertaken by a range of health service professionals in a community setting, with a focus on improving the overall health of the State population. Child health nursing, clinical psychology, occupational 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 Northampton Kalbarri Health Service achieved an overall satisfaction score of 88 for emergency and 87 for outpatient services over the last financial year.

The standard error for each is 1.38 and 1.78 respectively.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Emergency Patients – Centrally Administered	105	49	47%
Emergency Patients – Hospital Administered	65	42	65%
Outpatients – Centrally Administered	89	38	43%
Outpatients – Hospital Administered	113	22	19%

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.

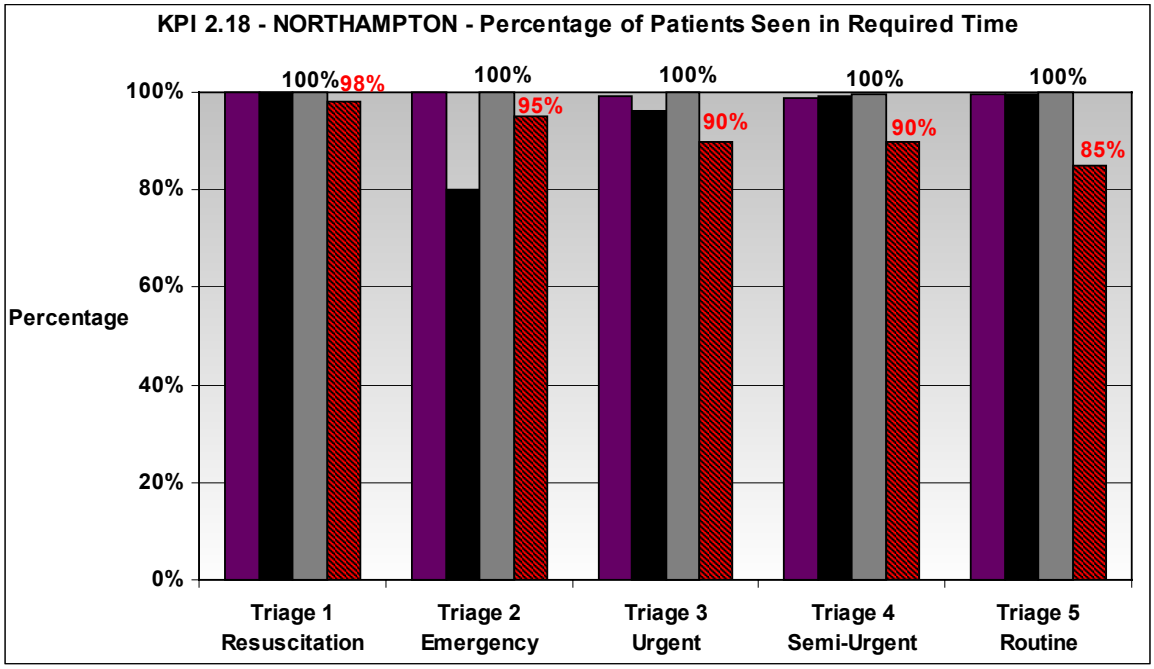
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

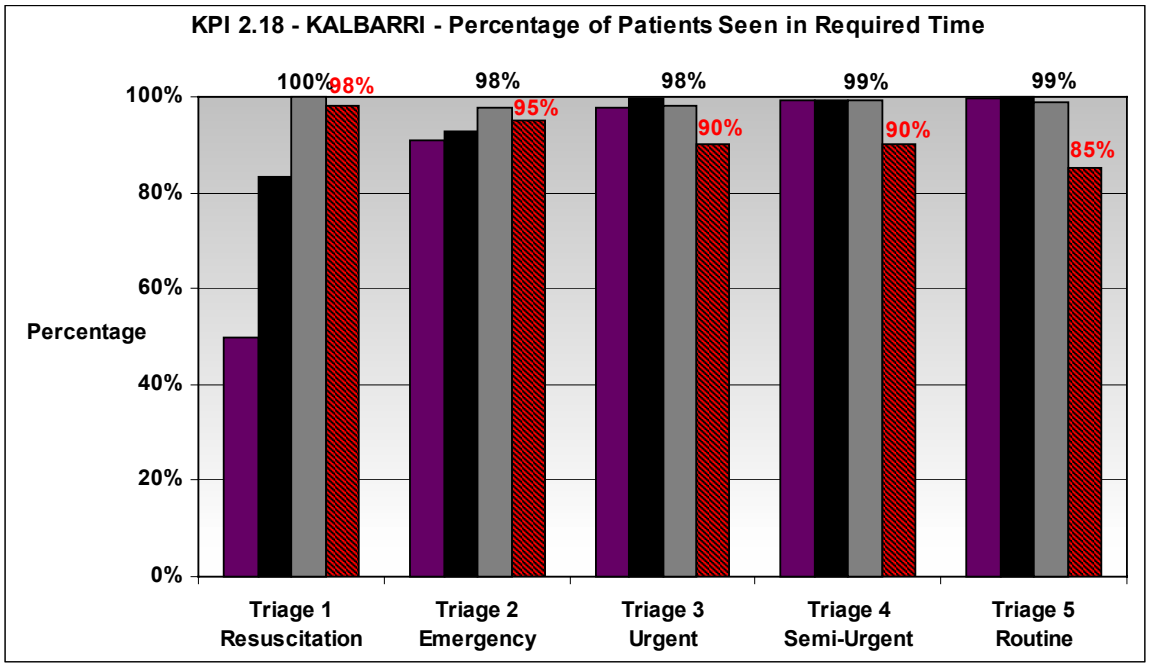
When patients first enter an Emergency Department, they are assessed by nursing staff and allocated a triage code between 1 and 5 that indicates their urgency. This code provides an indication of how quickly patients should be reviewed by medical staff. In rural areas however, where a medical practitioner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





Financial Year 1999/00 2000/01 2001/02

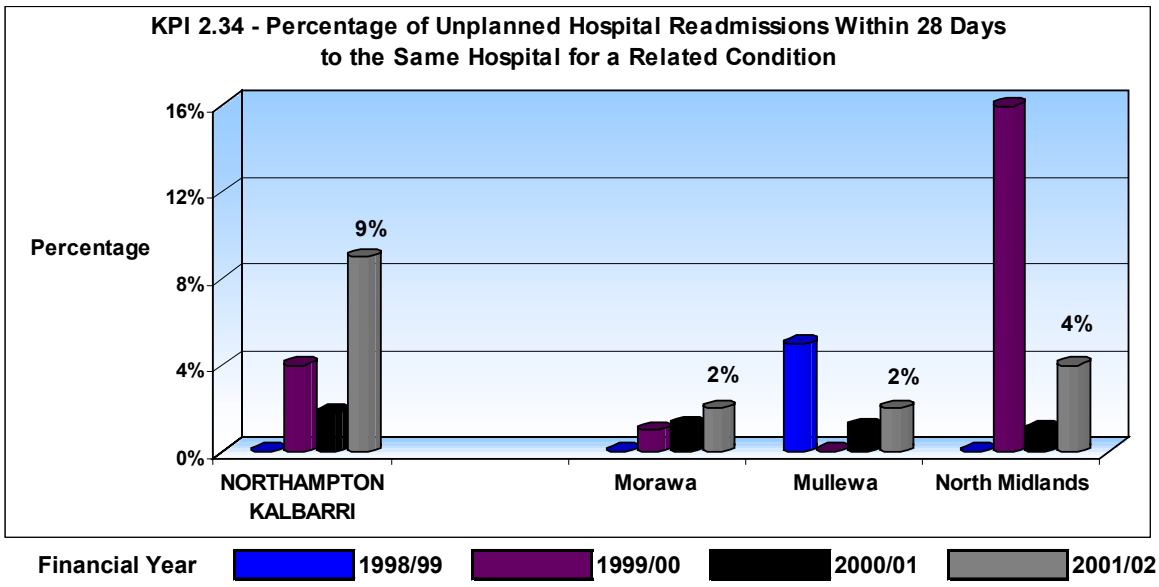
ACEM Threshold Percentage of Each Triage Category

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 increase in admissions within 28 days for a related condition is due to one client being readmitted 7 times.



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.

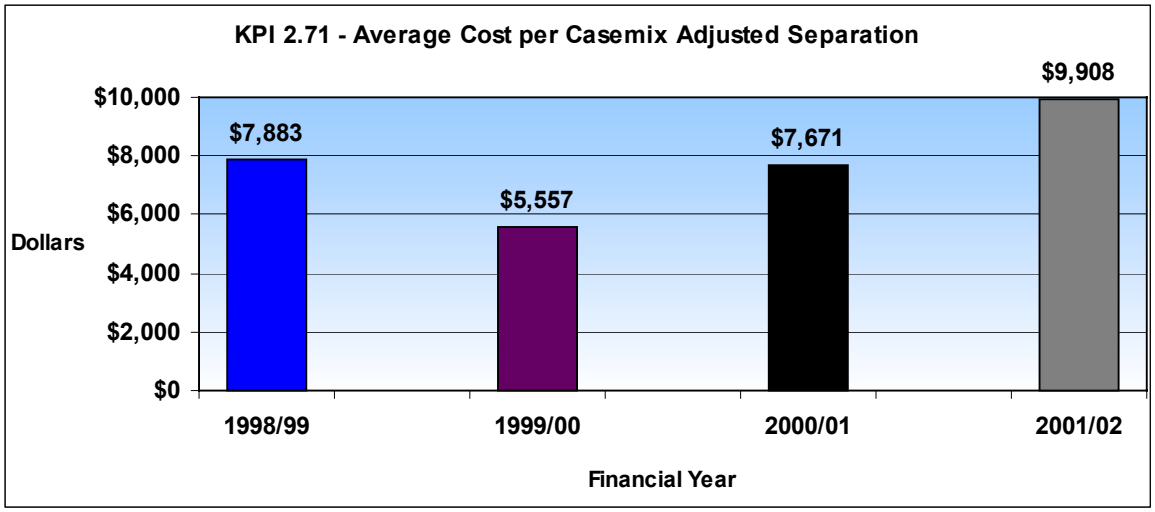
There were no unplanned readmissions within 28 days for treatment and care for a related mental illness in 2001/02

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.



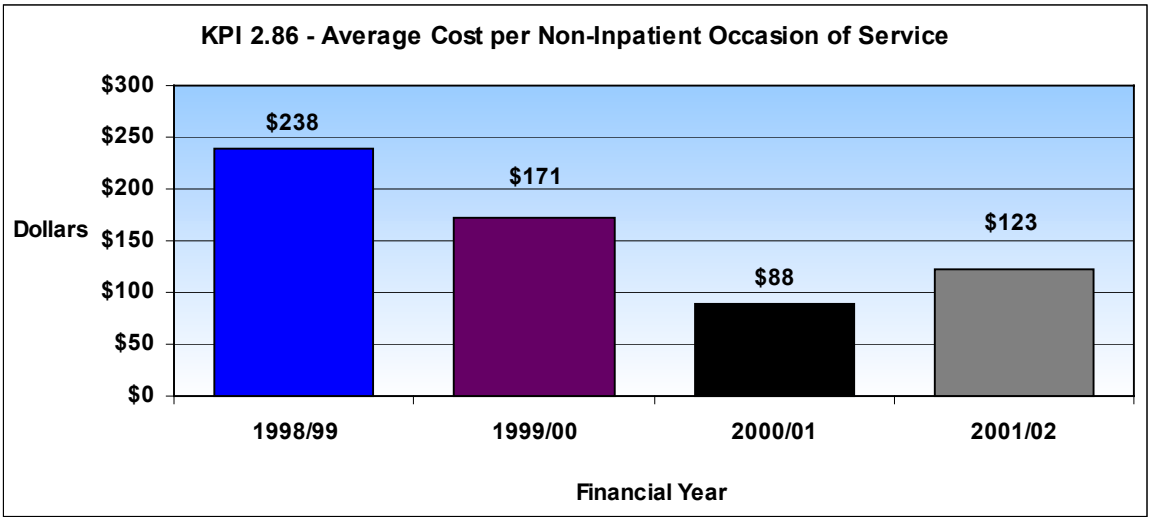
AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

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 increase in average cost per non-inpatient occasions of service is due to the increase in expenditure and a decrease in occasions of service for this year.



KPI 3.7 : Hospital separations for Asthma

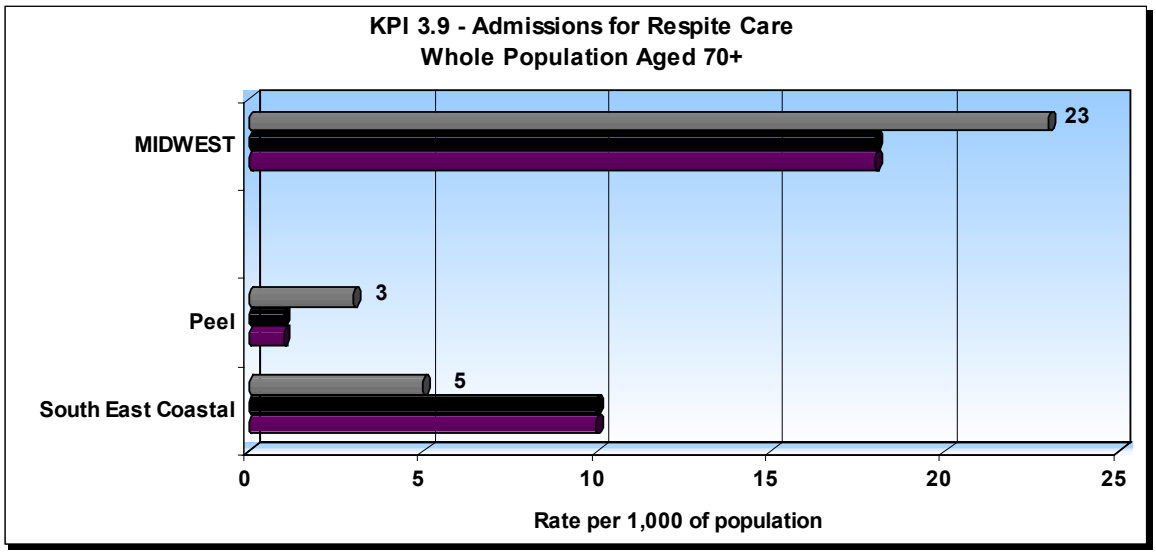
Hospitalisation for acute Asthma is part of managing chronic conditions. The indicator has been moved to Output 1 from Output 3 in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

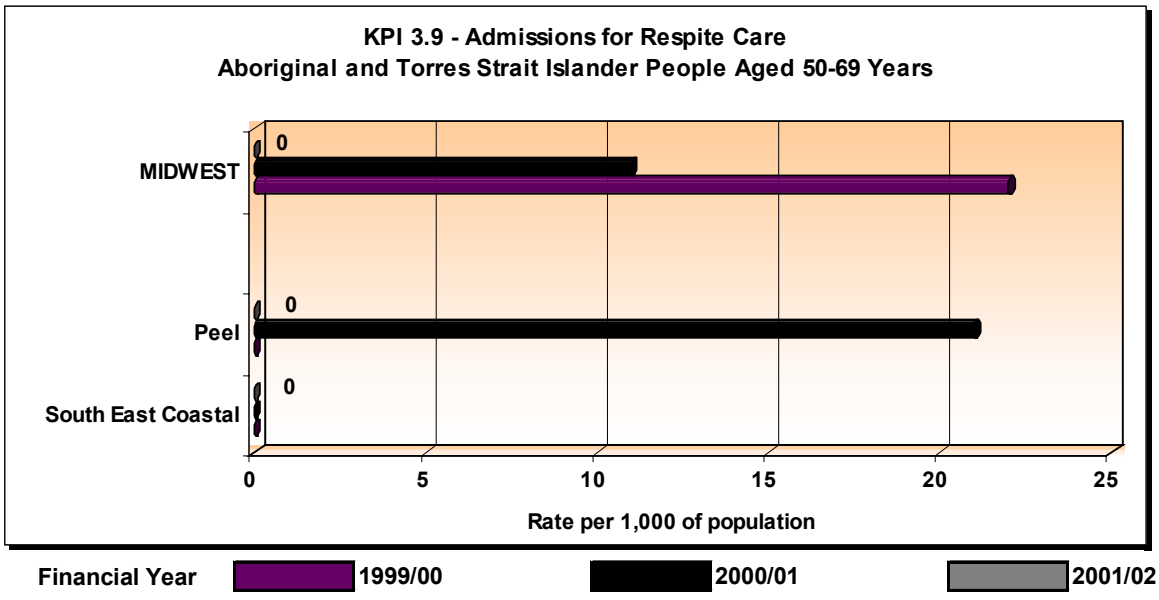
NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

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.

There were 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

NORTHAMPTON KALBARRI HEALTH SERVICES
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the accounts and financial statements of the Northampton Kalbarri Health Services 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

Northampton Kalbarri Health Services
Financial Statements for the year ended June 30, 2002

Audit Opinion
In my opinion,

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

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

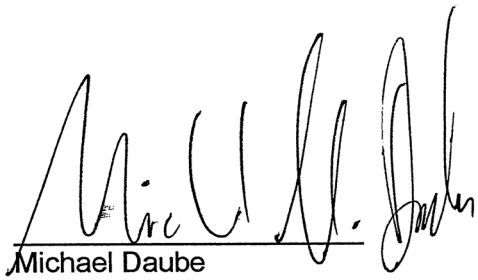
D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

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

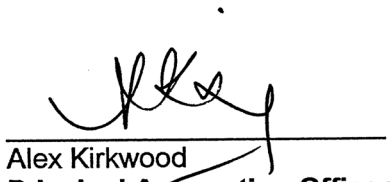
The accompanying financial statements of the Northampton Kalbarri Health Services have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June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

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Northampton Kalbarri
Health Services

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		1,796,225	1,668,188
Fees for visiting medical practitioners		120,261	132,538
Superannuation expense		153,614	123,794
Patient support costs	3	191,387	203,122
Patient transport costs		109,948	115,235
Repairs, maintenance and consumable equipment expense		115,898	225,180
Depreciation expense	4	204,835	214,804
Net loss on disposal of non-current assets	5	9,571	36,111
Capital user charge	6	476,306	0
Other expenses from ordinary activities	7	144,216	154,947
Total cost of services		3,322,261	2,873,919
Revenues from Ordinary Activities			
Patient charges	8	125,751	193,065
Commonwealth grants and contributions	9	0	2,075
Donations revenue	10	9,752	8,274
Interest revenue		1,617	10,201
Other revenues from ordinary activities	11	80,086	91,078
Total revenues from ordinary activities		217,206	304,693
NET COST OF SERVICES		**3,105,055**	**2,569,226**
Revenues from Government			
Output appropriations	12	3,155,424	1,955,170
Capital appropriations	12	0	133,497
Liabilities assumed by the Treasurer	13	9,766	123,712
Resources received free of charge	14	5,500	5,250
Total revenues from government		3,170,690	2,217,629
Change in net assets		**65,635**	**(351,597)**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**65,635**	**(351,597)**

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

Statement of Financial Position
As at 30th June 2002

	Note	2001/02 $	2000/01 $
CURRENT ASSETS			
Cash assets	15	12,420	7,755
Receivables	16	27,158	22,359
Inventories	18	42,420	43,547
Total current assets		81,998	73,661
NON-CURRENT ASSETS			
Amounts receivable for outputs	17	218,800	0
Property, plant and equipment	19	5,541,210	5,730,426
Total non-current assets		5,760,010	5,730,426
Total assets		**5,842,008**	**5,804,087**
CURRENT LIABILITIES			
Payables		20,862	101,158
Accrued salaries	20	35,879	26,503
Provisions	21	221,589	192,514
Total current liabilities		278,330	320,175
NON-CURRENT LIABILITIES			
Provisions	21	103,787	89,656
Total non-current liabilities		103,787	89,656
Total liabilities		**382,117**	**409,831**
Net Assets		**5,459,891**	**5,394,256**
EQUITY			
Asset revaluation reserve	22	1,195,112	1,195,112
Accumulated surplus	23	4,264,779	4,199,144
Total Equity		**5,459,891**	**5,394,256**

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

Statement of Cash Flows
For the year ended 30 June 2002

	Note	2001/02 $ Inflows (Outflows)	2000/01 $ Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT			
Output appropriations	24(c)	2,460,318	1,955,170
Capital contributions (2000/01 appropriation)	24(c)	0	62,976
Net cash provided by Government		2,460,318	2,018,146
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(892,518)	(724,731)
Employee costs		(1,755,398)	(1,615,295)
GST payments on purchases		(47,999)	(41,875)
GST payments to taxation authority		0	1,186
Receipts			
Receipts from customers		124,177	204,329
Commonwealth grants and contributions		0	2,075
Donations		3,825	4,949
Interest received		1,617	10,201
GST receipts on sales		9,422	1,063
GST receipts from taxation authority		37,315	36,916
Other receipts		83,169	84,183
Net cash (used in) / provided by operating activities	24(b)	(2,436,390)	(2,036,999)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	19	(19,263)	(23,225)
Net cash (used in) / provided by investing activities		(19,263)	(23,225)
Net increase / (decrease) in cash held		4,665	(42,078)
Cash assets at the beginning of the reporting period		7,755	49,833
Cash assets at the end of the reporting period	24(a)	12,420	7,755

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

Note 1 SIGNIFICANT ACCOUNTING POLICIES

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

(a) General Statement

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

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

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

(b) Output Appropriations

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

(c) Contributed Equity

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

(d) Acquisition of Assets

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

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

(e) Valuation of Non-Current Assets

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

i) Land and Non-Clinical Buildings

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

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

Recent valuations on this basis are equivalent to fair value.

ii) Clinical Buildings

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

(f) Depreciation of Non-current Assets

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

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

Buildings	50 years
Computer equipment	5 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).

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	1,156	1,835
Add Receipts		
- Patient Deposits	13,661	12,516
- Interest	0	1
	14,817	14,352
Less Payments		
- Patient Withdrawals	12,954	13,194
- Interest / Charges	3	2
Closing Balance	1,859	1,156
Note 3 Patient support costs		
Medical supplies and services	61,178	61,402
Domestic charges	20,740	32,579
Fuel, light and power	57,355	59,521
Food supplies	46,186	40,654
Purchase of external services	5,928	8,966
	191,387	203,122
Note 4 Depreciation expense		
Buildings	160,541	165,126
Computer equipment and software	6,547	8,655
Furniture and fittings	11,298	11,813
Motor vehicles	1,813	2,913
Other plant and equipment	24,636	26,297
	204,835	214,804
Note 5 Net (loss) on disposal of non-current assets		
(Loss) on disposal of non-current assets:		
Computer equipment and software	(2,427)	(8,653)
Furniture and fittings	(3,517)	(23,568)
Motor vehicles	(740)	0
Other plant and equipment	(2,887)	(3,890)
	(9,571)	(36,111)
Note 6 Capital user charge		
	476,306	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	21,959	19,779
Other employee expenses	3,434	2,620
Motor vehicle expenses	27,970	32,086
Insurance	11,551	10,811
Communications	22,160	30,434
Printing and stationery	12,265	19,494
Rental of property	10,258	0
Audit fees - external	9,262	8,250
Other	25,357	31,473
	144,216	154,947

	2001/02 $	2000/01 $
Note 8 Patient charges		
Inpatient charges	121,751	187,045
Outpatient charges	4,000	6,020
	125,751	193,065
Note 9 Commonwealth grants and contributions		
Immunisations	0	2,075
Note 10 Donations revenue		
General public contributions	9,752	8,274
Note 11 Other revenues from ordinary activities		
Rent from properties	5,134	6,331
Recoveries	47,966	34,161
Use of hospital facilities	7,714	9,869
Other	19,272	40,717
	80,086	91,078
Note 12 Government appropriations		
Output appropriations (I)	3,155,424	1,955,170
Capital appropriations (II)	0	133,497
	3,155,424	2,088,667

(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 Liabilities assumed by the Treasurer		
Superannuation	9,766	123,712

Note 14 Resources received free of charge

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

Office of the Auditor General		
- Audit services	5,500	5,250

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

Note 15 Cash assets		
Cash on hand	500	500
Cash at bank - general	9,550	2,982
Cash at bank - donations	2,370	4,273
	12,420	7,755
Note 16 Receivables		
GST receivable	3,899	5,964
Other receivables	23,259	16,395
	27,158	22,359

Note 17 Amounts receivable for outputs	2001/02 $	2000/01 $
Non-current	218,800	0

This asset represents the non-cash component of output appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Note 18 Inventories

Supply stores - at cost	21,224	34,080
Pharmaceutical stores - at cost	7,432	9,467
Engineering stores - at cost	13,764	0
	42,420	43,547

Note 19 Property, plant and equipment

Land		
At cost (i)	1,100	1,100
At valuation (ii)	55,000	55,000
	56,100	56,100
Buildings		
Clinical:		
At cost (i)	234,492	234,492
At valuation (ii)	7,190,000	7,190,000
Accumulated depreciation	(2,233,684)	(2,073,143)
	5,190,808	5,351,349
Computer equipment and software		
At cost	45,666	52,098
Accumulated depreciation	(29,461)	(26,919)
	16,205	25,179
Furniture and fittings		
At cost	168,618	157,313
Accumulated depreciation	(59,802)	(51,603)
	108,816	105,710
Motor vehicles		
At cost	109,190	110,190
Accumulated depreciation	(105,925)	(104,372)
	3,265	5,818
Other plant and equipment		
At cost	343,890	356,346
Accumulated depreciation	(177,874)	(170,076)
	166,016	186,270
Total of property, plant and equipment	5,541,210	5,730,426

Land and buildings

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

(ii) Land and clinical buildings have been subject to revaluations and are carried at their fair value.

Payments for non-current assets

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

Paid as cash by the Health Service from output appropriations	19,263	23,225
Paid by the Department of Health	0	36,520
Gross payments for purchases of non-current assets	19,263	59,745

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	56,100	56,100
Carrying amount at end of year	56,100	56,100
Buildings		
Carrying amount at start of year	5,351,349	5,516,475
Depreciation	(160,541)	(165,126)
Carrying amount at end of year	5,190,808	5,351,349
Computer equipment and software		
Carrying amount at start of year	25,179	27,374
Additions	0	15,113
Depreciation	(6,547)	(8,655)
Write-off of assets	(2,427)	(8,653)
Carrying amount at end of year	16,205	25,179
Furniture and fittings		
Carrying amount at start of year	105,710	125,706
Additions	17,921	15,385
Depreciation	(11,298)	(11,813)
Write-off of assets	(3,517)	(23,568)
Carrying amount at end of year	108,816	105,710
Motor vehicles		
Carrying amount at start of year	5,818	7,731
Additions	0	1,000
Disposals	(740)	0
Depreciation	(1,813)	(2,913)
Carrying amount at end of year	3,265	5,818
Other plant and equipment		
Carrying amount at start of year	186,270	188,210
Additions	7,269	28,247
Depreciation	(24,636)	(26,297)
Write-off of assets	(2,887)	(3,890)
Carrying amount at end of year	166,016	186,270

Note 20 Accrued salaries

Amounts owing for:	35,879	26,503
Nursing staff		
7 days from 24 June to 30 June 2002		
(2001: 6 days from 25 June to 30 June 2001)		
Non-nursing staff		
7 days from 24 June to 30 June 2002		
(2001: 6 days from 25 June to 30 June 2001)		

Note 21 Provisions

Current liabilities:		
Annual leave	163,740	152,590
Long service leave	57,849	39,924
	221,589	192,514
Non-current liabilities:		
Long service leave	103,787	89,656
	103,787	89,656
Total employee entitlements	325,376	282,170

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.

	2001/02 $	2000/01 $
Note 22 Asset revaluation reserve		
Balance at beginning of the year	1,195,112	1,195,112
Balance at end of the year	1,195,112	1,195,112
Note 23 Accumulated surplus		
Balance at beginning of the year	4,199,144	4,550,741
Change in net assets	65,635	(351,597)
Balance at end of the year	4,264,779	4,199,144

Note 24 Notes to the statement of cash flows

a) **Reconciliation of cash**

Cash assets at the end of the reporting period as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:

Cash assets (Refer note 15)	12,420	7,755

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)	(2,436,390)	(2,036,999)
Increase / (decrease) in assets:		
GST receivable	(2,065)	5,964
Other receivables	6,864	(4,063)
Inventories	(1,127)	14,891
Prepayments	0	(3,613)
Decrease / (increase) in liabilities:		
Payables	80,296	(80,138)
Accrued salaries	(9,376)	87
Provisions	(43,206)	(51,477)
Non-cash items:		
Depreciation expense	(204,835)	(214,804)
Profit / (loss) from disposal of non-current assets	(9,571)	(36,111)
Capital user charge paid by Department of Health	(476,306)	0
Donation of non-current assets	5,927	0
Superannuation liabilities assumed by the Treasurer	(9,766)	(123,712)
Resources received free of charge	(5,500)	(5,250)
Other	0	(34,001)
Net cost of services (Statement of Financial Performance)	(3,105,055)	(2,569,226)

c) Notional cash flows

Output appropriations as per Statement of Financial Performance	3,155,424	1,955,170
Capital appropriations as per Statement of Financial Performance	0	133,497
	3,155,424	2,088,667
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:		
Capital user charge	(476,306)	0
Other non cash adjustments to output appropriations	(218,800)	(70,521)
	(695,106)	(70,521)
Output appropriations as per Statement of Cash Flows	2,460,318	2,018,146

Note 25 Revenue, public and other property written off or presented as gifts

a) Revenue and debts written off.	90	0
b) Public and other property written off.	33,773	114,544

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

Note 26 Remuneration of members of the accountable authority and senior officers

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

	2001/02	2000/01
$50,001 - $60,000	1	0
$60,001 - $70,000	0	1
Total	1	1
	$	$
The total remuneration of senior officers is:	53,547	64,594

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

Note 27 Explanatory statement

a) **Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.**
Details and reasons for significant variations between actual results and the corresponding items of the preceding year are detailed below. Significant variations are considered to be those greater than 10%.

	2001/02 $	2000/01 $	Variation $
Expenditure			
Superannuation	153,614	123,794	29,820
Repairs and maintenance	115,898	225,180	(109,282)
Revenue			
Patient charges	125,751	193,065	(67,314)
Interest	1,617	10,201	(8,584)
Other Revenue	80,086	91,078	(10,992)

Explanation for variance	
Expenditure	
Superannuation	Increased percentage rate.
Repairs and maintenance	Prior year expenditure high, (Nurse Quarters upgrade, re-carpeting of Hospital and accrued expenditure for medical equipment.
Revenue	
Patient charges	Decrease in private inpatient activity.
Interest	Decrease in average balance of funds held by Health Service.
Other revenue	Prior year included once-off funding from DoH.

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			
Superannuation	153,614	125,000	28,614
Repairs and maintenance	115,898	97,000	18,898
Other expenses	144,216	185,000	(40,784)
Revenue			
Patient charges	125,751	182,000	(56,249)
Interest	1,617	5,000	(3,383)

Explanation for variance	
Expenditure	
Superannuation	Higher than anticipated cost of award increases.
Repairs and maintenance	Under estimate of cost of repairs and maintenance.
Other expenses	General decrease in administration costs.
Revenue	
Patient charges	Decrease in private inpatient activity.
Interest	Decrease in average balance of funds held by Hospital.

Note 28 Commitments for Expenditure	2001/02 $	2000/01 $
a) **Operating lease commitments:** Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	4,639	19,687
Later than one year, and not later than five years	21,589	17,632
	26,228	37,319

Note 29 Contingent liabilities

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

Note 30 Events occurring after reporting date

The Northampton Kalbarri 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 31 Related bodies

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

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

Note 32 Affiliated bodies

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

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

Note 33 Financial instruments

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

	Weighted average effective interest rate %	Variable interest rate $000	Fixed interest rate maturities: Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2002							
Financial Assets							
Cash assets	1.4%	11	0	0	0	1	12
Receivables	0.0%	0	0	0	0	27	27
		11	0	0	0	28	39
Financial Liabilities							
Payables	0.0%	0	0	0	0	21	21
Accrued salaries	0.0%	0	0	0	0	36	36
Provisions	0.0%	0	0	0	0	325	325
		0	0	0	0	382	382
Net financial assets / (liabilities)		11	0	0	0	(354)	(343)
As at 30th June 2001							
Financial Assets							
Cash assets	0.2%	7	0	0	0	1	8
Receivables	0.0%	0	0	0	0	22	22
		7	0	0	0	23	30
Financial Liabilities							
Payables	0.0%	0	0	0	0	101	101
Accrued salaries	0.0%	0	0	0	0	27	27
		0	0	0	0	128	128
Net financial assets / (liabilities)		7	0	0	0	(105)	(98)

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

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

Note 34 Output information

	Prevention & Promotion		Diagnosis & Treatment		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	251	234	1,275	1,184	269	250	1,796	1,668
Fees for visiting medical practitioners	17	19	85	94	18	20	120	133
Superannuation expense	22	17	109	88	23	19	154	124
Patient support costs	25	28	138	144	28	31	191	203
Patient transport costs	15	16	78	82	16	17	110	115
Repairs, maintenance and consumable equipment expense	16	32	82	160	17	34	116	225
Depreciation expense	29	30	145	153	31	32	205	215
Net loss on disposal of non-current assets	2	0	7	36	1	0	10	36
Capital user charge	67	0	338	0	71	0	476	0
Other expenses from ordinary activities	20	22	102	110	22	23	144	155
Total cost of services	464	397	2,360	2,051	498	426	3,322	2,874
Revenues from Ordinary Activities								
Patient charges	18	27	89	137	19	29	126	193
Commonwealth grants and contributions	0	0	0	1	0	0	0	2
Donations revenue	1	1	7	6	1	1	10	8
Interest revenue	0	1	1	7	0	2	2	10
Other revenues from ordinary activities	11	13	57	65	12	14	80	91
Total revenues from ordinary activities	30	43	154	216	33	46	217	305
NET COST OF SERVICES	**434**	**354**	**2,206**	**1,834**	**465**	**380**	**3,105**	**2,569**
Revenues from Government								
Output appropriations	442	274	2,240	1,388	473	293	3,155	1,955
Capital appropriations	0	19	0	95	0	20	0	133
Liabilities assumed by the Treasurer	1	17	7	88	1	19	10	124
Resources received free of charge	1	1	4	4	1	1	6	5
Total revenues from government	444	310	2,251	1,575	476	333	3,171	2,218
Change in net assets	**10**	**(44)**	**45**	**(260)**	**10**	**(48)**	**66**	**(351)**

Note 34 Output information (continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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